University of the Western Cape

Faculty of Community and Health Sciences

A CONCEPTUAL FRAMEWORK FOR NURSE EDUCATIONALISTS AND PROFESSIONAL NURSES TO FACILITATE PROFESSIONALISM AMONG UNDERGRADUATE LEARNER NURSES FOR NURSING PRACTICE IN THE WESTERN CAPE

Student Name: Portia Benita Bimray

Student Number: 8941299

A dissertation submitted in fulfilment of the requirements for the degree of Doctor Philosophiae in the School of Nursing, University of the Western Cape.

Supervisor: Prof K Jooste

Date: April 2017

DECLARATION

I, Portia Benita Bimray, declare that this research study titled "A conceptual framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape", is my own original work. It has not been submitted before for any degree or examination at any other university and all the sources that I have used or quoted are indicated and acknowledged as complete references.

Portia Benita Bimray
Student number: 8941299

Signature ……
Date ……

This thesis has been read and approved for submission by:

Prof Karien Jooste

Supervisor

Signature ……

Date ……

ABSTRACT

Learner nurses are socialised into the professional nursing culture through a formal undergraduate nursing programme, where the professional values of nursing are instilled in them throughout their four-year training. During the four years, learner nurses are prepared by nurse educationalists (nurse educators and clinical supervisors) and professional nurses to become professional to render a quality nursing service. This is in spite of the pressures and challenges related to the ever-changing socio-economic and political climate that influence the health context within which these nurses practice. The researcher became aware of a growing number of complaints from various stakeholders in the nursing profession in the Western Cape about the unprofessional conduct of learner nurses. Nurse educators and professional nurses in practice also complained that learner nurses had not developed professionalism by the end of their 4th years of the nursing programme. Perceptions of nursing professionals were that graduate nurses did not conduct themselves in a professional manner after they had completed the formal undergraduate nurses training programme. From these problems, it became evident that a clear framework for professionalism should be developed for nurse educationalists and professional nurses to facilitate professionalism in undergraduate learner nurses for nursing practice in the Western Cape. The purpose of this study was to develop a conceptual framework for nurse educationalists and professional nurses with which they can facilitate professionalism in undergraduate learner nurses of the nursing practice in the University of the Western Cape. The study departed within the paradigm of the professionalism taxonomy of Brown and Ferrill (2009) and Dickoff, James and Wiedenbach (1968).

An exploratory, descriptive and contextual qualitative design with a case study method was followed. The study population who were selected by means of purposive sampling technique consisted of three cases; (i) learner nurses, (ii) nurse educationalists and (iii) professional nurses. The study was conducted in *two phases*. In *Phase 1* (Objective 1), the accessible population was all learner nurses (Case 1) (N=886) undertaking the undergraduate four-year nursing programme at a university in the Western Cape. Objective 1 of the study was to explore and describe the experiences of learner nurses on professionalism during their undergraduate programme at a higher education institution in the Western Cape (Case 1). Non-probability purposive sampling was followed by selecting 1st to 4th year learner nurses to partake in focus groups. Two pilot focus groups were conducted. In total eight focus group interviews (including the pilot interviews) with between three to nine participants in a group were conducted until data saturation occurred. Interviews were never longer than 1 hour.

Objective 2 explored and described how nurse educationalists and professional nurses can facilitate professionalism among learner nurses for nursing practice in the Western Cape. For Objective 2 in Phase 1, all (i) nurse educationalists (nurse educators (n=26) and clinical facilitators (n=34)) of a school of nursing (Case 2), and (ii) professional nurses (n=180) of four training hospitals served as the accessible population (Case 3). Purposive sampling was used to select the sample, which consisted of nurse educationalists (nurse educators (n=8) and clinical facilitators (n=10)) of a school of nursing and professional nurses (n=18) of four training hospitals. Sixteen focus group interviews (between three to nine participants in each) and six unstructured individual interviews were conducted to gather data.

In Phase 2 of the study, a conceptual framework was developed based on the findings of Phase 1. Data in Phase 1 were analysed through cross-case synthesis. Data triangulation between transcripts of the focus group interviews, unstructured individual interviews and field notes was performed. Data reconstruction was achieved by using theory generation as proposed by Dickoff et al. (1968:423) as described under theoretical assumptions. The conceptual framework described the findings of the cross-case analysis of the themes, categories, and sub-categories of the three cases, learner nurses, nurse educationalists and professional nurses. The three cases were treated separately and aggregated into the overall case that informed the conceptual framework Chapter 7.

Six themes emerged from the cross-case analysis of the data in Phase 1 and were confirmed by the literature in Chapter 6.

The findings from *Phase 1* of the cross-case analysis show that the three cases (learner nurses, nurse educationalists and professional nurses) had varied experiences of nursing professionalism in the academic and clinical learning contexts. They were mindful that diversity in terms of culture, language and socio-economic background and the generational gap create challenges for developing professionalism in the nursing practice in a changing era.

Theme 1 indicated that nurses should demonstrate their professional values during interactions with authorities, fellow colleagues and patients. These professional values are necessary for respectful interaction with nurse authorities, fellow colleagues and patients and are categorised within the domains of professional capabilities, interpersonal compatibility and personal reliability.

Theme 2 focused on the interpersonal communication style of nurses with all stakeholders in the external environment. Verbal and non-verbal communication skills, assertiveness, entire image, professional dress code and demeanour reflected in practice and class were regarded as essential

aspects of how professionalism should be displayed by all stakeholders in higher nursing education and nursing practice.

Theme 3 indicated that the realisation of essential role modelling in different settings is needed. The findings brought to the fore that learner nurses should be orientated when they enter the clinical learning environment so that they feel part of the team of nurses. Proper orientation and the provision of information on what is expected of them in the patient care wards were articulated as essential in assisting learner nurses in developing professionalism. Learner nurses expected that the proper professional conduct and commitment to patient care be demonstrated by the professional nurses in practice as these qualities were essential in influencing learner nurses to conform and adapt to ethical and professional behaviour during their placement in the clinical learning environment.

Theme 4 addressed support mechanisms to promote professionalism in learner nurses. The findings from this theme emphasise the importance of allowing learner nurses to practice the clinical skills at the appropriate year level in the clinical environment in order for them to gain competence in practice. In addition, the organisational structures of the school of nursing of a higher education institution and the healthcare institution should be improved to address the learning needs of the learner nurses. These mechanisms should include mentorship in practice for academic and emotional support.

All nurses need to be mindful in nursing practice (Theme 5). Self-awareness and self-realisation were mentioned as essential skills for the learner nurse's internalisation and development of professional behaviour.

Theme 6 recognised the teaching and learning needs (in both theory and practice) for professional development of the new generation and the historical heritage of the profession. The findings of this category revealed that there should be consideration of diversity in culture, background and socio-economic environment, and that scaffolding of learning and more experiential learning to internalise professional values and reinforcements (such as rewards to promote professionalism) are needed. The expectation that nurse educators and professional nurses should work towards bridging the gap between theory and practice was also expressed.

Conclusions (Annexures R, S, T) were made for the three cases in Chapters 4 and 5, which led to the overall case (Chapter 6). This case was conceptualised in literature (Chapter 6) and then informed the conceptual framework for nurse educationalists and professional nurses to facilitate professionalism in undergraduate learner nurses in the Western Cape that originated in this study.

In *Phase 2* (Chapter 7), the data of Phase 1 was conceptualised in the theoretical framework of Dickoff, James and Wiedenbach (1968). The survey list of Dickoff et al. (1968) formed the foundation of the reasoning map for the development of the framework. The *agents* (nurse educationalists, primary agent) and professional nurses (secondary agents) were identified as leaders with the roles of mentor, advocate and counsellor who engender support and role model professional behaviour and effective interpersonal communication. In addition, the findings emphasised the characteristics that should enable an agent to carry out the identified roles. The characteristics (professional values) of the agent were categorised according to the professionalism taxonomy of Brown and Ferrill (2009) with the three domains i.e. connection (interpersonal compatibility), competence (professional capability) and character (personal reliability).

These three domains host the expected professional values that should be present in both the agent and the recipient that may lead to the desired professional behaviour required for professional practice. The *recipient* is an undergraduate learner nurse who is in need of support from both the primary and secondary agent to develop nursing professionalism through preparation at an institution of higher education that includes clinical nursing practice at healthcare facilities where nursing care is rendered. The recipient thus interacts and functions from within an internal environment that hosts the three domains of the professionalism taxonomy of Brown and Ferrill (2009); and in an external environment. The internal environment is described as body, mind and spirit, whereas the external environment refers to the context of a professional, ethical-legal nursing practice environment; the Higher Education Institution (academic environment); Nursing Practice environment; socio-economic-cultural environment and the influence of the 21st century generation on the professional behaviour of the recipient. The researcher discussed the *context* of the study while reflecting on the contextual realities in which nursing education and nursing practice take place (diversity, socio-economic and cultural background, the generational gap, professional ethical-legal framework within which nursing care is carried out and the new generation in the 21st century). The *underlying dynamics,* pointed out as necessary for the attainment of professionalism in undergraduate learner nurses, are described in terms of mindfulness and having a caring approach. The *procedure to* be used by the agents is the provision of support mechanisms, a good interpersonal style of communication, professional development and role modelling, which will facilitate professionalism in undergraduate learner nurses.

In Chapter 8, the researcher concludes with a brief overview of the research process, the dissemination plan of the outcome of the findings of the research study and recommendations for the utilization of the framework to improve nursing practice, nursing education and nursing

research. These recommendations are made in accordance with the findings of the study and the researcher's knowledge and expertise.

In the study, trustworthiness was ensured through credibility, transferability, dependability and conformability. Ethical principles such as autonomy, written consent, no harm and beneficence, justice, withdraw, privacy and confidentiality, were followed throughout the study.

The unique contribution of the study was in the field of nursing and is important for several reasons. First, this study is of relevance to nursing education and nursing practice in preparing nursing graduates for their future careers and service in a dynamic, yet unpredictable environment in which the professional values of the nursing profession could be compromised. Second, the study provides input into the implementation of the Provincial Nursing Strategy to address challenges faced by the nursing profession in the Western Cape in facilitating professionalism in professional nursing practice. Nurse educationalists (nurse educators and clinical facilitators) and professional nurses in practice have the responsibility to support learner nurses as competent professionals who will maintain the quality and commitment of the profession. This study developed an original conceptual framework to assist nursing educationalists and professional nurses to support learner nurses in developing and enhancing professionalism in nursing practice. This conceptual framework is also methodological unique as it incorporates the experiences of participants in three cases, representing the main stakeholders in the practice of nursing and education.

DEDICATION

This dissertation is dedicated to my children, Tamaryne and Sebastian. Thank you for staying focused on your academic achievements throughout the most difficult times of your developmental stages while I could not always give my full attention to your needs during my studies. Sometimes when you walk alone, it is the time when you grow the most because you depend on the small seed called faith. May this scholarly work inspire you to never start something that you will not finish. Persevere, work hard, and believe that you have the ability to reach any dream. Put your trust in the One who gives you strength to carry on, because, in the end, our purpose should always be to work to the honour and glory of God's Kingdom on earth.

ACKNOWLEDGEMENTS

I have to start with thanksgiving to the Lord who is omnipotent and whose presence surrounds me wherever I go, day and night. Thank you Lord Jesus, for guiding me through it all, for giving me strength to continue and for your tender mercies of forgiveness at times when I doubted and had little faith in trusting You. Thank You for the blessings of knowledge, wisdom, compassion, love and care that you provided throughout this work and continue to bless me with. May I use this work to the benefit of Your people here on earth in honour and glory of Your Holy Name. Amen.

To my supervisor Professor Karien Jooste: Prof., I cannot thank you enough for the many hours you spent reading and correcting my work. You are a person of precision and integrity who requests excellence. Thank you for inspiring me with your leadership qualities and being a role model and mentor to me.

My sincere appreciation goes to my co-supervisor, Professor Hester Julie, for her contribution, encouragement and spiritual messages of hope that carried me.

Thank you to Professor Susan Terblanche for assisting me with the data analysis, as well as for her support and advice.

I want to thank the participants (learner nurses, nurse educators, clinical supervisors and professional nurses) who made the research study possible by sharing their experiences. Thanks also to Gava Cassiem for transcribing the voice recordings of the focus group interviews and the individual interviews.

To Helene van Niekerk: Thank you for the editing and technical presentation of my dissertation.

I also want to convey my sincere gratitude to my study buddies. Juliana Willemse: for your continuous motivation. You were my pillar that I leaned on at times when I thought I was going to give up. Thank you also to Vatiswa Makie and Beryl Swartz. We travelled this road together.

To the fellow members of the leadership group: Dr. Luke Arunachallum, Mnr Jeffrey Hoffman, Mrs Hazel Rashe, Mrs Ilhaam Essa, former member Mrs Loretta le Roux, Ms Shahnaaz Mia, Mrs Harriet Ekole, Professors Karien Jooste and Hester Julie – thank you for your support and encouragement.

I want to extend my thanks to the lecturers and administrative staff of the school of nursing for their interest in my research and encouragement. Special thanks go to Annelene Traut for opening the door of my nursing education career at UWC in 2004. Annelene Traut challenged me to take up a temporary post at the time when three universities (Stellenbosch, Cape Town and Western Cape) merged and the common teaching platform was established. Thank you, Annelene, I am indebted to you.

And then to the other colleagues at Stellenbosch University: thank you for the role you played in my professional development. Returning to nursing practice in 2002 after being a stay-at-home mom for five years was not easy, but you gave me an opportunity to develop my skills for a career in higher education. Sincere thanks go to Professor Berine Welmann and Doctor Ethelwyn Stellenberg.

To my husband, Godwin: Thank you for all the sacrifices you had to make in our marriage. For the weekends you wanted to go away and we couldn't, for taking care of the rest of the family when I was too busy, for taking care of our daughter's matric ball shopping and attending all the karate events of our son without me. I will always be indebted to you because of all these sacrifices you made. Thank you for your love and for supporting me all the way.

To my children, Tamaryne and Sebastian: You are my biggest fans. Thank you for always cheering me on. Thank you for understanding the times I could not be there for you when you needed me. All of this was to teach you that no matter how long, how difficult, how impossible things seem – don't stop, carry on. Success is just around the corner. Believe in yourself.

To my mom and dad: I have appreciated you from the day I was born. You were always and are still there for me. You never say no. How grateful I am that you can experience and share in this joy of mine. This accolade goes to you. I hope I make you proud.

Words of gratitude go out to all my family and friends for your support and understanding.

To my dearest aunt Jackie and David Adonis: Words cannot express how grateful I am to you for always being there for me and for being my support through thick and thin. You were just a phone call away. You never judged me and you stood by me when I needed you most. Thank you.

And then last but not least. Thank you to all the special ladies who took care of the household: Joan, Agnes, Elsie, Johanna, Ragel, Magriet, Wilma and all the others. Thank you that you kept the house in order. I am most grateful to you for taking over as mother, cook and cleaner. Without all of you I would not have coped.

Thank you. Thank you.

May God bless you all!

CONTENTS

DECLARATION ..... **ii**
ABSTRACT ..... **iii**
DEDICATION ..... **viii**
ACKNOWLEDGEMENTS ..... **viii**
CONTENTS ..... **xi**
TABLES ..... **xix**
FIGURES ..... **xx**
ACRONYMS AND ABBREVIATIONS ..... **xxi**
CHAPTER 1 ..... **1**
ORIENTATION TO THE STUDY **1**
1.1 INTRODUCTION AND RATIONALE **1**
1.2 BACKGROUND TO PROFESSIONALISM IN NURSING **2**
1.2.1 The professional culture of nursing **2**
1.2.2 The legal and ethical framework of professionalism within the South African context **3**
1.3 BACKGROUND TO THE PROBLEM **4**
1.4 PROBLEM STATEMENT **6**
1.5 AIM OF THE STUDY **8**
1.6 OBJECTIVES OF THE STUDY **8**
1.7 PARADIGM AND ASSUMPTIONS **8**
1.7.1 Meta-theoretical assumptions **9**
1.7.2 Theoretical assumptions **10**
1.7.2.1 *Professionalism according to Brown and Ferrill (2009)* 10
1.7.2.2 *Practice oriented theory* 11
1.7.2.3 *Other definitions* 13
1.7.3 Methodological assumptions **14**
1.8 RESEARCH APPROACH **15**
1.8.1 Research design **15**
1.8.2 Case study method **16**

1.9 RESEARCH METHODS 17
1.9.1 Data gathering 17
1.9.1.1 *Phase 1: Situational analysis* 17
1.9.2 Data analysis 18
1.9.2.1 *Phase 2: The development of the conceptual framework* 19
1.9.2.2 Validation of the conceptual framework 19
1.10 TRUSTWORTHINESS 19
1.11 ETHICAL CONSIDERATIONS 20
1.12 CONTRIBUTION AND IMPORTANCE OF THE STUDY 21
1.13 LAYOUT OF THE REPORT 22
1.14 CONCLUSION 22
CHAPTER 2 25
OVERVIEW OF FRAMEWORKS, MODELS, THEORIES, PROGRAMMES AND GUIDELINES RELATED TO PROFESSIONALISM IN NURSING AND HEALTH 25
2.1 INTRODUCTION 25
2.2 TERMS OF PROFESSION, PROFESSIONAL, PROFESSIONAL VALUES, PROFESSIONALISM, ETHICS AND PROFESSIONAL VALUES 26
2.2.1 Profession, "a professional" and professional values 26
2.2.2 Defining professionalism 27
2.2.3 Ethics 31
2.3 PROFESSIONAL VALUE FRAMEWORKS 33
2.4 FRAMEWORKS AND VIEWS ON CRITERIA, MODELS AND THEORIES RELATED TO PROFESSIONALISM 33
2.4.1 Frameworks for professionalism 34
2.4.1.1 *International views on professionalism in nursing and other health professions* . 34
2.5 PROFESSIONAL STANDARDS OF PRACTICE AS FRAMEWORK FOR PROFESSIONALISM 36
2.6 MODELS OF PROFESSIONALISM 40
2.6.1 The Wheel of Professionalism in Nursing (Miller) 40
2.6.2 Hall's Care, Cure and Core model 40
2.6.3 Hall's (1968) Professionalism Model 41
2.7 THEORIES 42
2.7.1 Theory of professionalism in midwifery 42

2.8 PROGRAMMES AND GUIDELINES ON PROFESSIONALISM 43
2.8.1 The BEST Programme 43
2.8.2 Best Practice Guidelines on Professionalism in Nursing (Ontario) 44
2.8.3 The International Council of Nurses (ICN) 45
2.8.4 The Thai Nurses' Association Code of Ethics 46
2.8.5 The code of ethics for nursing practitioners in South Africa: excellence in professionalism and advocacy for healthcare users 46
2.9 CONCLUSION 47
CHAPTER 3 48
RESEARCH METHODOLOGY 48
3.1 INTRODUCTION 48
3.2 PARADIGM 49
3.2.1 Qualitative versus quantitative paradigms 49
3.3 RESEARCH DESIGN 51
3.3.1 Qualitative design 51
3.3.2 Exploratory design 51
3.3.3 Descriptive design 51
3.3.4 Contextual design 52
3.3.5 Case study research method 52
3.3.6 Study setting 54
3.3.7 Research population 59
3.3.8 Sampling technique and sample 59
3.3.9 Sampling criteria 60
3.4 RESEARCH METHOD 66
3.4.1 Preparation for the study field 66
3.4.1.1 *Pilot interviews* 68
3.4.2 Phase 1: Data collection 68
3.4.2.1 *Focus group interviews (Phase 1, Objectives 1 and 2)* 68
3.4.2.2 *Unstructured individual interviews (Phase 1 Objective 2)* 70
3.4.2.3 *Field notes of interviews* 71
3.4.3 The role and skills of the researcher during data gathering 71
3.4.3.1 *Active listening* 72
3.4.3.2 *Minimal verbal response* 72
3.4.3.3 *Clarifying* 72

3.4.3.4 *Paraphrasing* 73
3.4.3.5 *Probing* 73
3.4.3.6 *Summarising* 73
3.4.4 Data analysis of the cases in Phase 1 73
3.4.4.1 *Collecting the data* 74
3.4.4.2 *Organising the data* 74
3.4.4.3 *Reading and memoing* 75
3.4.4.4 *Describing, classifying and interpreting data into codes and themes* 75
3.4.4.5 *Interpreting the data* 76
3.4.4.6 *Representing and visualising the data* 76
3.4.4.7 *The use of a "thick description"* 76
3.4.5 Phase 2: Development of the conceptual framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses 77
3.4.6 Identifying and naming themes and categories 77
3.4.7 Deconstructing and categorising the concepts 77
3.4.8 Integrating concepts 77
3.4.9 Synthesis, re-synthesis and clarification of the concepts 77
3.4.10 Validation of the conceptual framework 78
3.5 REASONING STRATEGIES 79
3.6 MEASURES TO ENSURE TRUSTWORTHINESS 82
3.7 ETHICAL CONSIDERATIONS 83
3.8 CONCLUSION 86
CHAPTER 4 88
DISCUSSION OF RESULTS OF THE LEARNER NURSES IN PHASE 1 .. 88
4.1 INTRODUCTION 88
4.2 OVERVIEW OF THE PARTICIPANTS (PHASE 1) 88
4.2.1 Case 1: Learner nurses (first to fourth year) 92
4.2.1.1 Theme 1: First- and second-year participants experienced role modelling of unprofessional behaviour of specific nurse practitioners in specific settings 94
4.2.1.2 Theme 2: First- and second-year participants' perceptions and experiences of language barriers in the development of professional behaviour 106
4.2.1.3 Theme 3: Practitioners' prejudice towards degree students 108
4.2.1.4 Theme 4: Participants' understanding of professional behaviour 109

4.2.1.5 Theme 5: Participants experience students' professional behaviour as contributing to the image of the university degree students 120
4.2.1.6 Theme 6: Reasons for and implications of students and practitioners' unprofessional behaviour and suggestions for improvement 121
4.3 CONCLUSION 127
CHAPTER 5 128
RESULTS OF THE NURSE EDUCATIONALISTS (NURSE EDUCATORS AND CLINICAL SUPERVISORS) AND PROFESSIONAL NURSES IN PHASE 1 128
5.1 INTRODUCTION 128
5.2 FINDINGS OF CASE 2: NURSE EDUCATIONALISTS 128
5.2.1 Theme 1: Nurse educators' and clinical supervisors' expectations of professional behaviour 130
5.2.2 Theme 2: Suggestions to improve professionalism in nursing 137
5.3 FINDINGS CASE 3: PROFESSIONAL NURSES 143
5.3.1 Theme 1: Professional nurses' perceptions/experiences of unprofessional behaviour of university students 144
5.3.2 Theme 2: Expectations and experiences of professional behaviour in practice 145
5.3.3 Theme 3: Professional nurses' roles in enhancing/strengthening students' professional behaviour 152
5.3.4 Theme 4: Obstacles in mentoring and monitoring students' professional behaviour 155
5.3.5 Theme 5: Suggestions to support/enhance students' professional behaviour 157
5.4 SUMMARY OF THE OVERALL CASE 160
5.5 CONCLUSION 162
CHAPTER 6 163
FINDINGS ON AND CONCEPTUALISATION OF THE CROSS-CASE ANALYSIS 163
6.1 INTRODUCTION 163
6.2 DISCUSSION OF THE FINDINGS OF THE CROSS-CASE ANALYSIS 163

6.2.1 Nurses should demonstrate their professional values during interactions with authorities, fellow colleagues and patients 165
6.2.1.1 *Interpersonal compatibility* 165
6.2.1.2 *Professional (capabilities) competencies reflected in practice and class* 171
6.2.1.3 *Characteristics of personal reliability in professionalism* 173
6.2.2 Interpersonal communication style of nurses with all stakeholders in the external environment 177
6.2.2.1 *Displaying verbal and non-verbal communication skills* 178
6.2.2.2 *Assertiveness (interpersonal compatibility)* 180
6.2.2.3 *Total image, professional dress code and demeanour reflected in practice and classroom* 181
6.2.3 Realisation of essential role modelling in different settings 182
6.2.3.1 *Orientation to clinical placement environments* 183
6.2.3.2 *Conduct and commitment to patient care* 183
6.2.3.3 *Conforming and adapting to unethical and unprofessional behaviour* 184
6.2.4 Support mechanisms to promote professionalism in learner nurses 185
6.2.4.1 *Gaining appropriate clinical competence in practice* 185
6.2.4.2 *Improving organisational structures* 186
6.2.4.3 *Mentorship in practice for academic and emotional support* 191
6.2.5 All nurses should be mindful in nursing practice 192
6.2.5.1 *Self-awareness and self-realisation to internalise and develop professional behaviour in the learner nurse* 192
6.2.6 Recognition of the teaching and learning (educational needs) processes involved in the professional development of the new generation 193
6.2.6.1 *Diversity in culture, background, social economic environment and changing times (the use of technology)* 194
6.2.6.2 *Scaffolding learning (reinforcement each year)* 195
6.2.6.3 *More experiential learning to identify with and internalise professional values* 196
6.2.6.4 *Consistent reinforcements to promote professionalism: teaching strategies in practice and theory* 197
6.2.6.5 *Educators and Clinical Supervisors should work towards bridging the gap between theory and practice* 198
6.3 CONCLUSION 198
CHAPTER 7 200

CONCEPTUAL FRAMEWORK FOR NURSE EDUCATIONALISTS AND PROFESSIONAL NURSES TO FACILITATE PROFESSIONALISM AMONG UNDERGRADUATE LEARNER NURSES FOR NURSING PRACTICE IN THE WESTERN CAPE 200

7.1 INTRODUCTION 200

7.2 CONCEPTUAL FRAMEWORK 202

7.2.1 Context of professionalism 202

7.2.1.1 *The higher education institution and the nursing practice environment* 203

7.2.1.2 *The South African Nursing Council* 203

7.2.1.3 *Professional, ethical-legal framework of nursing* 204

7.2.1.4 *The new generation* 208

7.2.2 Agent: Who or what performs the activity 209

7.2.2.1 *The characteristics of the agent* 211

7.2.3 Recipient: Who or what is the recipient of the activity? 220

7.2.3.1 *Characteristics of the recipient* 223

7.2.3.2 *The role of the recipient* 227

7.2.4 Underlying dynamics: What is the energy source for the activity (physical, biological or psychological)? 228

7.2.4.1 *Caring* 229

7.2.4.2 *Mindfulness as an underlying dynamic of professionalism* 230

7.2.5 Procedure: What is the guiding procedure, technique, or protocol for the activity (processes)? 232

7.2.5.1 *Role modelling* 232

7.2.5.2 *Promoting interpersonal communication* 235

7.2.5.3 *Professional development* 237

7.2.5.4 *Support mechanisms* 240

7.2.6 Terminus: What is the end point of the activity? 245

7.3 VALIDATION OF THE CONCEPTUAL FRAMEWORK 247

7.4 CONCLUSION 248

CHAPTER 8 250

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY 250

8.1 INTRODUCTION 250

8.2 OVERVIEW OF THE RESEARCH PROCESS AND CONCLUSIONS 250
8.3 RECOMMENDATIONS FROM THE STUDY 252
8.3.1 Dissemination plan 252
8.3.2 Recommendations for the agent (nurse educationalist and professional nurses) 253
8.3.3 Recommendations for nursing practice, nursing education, nursing research and community 255
8.3.3.1 *Nursing practice* 255
8.3.3.2 *Nursing education* 256
8.3.3.3 *Nursing research* 257
8.3.3.4 *Original contribution of the study* 257
8.4 LIMITATIONS 258
8.5 CONCLUSION 258
References 260
ANNEXURES 298

TABLES

Table 1.1: Framework of the study 24
Table 2.1: Summary of definitions on professionalism 31
Table 3.1: Main places of the City of Cape Town Metropolitan Municipality area 56
Table 3.2: FGIs of learner nurse according to their year level in the undergraduate programme 64
Table 3.3: FGIs of nurse educationalists 65
Table 3.4 Unstructured individual interviews (pilot interview) 65
Table 3.5: FGIs of professional nurses at healthcare institutions where learner nurses were placed for clinical learning 65
Table 3.6: Individual interviews with professional nurses at healthcare institutions where learner nurses were placed for clinical learning 66
Table 3.7: The thinking map adopted in the study 78
Table 4.1: Composition of FGIs per year level of Case 1: Learner nurses 90
Table 4.2: Composition of FGIs and individual interviews of Case 2 (nurse educationalists) 91
Table 4.3: Composition of FGIs of Case 3: Professional nurses 91
Table 4.4: Composition of unstructured individual interviews of Case 3: Professional nurses 92
Table 4.5: Experiences of learner nurses regarding professionalism in the undergraduate nursing programme and possible ways of supporting the development of professionalism in learner nurses 93
Table 5.2: Professional nurses' experiences of learner nurses' professional behaviour 143
Table 6.1: Common themes of the three cases (learner nurses, nurse educationalists and PNs) 163

FIGURES

Figure 1.1: Reasoning map 13
Figure 3.1: Multiple case 54
Figure 3.2: Adjacent district municipalities with the City of Cape Town Metropole and its sub-districts 57
Figure 3.3: City of Cape Town Metropolitan Municipality (also refered to as the Western Cape Metropole) 58
Figure 4.1: Multiple case 88
Figure 5.1: Multiple case 128
Figure 7.1: Framework for nurse educationalists and professional nurses to facilitate professionalism among learner nurses for nursing practice in the Western Cape (adapted from Dickoff et al., 1968) 201
Figure 7.2: Context of the professionalism framework 202
Figure 7.3: The internal environment of the agent 209
Figure 7.4: The internal environment of the recipient 221
Figure 7.5: Underlying dynamics facilitating nursing professionalism 228
Figure 7.6: Procedure 232
Framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses 245
Figure 7.7: Terminus 245
Figure 7.8: Conceptual framework of professionalism for nurse educationalists and professional nurses to facilitate professionalism in undergraduate learner nurses 246

ACRONYMS AND ABBREVIATIONS

AACN :	American Association Colleges of Nursing
ABIM:	American Board of Internal Medicine
ACN:	Australian College of Nursing
ANA:	American Nurses Association
ANMF:	Australian Nursing and Midwifery Federation
BBM:	Black Berry Messaging
BEST:	Becoming Excellent Students in Transition to Nursing
B.NUR:	Bachelor of Nursing
BPG:	Best Practice Guidelines
CHN:	Community Health Nursing
CHS:	Community and Health Sciences
CNA:	Canadian Nurses Association
CPNVs:	Core Professional Nursing Values
CRNBC:	College of Registered Nurses of British Columbia
CS:	Clinical supervisors
DoH:	Department of Health
FGIs:	Focus group interviews
FNS:	Fundamental Nursing Science
GNS:	General Nursing Science
HCI:	Healthcare Institution
HCPC:	Health and Care Professions Council
HEI:	Higher Education Institution
HEIs:	Higher Education Institutions
HEI A:	Higher Education Institution (degree programme)
HEI B:	Higher Education Institution (diploma programme)
ICN:	International Council of Nurses

IMI:	Intramuscular Injection
IPNV:	Inventory of Professional Nursing Values
LN:	Learner Nurse
MDR-TB:	Multiple Drug Resistant Tuberculosis
NE:	Nurse Educator
NEs:	Nurse Educators
NEHAWU:	National Education, Health and Allied Workers Union
NEA:	Nurse Educators Association
NEI:	Nursing Education Institution
NMC:	Nursing and Midwifery Council
NPE:	Nursing Practice Environment
NP:	Nursing Practice
NPVS:	Nursing Professional Values Scale
PN:	Professional Nurse
RN:	Registered Nurse
RNAO:	Registered Nurses' Association of Ontario
RNAO-BPG:	Registered Nurses' Association of Ontario-Best Practice Guidelines
SANC:	South African Nursing Council
SoN:	School of Nursing
SNS:	Social Network Site
SMS:	Short Messaging Service
UCT:	University of Cape Town
UKCC:	United Kingdom Central Council
UNESCO:	United Nations Educational, Scientific and Cultural Organisation
WCGH:	Western Cape Government of Health
WCDH:	Western Cape Department of Health

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND RATIONALE

Nursing is a profession with values. Values are the core of a diverse world of human behaviour, and are expressed in every human decision and action (Rassin, 2008:614). According to Geyer, Mogotlane and Young (2010:33), a profession has its own culture and values, and the values of the nursing profession act as a unifying force to bring together individuals from many diverse backgrounds for a common purpose. Professional values represent the convictions of those in the profession, define what is right, good and desirable, and serve to motivate both social and professional behaviour (Rassin, 2008:614). Core professional values provide a shared foundation that gives meaning to the professional practice of nursing and unites students and nurses in a collective culture. In a study by Shaw and Degazon (2008:1), learner nurses reported that their development of professional values in the course of their training had led to a shared culture of professional nursing.

Professional nursing practice is one of the most important enabling subsystems in the healthcare system. Although it is the key to maintaining the public's high level of trust in the nursing profession, the profession and its integrity are subject to various threats. As the socio-economic and political environment changes constantly, the core professional values inherent in the profession are also subject to change (Mulaudzi, Mokoena & Troskie, 2001:2). It thus becomes increasingly challenging for the nursing profession to maintain its professional status and to deliver the quality of service expected in a society characterised by diversity such as that of South Africa. International research has revealed a multitude of underlying causes for the negative image of the profession worldwide. Lack of professionalism among nurses has been identified as one of the main causes for the decline in the status of the profession (Maben & Griffiths, 2008:12). The American Board of Internal Medicine (ABIM) (2002), for instance, stipulates the abuse of power, arrogance, greed and conflicts of interest as personal, value-based factors impacting negatively on the behaviour of healthcare professionals (McNair, 2005:458). In South Africa, Regulation 425 (as amended) of the South African Nursing Council (SANC) stipulates that a Professional Practice module should be a compulsory part of the training of learner nurses in order to develop and sustain professionalism in nursing practice (South African Nursing Council (SANC), 2004–2012). Nurses, including learner nurses, should view professionalism as a framework for identifying and guiding their professional conduct and roles

in a social context. In this context, the emphasis of the nursing professionals' value commitments was specifically focused on the professional status of their work (Fagermoen, 1997:434). Nursing professionalism has a core humanistic focus according to which the individual patient is the central focus (Evetts, 1999:122). This kind of focused humanist commitment on the part of the nursing professionals can be traced back to the 19th century, to Florence Nightingale's time, when the specific human values informing the nursing profession were codified (Kuhse & Singer, 2001 in Butts, 2013:82). These values focus on professional identity. A study, undertaken by Fagermoen (1997:434) shows how professional identity is addressed in terms of related concepts such as professionalism.

A key approach to the professionalisation process in the training of nurses would be one that applies core professional nursing values in practice. Much of the literature viewed core professional nursing values as synonymous with professionalism (Jooste, 2017:21; Altiok & Üstün, 2014:58). Jooste (2017:22) states that nursing values are those subjective notions that determine the behaviour and conduct of nurses. Nursing professionalism is therefore understood as a culture comprising shared values and behaviours (Steward, 2015:11). In a changing social context, however, professionalism may require the modification of old professional values and the development of new ones (Farenwald, Basset, Tschetter, Carson, White & Winterboer, 2005 in Shaw & Degazon, 2008:44). Professionalism is thus conveyed in the attitudes and behaviour demonstrated by nurses and in their willingness to make a positive contribution to creating a better world, for example by providing quality healthcare for all (Geyer et al., 2010:34; Scottish Government July, 2012).

1.2 BACKGROUND TO PROFESSIONALISM IN NURSING

1.2.1 The professional culture of nursing

The core values of professionalism are implicit in the scientific knowledge and practical skills addressed in nurse's professional training (Brown & Ferrill, 2009:7; Searle, Human & Mogotlane, 2009:3). By developing these professional values, a learner nurse develops her or his professional identity (Fagermoen, 1997:434). Geyer et al. (2010:33) are of the opinion that the student nurse entering the profession should positively commit to adjusting his or her behaviour in the interests of ensuring quality and safe patient care. This requires the student nurse to accept and adapt to those values of the profession that relate to human behaviour. According to Doheny, Cook and Stopper (1997:42), one's values are shaped by one's experiences, influence one's behaviour and interactions with others and are manifested in many aspects of professional behaviour. According to Jooste (2017:9), professional behaviour refers to standards of behaviour

professionals were expected to adhere to when they offer their specific knowledge and skills to the person in need. Professional behaviour is manifested not only in acts, but also in what we wear and how we perform (Jooste, 2017:9).

Martin, Yarbrough and Alfred (2003:291), and Iacobucci, Daly, Lindell and Griffin (2012:479) view the current healthcare environment as requiring professional nurses capable of managing complex professional issues. Thus, awareness of the need for strong professional values on the part of nurse educators, clinical facilitators and learner nurses is vital in preparing nurses to manage patient care in a capable and professional manner. McNair (2005:460) argues that professional curricula lack a framework for ensuring that healthcare students attain professional competencies. Brown and Ferrill (2009:3) argue that an educationally functional model was needed to address and develop the element of trust in professional relationships. They claim that professionalism should be understood within a specific framework of behaviours. Zlatic (2005:21) emphasises the need to instil professional values within a systematic framework in which the enculturation of professional values and the development of character occur in a premeditated, formalised way, rather than in a haphazard fashion in experiential settings. This study aimed to develop a conceptual framework for nurse educationalists and professional nurses according to which professionalism among undergraduate learner nurses in the Western Cape can be facilitated.

1.2.2 The legal and ethical framework of professionalism within the South African context

Chapter 2 of the Constitution of the Republic of South Africa (1996) sets out the Bill of Rights that reflects and preserves the values, based on respect for human rights, inherent in a democratic society (Jooste, 2017:67). Nursing is internationally a self-regulating profession, which means that governments have delegated to the profession the authority to regulate itself (College of Nurses of Ontario, 2009). The regulatory framework of the nursing profession consists of the legislation, regulations, regulatory processes, ethical codes, policies and practice standards which apply to nursing. According to the Nursing Strategy for South Africa (2008), it is internationally recognised and acknowledged that the fundamental purpose of regulating health professionals is to ensure that professional nursing practices and regulations protect the public. Professional nurses are guided by their ethical-legal framework and their personal and professional values to provide a professional nursing practice to society (Mathibe-Neke, 2015:19). Professional knowledge, skills and values should be developed throughout the training (theory and practice) of the nurse, within the legal framework and standards of practice, to prepare the novice nurse to become a competent professional nurse practitioner.

The strength and quality of nursing regulation, according to the Department of Health (DoH) (2008), depend on the nurses supervising trainee and professional nurses under their authority, whether in a training or in a work situation. It is the nursing profession itself which possesses the unique knowledge-base to set and maintain the standards and core professional values of nursing practice. Nursing is bound by the professional values that require nurses to base their practice on relevant and current knowledge, and to show respect for the wellbeing, dignity and autonomy of persons receiving care. These values promote safe, ethical and competent nursing care. The Code of Ethics provides a framework for the standards of conduct for nurses worldwide (International Council of Nurses (ICN), 2006). The first draft of the South African Charter of Nursing Practice, developed in 2004 (SANC, 2009), mentions the commitment that nurses should have towards values fundamental to nursing. According to the Nursing Regulation 425, published in the Government Gazette of December 2011, training programmes must aim to provide professionals with professional values that will enable them to make a meaningful contribution to health services. The training programmes should also equip professionals with a developed sense of equity, justice and service ethics that will ensure that they work in an accountable manner, irrespective of their chosen work place.

1.3 BACKGROUND TO THE PROBLEM

Healthcare service delivery in South Africa has undergone significant reform in the past few years. In 2008, the then Minister of Health, Dr Tshabalala-Msimang, announced that the country was experiencing serious challenges in nursing, which included the decline in professionalism and standards of nursing care. The national nurses' coordinator for the National Education, Health and Allied Workers Union (NEHAWU) confirmed that there was a decline in the status of the nursing profession (Breier, Wildschut & Mgqolozana, 2009:118). According to Searle et al. (2009:376), the relationship of trust between nurses and communities has been seriously damaged by the decline in the professional status of nursing. Many factors, such as the burden of disease, shortages of nurses, cultural diversity, and a stressed socio-economic environment could impact on professional nursing practice and health service delivery (Erasmus, 2008:62; Muller, 2009:75). However, nurses should be adequately prepared to practice within the South African political, socio-economic, professional, ethical and legal context. Professional nursing care service delivery occurs within a specific regulatory and contextual framework (Muller, 2009:75). Nursing professionals tend to follow social trends such as the search for convenience, economic stability, power and control, and in the process professional values such as altruism and equality were waived (Rassin, 2008:614). Furthermore, particularly since 1994, a diversified nursing workforce not only represented cultural and racial differences, but also included variation within

parameters such as age, ethnicity, gender, lifestyle and sexual orientation. Shaw argues for the necessity of bridging differences among nurses of varied backgrounds so that they can identify with, and be united by, a common nursing ideology (Shaw & Degazon, 2008:44). In addition, in the last two decades, nursing practice lawsuits have been on the increase internationally. In 1994, the United Kingdom Central Council (UKCC), now the Nursing and Midwifery Council, reported that the proportion of misconduct cases against nurses had trebled between 1990 and 1994 (Erasmus, 2008:1). In the United States, less than a decade ago, over 5000 nurses were disciplined annually for professional misconduct (LaDuke, 2000:26). Between 2005 to 2009, four hundred (400) nurses were found guilty of misconduct in South Africa and 52 were removed from the register. Newspapers frequently report on nurses' negligence, lack of caring and misconduct (Searle et al., 2009:376). In a newspaper report about the above mentioned cases, 22 Western Cape nurses were found guilty of misconduct for offences, including sexual and physical abuse of patients as well as poor patient care (Lewis, 2009). International studies have shown that fatigue and high stress conditions can lead to human error, which in turn impacts on patient outcomes. This situation, in combination with the growing trend towards civil suits, has made nurses and the nursing profession easy targets for litigation (Sounart, 2007).

According to McNair (2005:457), the aim of a curriculum that includes a course in professionalism, should be to develop a value-based perspective in students that will have a powerful and sustained influence on their professional behaviour. According to the United States of America's Institute of Medicine (Greiner & Knebel, 2003:1), professional education does not take place in a vacuum: hidden curricula of observed behaviour, social and professional interactions and the overall professional culture of a student's training environment are powerful determinants in shaping professional values and attitudes and can contradict, or work against, what is learned in the classroom. Professional nursing values are taught theoretically as well as in clinical practice in nursing programmes. Ignoring the intrinsic values of the nursing profession not only tarnishes the image of the profession, but also has consequences for the service provider, the individual nurse and ultimately the clients receiving care (Jooste, 2017:22). The development of professional values and behaviours forms a significant part of the professional socialisation process (Hammer, 2000:455). Professional socialisation is a process through which people selectively acquire the current values and attitudes, interests, skills and knowledge (culture) in the groups in which they are, or groups of the profession they seek to become a member of (Hammer, 2000:455). Kubsch, Hansen and Huyser-Eatwell (2008:375) state that despite nursing's gains in the process of professionalisation, the profession continues to struggle with some aspects of professional status. They agree that institutions of higher education play a role in how professional values are learned and demonstrated in nursing practices. Kubsch et al.

(2008) argue that the educational preparation of the registered nurse (RN) may make a difference in professional values, as nursing education programmes instil in their learner nurses the notion that they are professionals and members of the nursing profession. However, the latter authors state that these values acquired in nursing education programmes may be discarded after the nurse graduates. Some of the reasons for this may be that values were imposed on the student rather than freely chosen, or because of work pressures.

Leners, Roehrs and Piccone (2006) and Lin, Wang, Yarborough, Alfred and Martin, in Iacobucci et al. (2012:418), confirm that the internalisation of professional nursing values among undergraduate nurses continuously increase from junior to senior levels during their training. However, despite findings which indicate that professional value internalisation evolves during undergraduate nursing programmes, learner nurses continue to report difficulty in enacting behaviours that support values due to various professional and organisational factors (Maben, Latter & Clark, in Iacobucci et al., 2012:418). Iacobucci et al. (2012) suggest that future research is necessary to explore intrinsic variables that may transcend the reported external influences on ethically competent behaviour.

1.4 PROBLEM STATEMENT

According to the regulatory framework of the nursing profession, professional nursing practice, which includes the values specific to nursing, constitutes part of the learning outcomes in the formal curriculum of the four-year undergraduate nursing programme leading to a professional qualification (Government Gazette, 2011). It is assumed that, once nurses have undergone accredited training, and are socialised into the professional culture, these professional values will be developed and internalised in the individual learner nurse (Jooste, 2017:22). However, this assumption did not take into account certain obstacles. According to Breier et al. (2009:117), the admission of people unsuited to the nursing profession constituted another factor which led to a decline in professional values and a lack of caring, and contributed to the deterioration of the nursing reputation. Students enter the nursing profession from diverse backgrounds and they all have their own personal set of values. These personal values are not necessarily congruent with the professional values of the profession. Learner nurses should therefore be socialised into the professional culture of nursing and assimilate the profession's standards of practice and competencies which provide a guide for the conduct of nurses. This conduct should adhere to the professional values of nursing. Day, Field, Campbell and Reutter (2005:636) are of the opinion that it is possible for learner nurses to transition from a lay to a professional nurse over the course of their four years.

The researcher became aware of a growing number of complaints from various stakeholders in the nursing profession in the Western Cape about the unprofessional conduct of learner nurses. The learner nurses were part of a school of nursing that offered an undergraduate nursing programme and viewed as the largest nursing school in South Africa. Although learner nurses followed a competency curriculum that covered the elements of professionalism and the ethical-legal framework for safe nursing practice, the stakeholders involved in the undergraduate nurse training programme (nursing educators, clinical facilitators and professional nurses in practice) all complained about the learner nurses. Complaints regarding the lack of professionalism included irresponsibility on the part of learner nurses who stayed away from work without permission, did not carry out their nursing tasks in a responsible manner, showed an uncaring attitude or a complete absence of empathy towards patients, showed a lack of respect towards colleagues, and, within the first few months after graduating as professional nurses, were unable to adequately carry out the tasks and responsibilities of professional nurses. The perceptions of these nursing professionals were that graduate nurses did not conduct themselves in a professional manner after they had completed the formal undergraduate nurses training programme.

In this context, complaints also came from learner nurses who were not happy about the poor professional behaviour of professional, qualified nurses in the theoretical and practical environment of their training. Nurses, especially learner nurses, often speak of being exposed to poor role models who do not reflect their professional ideals (Price, 2008:16). It was therefore unclear what the experiences of learner nurses were concerning professionalism in nursing practice. The researcher was also uncertain how nurse educationalists (nurse educators and clinical facilitators) and professional nurses in nursing practice could support learner nurses in facilitating professionalism in the undergraduate nursing programmes offered in the Western Cape. From these initial perceptions, and from the research, it became evident that a clear framework for professionalism should therefore be developed for learner nurses, nurse educationalists and professional nurses for facilitating professionalism among undergraduate nurses for nursing practice in the Western Cape. From the problem statement the following questions were posed:

- What are the experiences of learner nurses on professionalism during their undergraduate nursing programme at the University of the Western Cape?

- How can nurse educationalists and professional nurses facilitate professionalism among undergraduate learner nurses in nursing practice?

- Within which framework should nurse educationalists and professional nurses facilitate professionalism among undergraduate learner nurses?

1.5 AIM OF THE STUDY

The aim of the study was to develop a conceptual framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape.

1.6 OBJECTIVES OF THE STUDY

Phase 1:

- To explore and describe the experiences of learner nurses of professionalism during their undergraduate nursing programme at a university in the Western Cape.
- To explore and describe how nurse educationalists and professional nurses can facilitate professionalism among undergraduate learner nurses in nursing practice in the Western Cape.

Phase 2:

- To develop a conceptual framework for nurse educationalists and professional nurses within which professionalism among undergraduate learner nurses for nursing practice in the Western Cape can be facilitated.

1.7 PARADIGM AND ASSUMPTIONS

A paradigm is a guiding framework for resolving problems, conducting research and deriving theories. Maree (2011:47) defines a paradigm as a set of assumptions or beliefs about fundamental aspects of reality that gives rise to a particular world view. According to Lincoln and Guba (1985:15), paradigms represent what we think about the world (but cannot prove). Our actions in the world cannot occur without reference to those paradigms. The researcher used a constructivism paradigm, positioning herself in the research to acknowledge and recognise that backgrounds shape interpretation. The researcher's intent was to make sense and interpret the meanings others have about the world. Therefore, rather than starting with a theory, the researcher inductively developed a framework or pattern of meaning (Creswell, 2014:37).

1.7.1 Meta-theoretical assumptions

The four basic concepts or components underpinning nursing theory, and influencing and determining nursing practice, are: the person or recipient of care (learner nurse) and person facilitating professionalism (agent); the environment, which is the context within which nurse-patient interactions takes place (nursing practice); health, which is the wellness or illness experienced by the person (professionalism); and nursing, which includes the actions, characteristics and attributes of the individual providing the nursing education (Mellish, Brink & Paton, 2000:13). In this study it is assumed that the *person* is a complex human – a nurse, a learner, a nurse educationalist (nurse educator or clinical supervisor in theory and practice), or a professional nurse. They (recipients and agents) should demonstrate professional values when facilitating the promotion of health (professionalism). The individuality of the learner nurse (recipient) is unique and must be seen in the context of her/his year of development in the nursing programme. Learner nurses develop in relation to the internal and external environment within which they interact with patients and qualified nursing professionals, i.e. nurse educationalists and professional nurses (primary and secondary agents). The assumption is that the internal environment of all nurses is determined by cultural influences throughout their personal development. The nurse is expected to maintain an internal equilibrium (a constant professionalism in terms of good behaviour, internal self-control and conscience) in a constantly changing socio-political environment.

The *environment* refers to the internal and external environment of the learner nurse, nurse educationalists and professional nurse whose internal environment consists of body, mind and spirit. The *body* includes physical structures and biological processes, while the *mind*, known as the psyche, includes emotions and all intellectual processes. The emotions of the nurse include affection, desires and various feelings and moods, whereas the intellect includes competence and the processes of thinking, analysing, interpreting and understanding. *Spirit* refers to the nurse's relationship with a 'God' or a higher being, which provides the moral foundation on which the nurse's value system is based. The external environment of the nurse is the physical environment, including the culture of professional nursing, within which his or her nursing practice takes place. The external environment is ever-changing and determined by factors of health, education and the political and government sphere. The nurse's internal and external environments influence how the learner nurse's professional values are shaped and how the learner nurse should behave in order to strive for and achieve excellence in being a professional (health).

Health in this context is seen as behaving professionally in the nursing practice. Professionalism has a core humanistic focus, which is fundamental and essential to the discipline of nursing. Each person (nurse) must define an internal state of professionalism which encompasses a high level of physical, mental (intellectual) and social functioning.

Nursing is concerned with promoting and restoring health (professionalism). During the undergraduate training programme, nurse educationalists and professional nurses (agents) adopt a caring approach towards learner nurses (recipients) and support them to attain a high level of professional growth. It could be argued that it is the ever-changing external environment that causes nurses to behave unprofessionally during their interaction with patients. The development of sustained professional values in the context of a changing environment is a long-term learning process that takes place through the interaction of the learner nurses with nurse educationalists in the classroom and professional nurses in the practice environment. The professional nurse practitioner can be said to be on a continuum of health (professionalism): the role of nurse educationalists and professional nurses is to assist and support learner nurses to make the values of the profession their own, while the professionally mature and competent practitioner continually displays all the characteristics of professionalism (Muller, 2009:7).

1.7.2 Theoretical assumptions

1.7.2.1 *Professionalism according to Brown and Ferrill (2009)*

Baxter and Jack (2008:550) indicate that a theoretical framework could be used in qualitative case study research. The theoretical assumptions of this study were based on a taxonomic model of professionalism (Brown & Ferrill, 2009:4). Brown and Ferrill (2009) created a professionalism model to organise the abstract concept of professionalism and reflect how professional values link with professional behaviours. Generally, value development is a long-term process of consolidating and embedding one's own beliefs, attitudes and values into one's moral behaviour. Any kind of human development is associated with learning; for example, learning ideas and skills, and then making use of them. The model of Brown and Ferrill (2009:4) assumes a focus shift from learning to practical performance or behaviour. Assumptions about professionalism in nursing that emanate from the model were adapted for this study as follows:

- Professionalism is a multi-dimensional and complex concept in the environment of nursing.

- Professionalism means to demonstrate the behaviours, attitudes and values (corresponding with the three domains of professional capability, interpersonal compatibility and personal reliability).

- Professional capability (behaviour) refers to competencies such as self-directed learning (autonomy), appropriate and sufficient knowledge, applied skills, proactivity and wisdom, as well as roles to promote the nursing education of learner nurses.

- Interpersonal compatibility (attitude) refers to a person's capacity to connect with other people and includes basic communication skills, self-control, empathy, compassion, kindness and influence.

- Personal reliability (value) refers to the character domain, which is the key to trustworthiness and requires functioning from a base of morality and ethics. A person of character has a sense of right and wrong, based on ethical professional standards that include honesty or integrity, humility, responsibility, service and moral courage.

- The elements of professionalism include the core professional values (also referred to as characteristics) of nursing. Professional values of nurses are thus linked to their expected professional behaviour in practice.

- A student's professional values determine his/her professional behaviour in nursing practice.

- The development of professional values is a long-term process of learning that leads to professional behaviour in a professional practice setting.

- There is a need to develop the professional values of nurses within a systematic professionalism framework.

1.7.2.2 *Practice oriented theory*

The survey list of Practice Oriented Theory of Dickoff et al. (1968:434) was followed as a reasoning map. In Phase 2 of the study, a conceptual framework was developed based on the findings of Phase 1, Objectives 1 and 2. A conceptual framework is an abstract mental structure made up of concepts and statements integrated into the structure. The framework is presented in a systematic way through the identification of relationships and patterns between these concepts and statements (Jooste, 2017:269). The reasoning map addresses the following questions:

Who or what performs the activity? (Agent)

In this study, the researcher conceptualised a framework for nurse educationalists and professional nurses (the primary and secondary agents) for facilitating professionalism in learner nurses in an undergraduate nurse training programme that will be implemented at a university in the Western Cape. The primary agents are nurse academics and clinical supervisors involved in teaching the theory and practice of nursing to the learner nurses in the undergraduate programme at the university. Similarly, important are the secondary agents who are professional nurses employed by the Department of Health in public hospitals in the Western Cape and who are accredited for the clinical placement of the learner nurses from an institution of higher education.

Who or what is the recipient of the activity? (Recipient)

The recipients in this study are undergraduate learner nurses who are registered for the four-year undergraduate nursing programme at a school of nursing at a university in the Western Cape. Their training leads to their graduation as professional nurses in the disciplines of general nursing, community nursing, midwifery and psychiatry.

In what context is the activity performed?

The framework outlines the context of professionalism within the professional-legal context of the nursing practice at three academic hospitals in the Western Cape Metropolitan area.

What is the energy source for the activity – whether physical, biological, or psychological? (Underlying dynamics)

The framework outlines the dynamics of the facilitation of professionalism among undergraduate learner nurses for nursing practice.

What is the guiding procedure, technique, or protocol for the activity? (Procedure)

The procedure focuses on the specific processes needed for facilitating professionalism among undergraduate learner nurses.

What is the end point of the activity? (Terminus)

The terminus is the outcome of an activity that confirms whether the goal which has been set for the activity has been achieved or not. For the purposes of this study, the terminus is a framework to facilitate professionalism among undergraduate learner nurses for the nursing practice in the Western Cape.

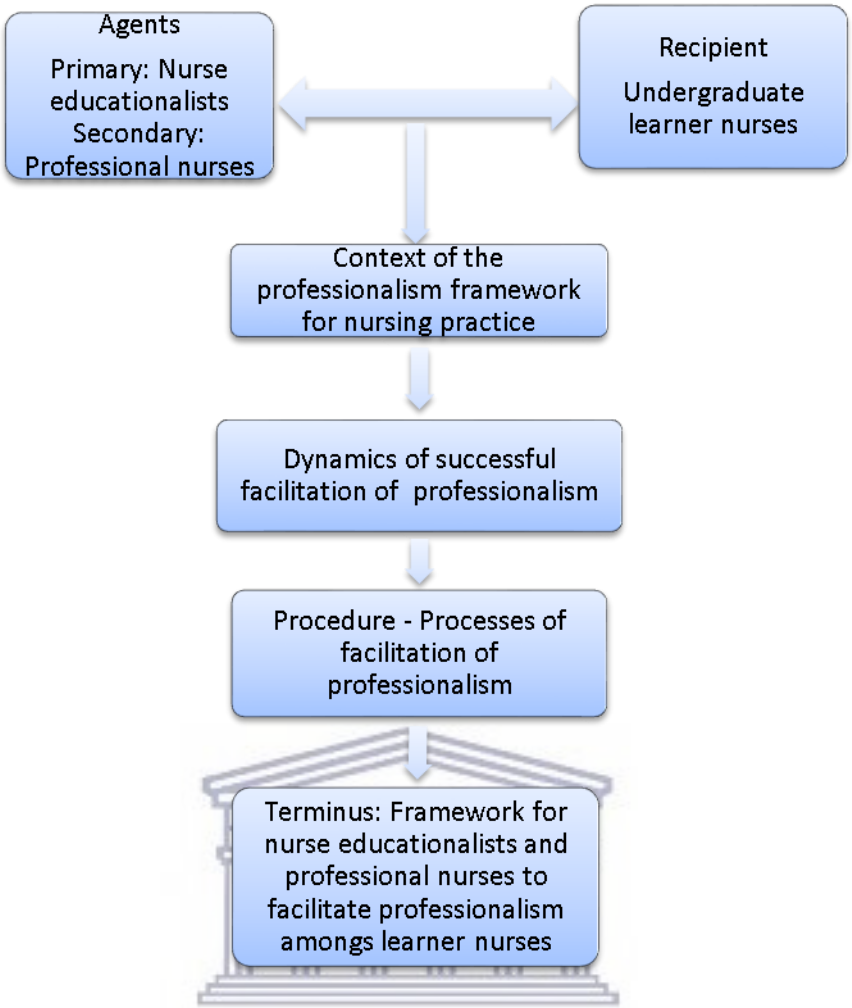


Figure 1.1: Reasoning map

1.7.2.3 *Other definitions*

Professional nurse: A professional nurse is the registered nurse/midwife who has undergone a period of study at a recognised and accredited nursing education institution and who is registered as such with the SANC under the Nursing Act 33 of 2005 in terms of Section 31 (Government Gazette, 2011).

Nursing education: Nursing education refers to formal learning and training in the science of nursing. This includes the functions and duties of the nurse in the holistic care of patients, and a combination of different disciplines that both accelerate the patient's return to health and help to maintain it (Encyclopedia of Nursing and Allied Health, 2002).

Nurse educator: A nurse educator is a professional RN with a one year post basic diploma in Nursing Education recognised by the SANC under Regulation 118 (SANC, 2004-2016). For the purposes of this study, a nurse educator is a person involved in the theory and practice of learner nurses in an undergraduate nursing programme at an institution of higher education.

Clinical facilitator: Clinical facilitator is a RN involved in a current nursing practice and engaged in facilitating student learning in clinical settings on and/or off campus (Charles Darwin University, n.d.).

Educationalists: An educationalist is a specialist in the theory and practice of education (http://www.thefreedictionary.com/ educationalists). Nurse educationalists in this study are nurse educators and clinical facilitators (also referred to as clinical supervisors) involved in the professional undergraduate nursing training programme of learner nurses.

Learner nurse: A learner nurse is a person registered as such with the South African Nursing Council in terms of Section 32 of the Nursing Act 33 of 2005 to undergo education and training at a nursing education institution accredited by the SANC (SANC, 2004-2016).

Conceptual framework: This is a structure composed of related concepts that form a whole (Chinn & Kramer, 1995:212).

1.7.3 Methodological assumptions

From the perspective of the researcher, and for purposes of this study, the following assumptions about qualitative research were made:

- Qualitative research is based on a belief in individuals residing in the real world who are able to report on their experiences.
- Qualitative research is descriptive when it pertains to process, meaning and understanding gained through words.
- The interest and focus of qualitative research is in meaning, how people make sense of their experiences and social structures in the world.

The following assumptions underpinned the theory of generative research to develop a connceptual framework:

- It is best positioned within the levels of theory development to describe a framework for nursing practice (Dickoff et al., 1968:416).
- It provides the opportunity to refine concepts and provide evidence to support practice (Chinn & Kramer, 2008:183).

- Theory is assigned according to different levels that include practice theory. The level of theory in this study focuses on nursing concepts that are grounded in a practice context.

1.8 RESEARCH APPROACH

Qualitative approaches provide more in-depth views of the phenomena under study. Maree (2011:259) describes qualitative research as an inquiry process on the part of the researcher to develop a complex, holistic picture of the views of the participants as they experience a phenomenon, e.g. professionalism.

1.8.1 Research design

The researcher used a qualitative, exploratory, descriptive, contextual design with a case study method. According to Babbie and Mouton (2010:270), qualitative research is social research which takes as its point of departure the insider's perspective (i.e. the students' views) about a particular social action. The emphasis of qualitative description is on thick description. It places events into contexts that are understandable to the role players themselves (Babbie & Mouton, 2010:272). Thus, qualitative researchers attempt to study human action from the perspective of the social role players themselves. The primary goal of the qualitative approach is to describe and understand (rather than to explain) human behaviour (Babbie & Mouton, 2010:270). An *exploratory* design was followed in order to satisfy the researcher's curiosity and her desire for a deeper understanding of the phenomenon of learner nurse professionalism (Babbie & Mouton, 2010:79). Because exploratory studies usually lead to insight and comprehension rather than to the collection of detailed, accurate and replicable data, these studies frequently involve the use of in-depth interviews (Babbie & Mouton, 2010:80). In a *descriptive* and *contextual* design, qualitative researchers are primarily interested in describing the actions of the research participants in great detail, and then attempt to understand these actions in terms of the participants' own beliefs and context (Babbie & Mouton, 2010:271). In this study, the researcher explored and described the professionalism of learner nurses in the context of nursing from the experiences of (i) learner nurses; (ii) nurse educationalists (nurse educators and clinical facilitators); and (iii) professional nurse practitioners (the three cases). In qualitative *case study designs*, researchers ensure that enough detail is provided to assess the credibility of the study. As a basic foundation, the researcher ensures that (i) the research question is clearly written; (ii) the case study design is appropriate for the research question; (iii) purposeful sampling strategies for case study have been applied; (iv) data are collected and managed systematically; and (v) the data are analysed correctly (Russel, Gregory, Ploeg, DiCenso & Guyatt (2005) in Baxter & Jack, 2008:556). The primary strategy used in this study was the triangulation of data sources through

focus group interviews and unstructured individual interviews. The principles of case study research, according to which the phenomena of nursing professionalism should be viewed and explored from multiple perspectives (Baxter & Jack, 2008:556), are thereby supported. Knafl and Breitmayer, in Baxter and Jack (2008:556) state that the collection of rich data, based on the principles of convergence and confirmation of findings, enhances data quality.

1.8.2 Case study method

Yin in Baxter and Jack (2008:548) claims that a multiple case study method enables the researcher, to explore differences and similarities within and between cases. In this study, learner nurses, nurse educationalists and professional nurses were chosen as three cases and results were described and contextualised in the overall case (see Chapter 5). Focus group interviews and unstructured individual interviews were used as multiple data sources in this study, where after the data were converged in the analysis process.

Phase 1: Situational analysis

Population and sampling

Objective 1:

The accessible target population was all undergraduates: 1st (N=300), 2nd (N=234), 3rd(N=190) and 4th (N=162) year learner nurses who were undertaking for the four-year nursing programme (leading to registration as professional nurses) at a university in the Western Cape. This university is the only university offering the undergraduate nursing degree programme in the Western Cape. In this study, the purposive sample population were learner nurses in their 1st, 2nd, 3rd and 4th year of study who were registered at a school of nursing at a university in the Western Cape (Table 3.2). Eligibility criteria were used to select participants (see 3.3.9).

The researcher conducted a total of eight focus group interviews (including two pilot focus group interviews) with *learner nurses* (see 3.4.1, Tables 3.2 and 4.1). The number of participants to be recruited for qualitative studies was guided by the process of saturation (Hennink, Hutter & Bailey, 2011:88). The saturation point was reached when the information collected began to repeat itself. In qualitative research, the focus is on the methodological depth and interpretation of the data, and not on the number of participants (Caelli, Ray & Mill, 2003:8).

Objective 2:

The accessible population in Phase 1, Objective 2, consisted of nurse educationalists (26 nurse educators and 34 clinical facilitators) at a university in the Western Cape offering the nursing programme degree, and the professional nurses in the Western Cape Metropole guiding students of this university, who were registered with the SANC (Table 1.1). The purposively selected sample was (i) nurse educationalists, namely nurse educators (n=8) and clinical facilitators (n=10) at a school of nursing (SoN); and (ii) professional nurses (n=18) at the four hospitals (two tertiary, one secondary and one psychiatric hospital). Two focus group interviews were conducted with nurse educators across all four-year levels in the undergraduate nursing programme, and one focus group was conducted with clinical facilitators across all four-year levels of the undergraduate nursing programme. Five focus groups and five unstructured individual interviews were conducted with professional nurses at the healthcare facilities where the undergraduate learner nurses were placed for clinical learning. One pilot that was an unstructured individual interview was conducted with a midwifery clinical supervisor during an individual interview, and data were included in the findings (see Chapter 3). The criteria for the inclusion of these two cases (nurse educationalists and professional nurses) were discussed under 3.3.9.

1.9 RESEARCH METHODS

Research methods are the techniques researchers use to structure the study and to gather and analyse data in a systematic manner (Polit & Beck, 2008:765).

1.9.1 Data gathering

1.9.1.1 *Phase 1: Situational analysis*

Focus group interviews and unstructured individual interviews were conducted to obtain data from participants (learner nurses, nurse educationalists and professional nurses) as the three cases who were experienced and knowledgeable in facilitating professionalism in learner nurses. The researcher used interviews in order to be able to see the phenomenon through the eyes of the participants who could yield valuable information about professionalism among learner nurses. The data helped the researcher to understand the participants' reality of the phenomenon (Maree, 2011:87). Data were collected in the form of audio-taped focus group interviews and unstructured interviews, which were then transcribed and coded with the assistance of an independent coder. Each focus group consisted of between three to nine participants since this number allowed everyone to participate. Although it is recommended that focus groups contains between six to twelve participants, the use of mini-focus groups with three or four participants are on the other hand used to get more in-depth information (Onwuegbuzie, Leech & Collins,

2010:711). The researcher asked an open-ended question to the participants in all interviews (Annexure P). The purpose was to stimulate a discussion about the experiences of the participants. During the discussions, the researcher followed the opening question up with relevant probing questions. The interviews were conducted by the researcher and were no longer than an hour. Data collected from the transcripts of the interviews were combined and supplemented with field notes made on observed non-verbal communication between the participants. Further description of Phase 1 is outlined in 3.4.2.

1.9.2 Data analysis

Maree (2011:99) views qualitative data analysis as being aimed at examining the meaningful and symbolic content of qualitative data. This process established how participants made meaning of professionalism by analysing their experiences of professionalism. Data analysis in this study was conducted separately for the three cases to obtain themes and categories. The findings of the three cases were aggregated (combined) into a main case (Yin, 2014:164), as summarised at the end of the findings (see 5.4). All the transcripts for the separate cases (learner nurses, nurse educationalists and professional nurses) were first carefully read and reviewed in order to contribute to a meaningful whole. The data were subsequently analysed using a process of identifying themes in the data for underlying meanings. Categories were assigned to the themes and the researcher also reviewed documented observations made during the interviews. General patterns in the data, such as themes of the individual respondents and of the groups of participants in the study, were identified (Collins, Onwuegbuzie & Sutton, 2006). Tables were created that display the data from the separate individual groups according to the themes and categories (Tables 4.5; 5.1; 5.2). A qualitative analysis of the entire collection of tables enabled the researcher in this study to draw a cross-case about the three groups of participants (Yin, 2014:166) (see Annexure Q). The common themes which emerged from the initial separate cases were then merged to present the researcher with a complete picture of nursing professionalism from the perspectives of learner nurses, nurse educationalists and professional nurses. Table 6.1 was created to capture and display the findings of the common themes which emerged from the cross-case analysis. The merged common themes are the actual accounts of the experiences of all participants and their descriptions of nursing professionalism, which was used to develop a framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape.

The data analysis technique used in this study was cross-case synthesis. This technique treats each individual case as a separate case study. The researcher is of the opinion that the findings of the three cases (learner nurses, nurse educationalists and professional nurses) are stronger than

one single case. In this way the technique is not different from other research synthesis, because the findings are aggregated across the three cases (Yin, 2014:164). The data of the focus group interviews and the unstructured individual interviews were converged to understand the overall case about nursing professionalism as it was experienced by the three cases. The findings and conclusions were based on separate data from the three cases of analysis that serve as the main case (within analysis), in addition to cross-case data (between analysis) that feed into the overall case study. The researcher's supervisor and an independent coder were involved in the analysis to ensure that the researcher stayed true to the original case (Baxter & Jack, 2008:555). The results were used to develop a framework to be used by nurse educationalists and professional nurse practitioners for facilitating professionalism in learner nurses for nursing practice in the Western Cape.

1.9.2.1 *Phase 2: The development of the conceptual framework*

In Phase 2 an original professionalism conceptual framework for nurse educationalists and professional nurses was developed with the aim of facilitating professionalism among undergraduate learner students and preparing them for professional practice. This conceptual framework was developed from the results in Phase 1. Data reconstruction was achieved by using theory generation as proposed by Dickoff et al. (1968:423) as described under theoretical assumptions (see 8.3). The conceptual framework described the findings of the cross-case analysis of the themes, categories, and sub-categories of the three cases, learner nurses, nurse educationalists and professional nurses, as identified in Phase 1. The three cases were treated separately and aggregated into the main case that informed the conceptual framework in Chapter 7.

1.9.2.2 Validation of the conceptual framework

The conceptual framework was validated by experts in the field of professional practice in nursing, using the adapted criteria of Chinn and Kramer (2008:183), which included questions around clarity, simplicity, generality, accessibility and the importance of the framework. Based on the final conceptual framework, recommendations were made to nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses in preparation of nursing practice in the Western Cape.

1.10 TRUSTWORTHINESS

To ensure *credibility*, and to gain the trust of the participants, the participants in the focus group interviews were informed about what the study entailed and how it would be conducted. During

the interviews, the researcher took field notes while aiming to maintain eye contact with the participants throughout the interview. Reflective notes supplemented the credibility of the data collected. Data triangulation of transcripts, field notes and reflective notes were undertaken. Prolonged involvement during the focus group interviews allowed the researcher to continue collecting data until data saturation had been reached and no new data emerged. The researcher ensured *dependability* by conducting an audit trail throughout the study, reviewing all the data, re-constructing, synthesising and reducing the data (Jooste, 2017:322). *Confirmability* was undertaken when participants were asked to validate their individual responses in terms of the transcription accuracy from the audiotape ("member checking"). The researcher made use of an independent coder and multiple sources of data collection to ensure thickness in the description of the results. *Transferability* means that the findings of the research will be applicable to similar contexts. The researcher made use of the actual quotes from participants to ensure neutrality and to avoid bias in the research procedure and results. During the process, the researcher kept a self-reflective journal of any thoughts and insights have emerged in her consciousness (Burns, 2011:549). Trustworthiness will be fully described in Chapter 3.

1.11 ETHICAL CONSIDERATIONS

After ethical approval to conduct this study was granted by the Senate Research Committee of a university in the Western Cape (Annexure A) and a SoN (Annexure B), permission to conduct this study with participants at a tertiary healthcare institution was sought from the Research Committee of the University of Cape Town (Annexure M). The Western Cape Department of Health then granted permission to conduct the research at the accredited healthcare facilities where the learner nurses were placed for clinical learning in the Cape Metropole (Annexures J, L, O, U).

The principles of no harm and beneficence

A participant information sheet (Annexures C, D, E) and consent letters (Annexures F, G, H) were disseminated to all participants, explaining the purpose, ethical considerations and guidelines for participating in the study. Participants were informed about the significance of the study and were allowed to ask questions to clear up possible confusion and enable them to make informed decisions about participating in the study. To avoid any form and feelings of coercion, data were collected in a relaxed environment familiar to the participants. A counsellor was available during and after the interviews if any participants were in need of emotional support (Streubert & Carpenter, 2011:61).

The principle of respect and justice

The researcher respected each participant as an autonomous individual who is self-determinant in deciding to answer the questions posed to her or him. Respondents had the right to participate voluntarily in the study and to withdraw at any stage. The researcher respected the times when group appointments were made with the participants. All participants were treated equally and with respect. The researcher selected participants for reasons directly related to the research problem. The participants have the right to know to whom the findings will be disseminated within the university and the wider academic community, as well as through publication in journals (Streubert & Carpenter, 2011:61).

The principle of privacy and confidentiality

Confidentiality was ensured by withholding the names of participants in the study. Anonymity and confidentiality of the participants were ensured by using codes to prevent identification of the participants. The researcher also made use of audacity software to disguise the voices of the participants so that the data cannot be linked to any specific person. The audiotapes are kept in a secure locked place to which only the researcher has access and will be destroyed five years after publication of the results. Participants signed a confidentiality binding focus group form (Streubert & Carpenter, 2011:61). The ethical considerations are discussed in more detail in Chapter 3.

1.12 CONTRIBUTION AND IMPORTANCE OF THE STUDY

This study has significance and importance for the field of nursing for several reasons. First, in the context of a rapidly changing society, professional nurses are challenged on a daily basis to withstand certain demands placed upon the profession, and to maintain a standard of professionalism based solidly on professional values (Meulenbergs, Verpeet, Schotsmans & Gastmans, 2004:331). Nursing core professional values form the foundation of the nursing profession, and, together with the competencies of nurses, convey the image of the nursing profession to the public (Jooste, 2017:22). Thus, this study is of relevance to nursing education and nursing practice in preparing nursing graduates for their future careers and service in a dynamic, yet unpredictable, environment in which the professional values of the nursing profession may be compromised. Second, the study provides input into the implementation of the Provincial Nursing Strategy to address challenges faced by the nursing profession in the Western Cape, i.e. to strengthen and socially position the nursing profession and enhance professionalism in professional nursing practice (National Nursing Strategy, 2008:3). It is also in line with

meeting those challenges of healthcare in a developing country that requires nurses to strengthen their professional practice through on-going training (Geyer et al., 2010:28). Nurse educationalists (nurse educators and clinical facilitators) and professional nurses in practice have the responsibility to support and help learner nurses to develop into competent professionals who will maintain the quality and commitment of the profession. This study developed an original conceptual framework to assist nursing educationalists and professional nurses to support learner nurses in developing and enhancing professionalism in nursing practice. This conceptual framework incorporates the experiences of three cases representing the main stakeholders in the practice of nursing and education.

1.13 LAYOUT OF THE REPORT

The layout of the chapters in this study is presented below:

Chapter 1	Orientation to the research study
Chapter 2	Overview of frameworks, models, theories, programmes and guidelines related to professionalism in nursing and health
Chapter 3	Research methodology
Chapter 4	Discussion of the results of learner nurses in Phase 1
Chapter 5	Results of the nurse educationalists (nurse educators and clinical supervisors) and professional nurses in Phase 1
Chapter 6	Findings and conceptualisation of the cross-case analysis
Chapter 7	Conceptual framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape
Chapter 8	Conclusions, dissemination plans, recommendations and limitations of the study

1.14 CONCLUSION

Chapter 1 presents the rationale and overview of this research project. Articulation of the research questions and objectives assisted with focusing the scope of the research. The conceptual phase started with the researcher's delineation of her investigation and the context of such an investigation.

The context of the research study was discussed to explain the fundamental issue of nursing professionalism in the community of study and to indicate the absence of a framework for nurse educationalists and professional nurses for facilitating professionalism among undergraduate learner nurses for nursing practice in the Western Cape. The introduction and background presented in this chapter, incorporate references to empirical studies, and theoretical and policy documents nationwide. This illustrated the importance of the research problem and provided a transparent motivation for the significance of the study. The research questions assisted with focusing the scope of the research on developing a conceptual framework. The point of departure and suppositions for a conceptual framework of the study were based on meta-theoretical, theoretical and methodological assumptions. Those assumptions were described in relation to the four concepts of nursing theory, the Professionalism Model of Brown and Ferrill (2009), Practice Orientated Theory of Dickoff et al. (1968) and the case study method (Yin, 2014). From the researcher's point of view, it was important to outline the assumptions early because they resonated with the researcher's principles and would later be reflected in the description of the conceptual framework in subsequent chapters.

These assumptions facilitated the research approach and purpose of the study (Knight & Cross, 2012). The researcher subscribed to using a qualitative, exploratory, descriptive and contextual design with a case study method. The research design was described and presented logically, starting with the manner in which the study would be conducted in three phases, the methods of data collection and analysis, and the organisation and explanation of the elements of the conceptual framework by using the survey list of Dickoff et al. (1968). Also, the researcher described how the developed framework would be validated. It was important that the researcher outlined the strategies employed to ensure the trustworthiness of the findings and to observe the ethical considerations. The researcher was committed to conducting the research study owing to her understanding of and training in nursing and her involvement in an undergraduate training programme at a higher education institution as nurse educator. The researcher was an integral part of developing the framework based on the phenomenon of the research project; therefore, she became more knowledgeable in the field of interest. Also, the act of researching, e.g. determining methodology, had the accumulative effect of improving research skills. Furthermore, during the writing of this chapter, the researcher reflected on the importance and impact of the study. These reflections emphasised the unique contribution of this research project to the nursing knowledge-base by taking the background of the study into account.

Table 1.1: Framework of the study

PHASE	Research question	Research objectives	Method
Phase 1: Situational Analysis			
Objective 1	What are the experiences of learner nurses of professionalism during their undergraduate nursing programme at a University of the Western Cape?	To explore and describe the experiences of learner nurses of professionalism during their undergraduate nursing programme at a University of the Western Cape.	Focus group interviews and unstructured individual interviews Inductive reasoning
Objective 2	How can nurse educationalists and professional nurses facilitate professionalism among undergraduate learner nurses in nursing practice?	To explore and describe how nurse educationalists and professional nurses can facilitate professionalism among undergraduate learner nurses in nursing practice in the Western Cape.	
Phase 2: The development of the conceptual framework will portray concepts and their relationships with one another			

CHAPTER 2

OVERVIEW OF FRAMEWORKS, MODELS, THEORIES, PROGRAMMES AND GUIDELINES RELATED TO PROFESSIONALISM IN NURSING AND HEALTH

2.1 INTRODUCTION

The rationale for doing a literature review is, according to Houser (2012:109), to add credibility to the researcher's contentions of the importance of the topic proposed for the research study. The researcher in this study determined what other researchers have discovered about nursing professionalism. Of equal importance to the reason why the researcher conducted the literature review, was that the purpose of a literature review had to be kept in mind. The main or most important purpose of a literature review generally is to know what is already explored and written about a topic (Nieswiadomy, 1998:74; Houser, 2012:109). A review of the literature gives the reader an indication of the problem area and the feasibility of the study. Houser (2012) states that the literature review provides inter alia a rich basis for establishing the importance of the study and verifies that the study has not already been conducted by other researchers. Houser (2012) furthermore suggests that a study should be framed within its historical and clinical context to establish its uniqueness such as in this study.

In qualitative studies, researchers have differing opinions about reviewing the literature before doing a new study (Polit & Beck, 2008:105). In grounded theory, for instance, researchers often collect data in the field before reviewing the literature. As the data are analysed, grounded theory begins to take shape. Once the theory appears to be sufficiently developed, researchers turn to the literature to relate prior findings to the theory. Phenomenologists often undertake a search *for relevant materials* at the beginning of the study to expand the researcher's understanding of the phenomenon from multiple perspectives (Polit & Beck, 2008:105). The purpose is to expand the researcher's understanding of the phenomenon from multiple perspectives. In ethnography, a review of the literature that led *to the choice of the cultural problem to be studied* is often done before data collection (Polit & Beck, 2008:105).

Regardless of tradition, it is at times necessary for an upfront review of the literature to provide context and lay a foundation for the proposed study. Polit and Beck (2008:107) state that it helps to identify relevant frameworks or appropriate research methods used in previous studies. This chapter aims to provide an overview of the theoretical concepts of the study, existing

frameworks and views on criteria, models, theories, programmes and guidelines related to nursing professionalism in general.

2.2 TERMS OF PROFESSION, PROFESSIONAL, PROFESSIONAL VALUES, PROFESSIONALISM, ETHICS AND PROFESSIONAL VALUES

There have been many attempts to define professionalism, but many authors find the definitions lacking in detail and focus (Birden, Glass, Wilson, Harrison & Usherwood, 2014:23). It is also suggested that the concept should be "professionalism and ethics" as an indication that professionalism should be associated with the terms "good" and "right" (Birden et al., 2014:23). This study explored professionalism within certain assumptions of the framework of Brown and Ferill (2009), as indicated in Chapter 1.

2.2.1 Profession, "a professional" and professional values

In order to understand the concept of professionalism in nursing, the word "profession" first needs to be defined (Gokenbach, 2012). The definition of a *profession* according to Huber (2000 in Black, 2014:54) makes a distinction between an occupation and a profession. A profession is a "calling, vocation or a form of employment that provides a needed service to society and possesses characteristics of expertise, autonomy, long academic preparation, commitment and responsibility" (Huber, 2000:34). Professions evolve from occupations that originally consisted of tasks, but developed into more specialised educational pathways and obtained publicly legitimized status. Practitioners from the earliest professions, such as law, medicine and divinity, performed fulltime work in their disciplines. They then determined work standards, identified a body of knowledge and established educational programmes in institutions of higher learning (Black, 2014:54). These professions promote occupational associations, then worked to establish legal protection that limited practice of their unique skills by outsiders, and established codes of ethics, calling the process "professionalisation" (Black, 2014:54). The word "profession" also means to make an open or public statement of one's beliefs and intentions and of one's acknowledgement of a certain way of life (Searle et al., 2009:3). The *profession* is seen as a calling or vocation requiring specialised knowledge and skills within a recognised system of learning, authenticated by professional members. It has its own culture, definite norms and values, and acts as a unifying force to unite individuals from many diverse backgrounds with a common purpose (Geyer et al., 2010:33).

An American researcher in professions and professionalism (Darley, 1961:83) states, that the truly professional person is one who, by virtue of intellectual capacity, education and moral

outlook, is capable of exercising intellectual and moral judgement at a high level of responsibility. The essence of professionalism, therefore, is that judgement is based on broad knowledge, wisdom and great moral certitude about one's actions that engender societal trust (Darley, 1961). *Professionals*, therefore, are defined as individuals expected to display competent and skilful behaviours in alignment with their profession (Gokenbach, 2012). The author states that being professional is the act of behaving in a manner defined and expected by the profession.

Professional values are standards for conduct that are preferred by practitioners and a professional group, and provide a framework for evaluating beliefs and attitudes that influence behaviour such as critical thinking and decision-making (Weiss & Schanck, 2000; Jomsri, Kunaviktikul, Ketefian & Chaiwalit, 2005; Hayes, 2006). Professional values become the basis for standards of practice that produce a corresponding shift in professional identity and behaviour. In other words, professional values are conceptualised as the fundamental values that provide direction for nursing practice (Jomsri et al., 2005). Acquiring professional values in nursing are therefore central to professional development, because it results in enhanced patient care and greater job satisfaction among nurses (Bang, Kang, Jun, Kim, Son, Yu, Kwon & Kim, 2011). To acquire and internalise professional development, learner nurses must acquire skills and knowledge in cognitive, psychomotor and affective domains. Student's professional values incorporate personal and societal values that are modified and expanded through education and clinical experiences.

2.2.2 Defining professionalism

Professionalism, professionalisation and professional socialisation, according to Brown and Ferrill (2009), are synonymous terms that demonstrate the attitudes, values and behaviours of a professional. *Professionalism* or professionalisation is described as a growth process that can be compared to a journey and is never an end in itself (Geyer et al., 2010). The American Association Colleges of Nursing (AACN) (2008) defines professionalism as the consistent demonstration of core values. Core nursing values dictates the beliefs and behaviours of nurses (Gokenbach, 2012). The Merriam-Webster's dictionary (1997) outlines professionalism as a set of attitudes and behaviours believed to be appropriate to a particular occupation. It has also been described as those attitudes and behaviours that serve to maintain patient interest above self-interest and as the display of values, beliefs and attitudes that put the needs of another above the personal needs of the professional (Hammer, 2000).

Professionalism in nursing began with Florence Nightingale who had high expectations of excellence in nursing practice (Gokenbach, 2012). As an inventor, visionary and missionary, Nightingale delivered nursing practice with passion and love. During Nightingale's time, formal schooling in nursing was just beginning (Black, 2014:115). In 1859, Nightingale published *Notes on Nursing: What It Is and What It Is Not* and became the first person to draft a definition of nursing, stating: "And what nurses has to do … is to put the patient in the best condition for nature to act upon him" (Nightingale, 1946:75). She was also the first person to differentiate between nursing provided by a professional nurse using a unique body of language, and nursing care provided by a layperson such as a mother caring for a sick child (Black, 2014:115). Geyer et al. (2010) state that professionalisation of a nurse is the result of assimilating a variety of influences and experiences through which the culture and value system of the profession becomes part of the practitioner's identity. It is a process which takes place within practitioners themselves through contact with other practitioners in the health sector with whom they work throughout their careers. Professionalism could be viewed as being based primarily on professional solidarity, accountability, proficiency, the maintenance of a code of ethics, and the welfare of the public (Geyer et al., 2010:34). It could be interpreted that Geyer et al. (2010) focus on the character domain in professionalism of practitioners.

The process or stages of professionalisation start with a need identified by society (Mulaudzi et al., 2001:5). In response to this identified need, trained personnel identify skills and knowledge needed to care for sick people; develop formal programmes to educate learners; and conduct constant research to improve practice. Interested learners with a desire to increase knowledge enrol for training, take part in participative teaching (resulting in competence) and become further trained after being qualified as a nurse. In the learner-educator relationship, it is important that there should be trust and confidence to build collegiality. Mulaudzi et al. (2001) state that society, trained nurses and all learners share a common goal of providing care to people who are in need of care, thereby reinstituting a state of wellbeing. Their viewpoint could be interpreted as being focused on the competencies of nurse practitioners. The emphasis is placed on the connection domain, with the capacity of the nurse practitioner to build meaningful interpersonal relationships. Muller (2009:7) refers to professionalism as the professional attributes of practitioners who practise the profession of nursing. She emphasises that it implies that the nurse fulfils all the norms and expectations of the professional practitioner. The behaviour of the practitioner should therefore be in line with the codes of conduct and rules and principles of behaviour as determined by the profession. Muller further states that the nurse practitioner's level of professional maturity will determine his or her level of professionalism. The novice nurse still needs professional socialisation in order to make the expertise, norms and values of

the profession his or her own, while the professionally matured and competent practitioner demonstrates all the characteristics of professionalism. According to Muller (2009), the attributes of professionalism are: accountability; competencies (knowledge, skills, values and attitudes); leadership; self-regulation; commitment to excellence; social values; service-directedness and duty; honour and integrity; respect for others; compassion; and empathy. These attributes are some elements that occur within the competence (professional capability) and character (personal reliability) domains. On the other hand, Gordon (2003:341) sees altruism; accountability; duty; respect for others; and integrity as the essence of professionalism, placing the focus on the character domain in the medical society.

Professionalism means fulfilling all responsibilities as defined in the scope of practice, and includes independent and interdependent activities that demonstrate knowledge of boundaries and collaboration (Van der Merwe in Jooste, 2017:9). Van der Merwe further states that it forms the essential moral basis of the nurse's contract with society and consists of a commitment to service; adherence to ethical standards or values; being responsible and accountable; and commitment to professional advancement and lifelong learning. She therefore places a focus on the competence and character domains in the nursing profession (Brown & Ferill, 2009).

Professionalism is reflected in appearance, behaviour, dress and communication skills. These are important elements of the professional image that the nurse should demonstrate and that communicate respect for self and others (LaSala & Nelson, 2005:63). Projecting a positive image communicates that nurses care about themselves. LaSala and Nelson (2005) believe that first impressions should be positive because they communicate a message to others about how the nurse respects (values) the self, patient and the public. A focus is thereby also placed on the connection domain while emphasising interpersonal relationships. Evetts (1999:1) states that professionalism is regarded as a core humanistic focus in which the interest of the patient and community is central. This commitment to social responsibility is increasingly becoming a focus of more responsive educators and medical schools (McNair, 2005:457). On the other hand, a focus on individual characteristics and behaviour alone is insufficient as a basis on which to build understanding of professionalism (Martimianakis, Maniate & Hodges, 2009:829). On the contrary, the authors claim that professionalism is a role that draws attention away from the traits and behaviours of individuals and rather focusses on professionals in general, thus highlighting the connection domain.

According to Martimianakis et al. (2009:831), professionals as a group are assumed to act in the public interest, and for this reason their behaviour is regulated and their actions scrutinised by

public and professional bodies. The authors further state that "…the context of social roles provides a larger framework in which to situate professionalism". Furthermore, they state that sociologists argue that: "… focusing on any trait-based, behaviour-based or role-based definitions of professionalism leads to an over-emphasis on codes of behaviour and misses the influences of context, institutions and socio-economic and political concerns in the creation of the definitions". The domain of interpersonal compatibility (connection domain) comes to the fore with a strong emphasis on the legal framework in which nurses practise. This view is confirmed by Wear and Kuczewski (2004) and Hafferty and Levinson (2008) who argue that a deep understanding of professionalism requires attention to the sociological, political and economic dimensions of the concept at both individual and institutional levels. Wear and Kuczewski in Martimianakis et al. (2009:834) suggest that one should think of professionalism in ways that allow the possibility of multiple experiences and identities that challenge narrow, rigid and historically rooted assumptions about what it means to be professional, thus placing the emphasis on the connection domain.

Hafferty and Levinson (2008:599) propose a shift in the focus on professionalism: from changing individuals, to modifying the underlying structural and environmental forces that shape social actors and actions. Seen as a complexity science, Hafferty and Levinson's view is that professionalism is more incubatory in nature and seeks to recast social actors, social structures and environmental factors as interactive, adaptive and interdependent, and that it is necessary to move towards such a framing of professionalism. The authors thus see professionalism as a function of relationships within systems (Hafferty & Levinson (2008) in Birden et al., 2014:24). The medical definition of professionalism by Hafferty and Levinson (2008), suggests that this concept should further be based on core knowledge and skills, ethical principles and a selfless devotion to service. Hafferty and Levinson (2008) also acknowledge a social definition grounded in self-regulation and altruism that balances medical values with societal values.

Nurses today, despite the many definitions of professionalism, continue to uphold the values of the profession that define the beliefs and behaviours of nurses. The nursing profession embodies the core nursing values of honesty, responsibility, knowledge, human dignity, equality and the desire to prevent and alleviate suffering to improve the quality of life for all (Gokenbach, 2012). Professionalism is therefore judged by the personal behaviours of the nurse. Components of professionalism include the nurse's attitude, appearance and willingness to help others (Gokenbach, 2012).

Table 2.1: Summary of definitions on professionalism

Author	Definition	Domain of professionalism as
Fagermoen (1997)	Professionalism is viewed as professional attitudes and used by professionals in identifying their work in a social role context; thus the emphasis of professionals' value commitments is on the professional status of their work.	Connection domain
McNair (2005)	Defined as a commitment to standards of excellence in professional practice designed to serve the interest of the patient and the community with a core humanistic focus.	Character domain
Evetts (1999)	Professionalism is regarded as a core humanistic focus in which the interest of the patient and community is central.	Character domain
Mulaudzi, Mokena and Troskie (2001)	The process or stages of professionalisation starts with a need that is identified by society. Society, trained nurses and all learners share a common goal of providing care to people who are in need of care. Trust and confidence are important to build collegiality in this relationship. The focus is on the competencies of nurse practitioners.	Connection domain
Geyer, Mogotlane and Young (2010)	Professionalisation of a nurse is a process which takes place within him or herself and is the result of assimilating a variety of influences and experiences through which the culture and value system of the profession forms part of the practitioner's identity.	Character domain
Muller (2009)	The norms and expectations of the profession should be adhered to and the behaviour of the professional practitioner should be in line with the codes of conduct and principles of behaviour.	Competence and character domains
Van der Merwe (2010)	The moral basis of the nurse's contract with society.	Competence and character domains
Wear and Kuczewski (1997)	Emphasis is placed on allowing the possibility of multiple experiences and identities that challenge narrow, rigid and historically rooted assumptions of professional practice.	Connection domain
LaSala and Nelson (2005)	Professionalism is reflected in appearance, behaviour, dress and communication skills. These are important elements in the professional image projected by the nurse.	Connection domain
Gordon (2003)	Central qualities to professionalism are altruism, accountability, duty, integrity respect for others and lifelong learning.	Character domain

2.2.3 Ethics

Ethics seek the best way of taking care of the patients, as well as the best nursing operation (Shahriari, Mohammadi, Abbaszadeh & Bahrami, 2013:3). Maintaining ethics is considered as one of the features of professionalism. Ethics are guidelines for individuals, which clearly state do's and don'ts referring to the values and principles concerning human conduct. Professional ethics, on the other hand, refers to the general moral norms acceptable in a certain occupational group for dealing with morally ambiguous situations and thus preventing and avoiding ethical harm (Kangasniemi, Pakkanen & Korhonen, 2015:2). Professional ethics in nursing refers to the nurses' personal characteristics, etiquette or manner. It also focuses on groups of professionals

guided by shared ethical codes (Kangasniemi et al., 2015). Professional ethics is thus linked to the organisational and institutional ethics guiding nurses' everyday work. Nursing ethics is thus not different from that of other health professions, as it includes the same rules of ethical values and norms (Kangasniemi et al., 2015). Kangasniemi et al. conclude that professional ethics in nursing creates a basis for the nursing profession, as it comprises the values, rights, duties and responsibilities of nurses when they interact with patients, colleagues, other professionals and organisations. The overall purpose, according to Kangasniemi et al. (2015:10), is to guide nurses' contribution to the development of a healthy society. The code of ethics is used as a written, public document that reminds professional practitioners and the public they serve of the specific responsibilities and obligations accepted by the professions' practitioners (Black, 2014:59). It exists to strengthen and guide nurses' decision-making and empowers nurses to maintain their focus on the patient as the centre of healthcare.

Code of ethics

The existence of a code of ethics is considered a hallmark of professionalism: first because of the nurse's obligation to individuals, to society, to the profession, to nursing co-workers and other members of the healthcare team and to themselves; and second because it is a statement of the primary goals, values and obligations of the nursing profession (Jomsri et al., 2005:585; LeDuc & Kotzer, 2009:280). Ethical codes are defined as systematic guidelines for shaping ethical behaviour that answers questions of what beliefs and values should be morally accepted (Butts, 2013:83).

The ANA Code of Ethics for Nurses with Interpretive Statements (ANA, in Black, 2014), is the most recent version and has nine provisions and an interpretive statement intended to clarify the provisions. The first three provisions describe "the fundamental values and commitments of the nurse; the next three address boundaries of duty and loyalty and the last three address aspects of duties beyond individual encounters". The ANA and ICN codes of ethics contain multiple professional boundaries and moral obligations of professionalism and practice (Butts, 2013:88). Embedded in them are the overlapping concepts of respect, confidentiality, moral courage, cultural sensitivity and power. Practising nursing ethics and using the code of ethics as guides help nurses to develop moral grounding by which to function in nursing practice (Butts, 2013:88).

2.3 PROFESSIONAL VALUE FRAMEWORKS

A Nursing Professional Values Scale (NPVS) was conceptualised, based on a critical review of literature pertaining to the code of ethics in nursing and nursing values (Krathwohl, Bloom & Masia, 1964), as well as professional value development in nurses (Lutz, Elfrink & Eddy, 1991; O'Neill, 1973). The NPVS was developed by Weis and Schank (2000) and is the only standardized instrument that measures professional nursing values based on the American Nurses Association Code of Ethics for Nurses (2001) (LeDuc & Kotzer, 2009:281). The 44-item scale is divided into 11 subscales, based on the 11 ANA code value statements. The character domain comes to the fore with the statements that the nurse: i) provides services with respect for human dignity; ii) safeguards the client's right to privacy; iii) acts to safeguard the client and the public; iv) assumes responsibility and accountability for individual nursing judgements and actions; v) maintains competence in nursing; vi) exercises informed judgment; vii) participates in activities that contribute to the ongoing development of the profession; viii) participates in efforts to implement and improve standards of nursing; ix) participates in establishing and maintaining conditions of employment; x) protects the public from misinformation and misrepresentation; and xi) collaborates with members of the health professions. The NPVS was revised in 2004 and now includes 26 items and seven sub-dimensions (Özsoy & Donmez, 2015:16).

In 1996 Anita Kay Ochsner developed the Ochsner's Inventory of professional nursing values as a model to measure nurses' professional values. Her study evolved from a belief that higher education has a responsibility to provide an environment in which students can pursue moral growth and development and learn principles of ethical decision-making. The study addressed moral concepts of beneficence, truthfulness, confidentiality, justice, autonomy and integrity (Yeo, 1998 in Ocshner, 1996:7). Ocshner included relevant codes, policies and laws in his description of nursing knowledge, while reporting on nursing ethics and altruism, equality, esthetics, freedom, human dignity, justice and truth as essential values (Ochsner, 1996:8). These values could be linked to the connection and character domains. The Ochsner Inventory of Professional Nursing Values (IPNV) contributes to an essential knowledge-base for ethical nursing practice. The need to discover innovative ways to teach values to undergraduate nurses has been identified as early as the 19th century.

2.4 FRAMEWORKS AND VIEWS ON CRITERIA, MODELS AND THEORIES RELATED TO PROFESSIONALISM

In this section, professionalism is viewed from different international and national perspectives as discussed under frameworks, views on criteria, models and theories related to professionalism.

2.4.1 Frameworks for professionalism

Frameworks for professionalism will be discussed under the (i) international views on professionalism in nursing and other health professions; and (ii) professional standards of practice as a framework for professionalism.

2.4.1.1 *International views on professionalism in nursing and other health professions*

International views will include various criteria and frameworks such as; i) Flexner's (1915) criteria of a profession; ii) Pharmacy Task Force on Professionalism; iii) Kelly's (1981) criteria of a profession; and iv) Professionalism Framework for Medical Education.

Flexner's (1915) criteria of a profession

In 1910, a sociologist by the name of Flexner called on medical schools to implement high standards for admission and graduation, and to follow long accepted beliefs of science in teaching and research (Black, 2014:53). In 1915, the characteristics of true professions were published by Flexner as a list of criteria that stipulated that a profession is intellectual and is accompanied by a high degree of individual responsibility. It was meant to be based on a body of knowledge and practical skills that could be learned and taught through a process of highly specialised professional education. The opinion was held that the knowledge and skills that the nurse acquires are developed and refined through research that nurses are motivated by altruism or the desire to help others and are responsive to public interests. Flexner's (1915) criteria have been used as a benchmark for determining the professional status of various occupations and is said to have had a profound influence on professional education, including nursing (Black, 2014). In conclusion, Flexner's criteria mainly focus on acquiring the knowledge and practical skills by undergoing specialised education. This domain refers to the professional capability a practitioner should possess and indicates knowledge and applied skill as elements in the professionalism taxonomy. A second area of focus draws attention to service or altruism, indicating that practitioners should possess personal reliability under the character domain of Brown and Ferrill's (2009) professionalism taxonomy.

Pharmacy task force on professionalism (2000)

A task force of pharmacists found that members of professions shared certain characteristics (Black, 2014:53). These characteristics can be linked to a profession's *ideology* and the *education and training* of its members. Members of health professions subscribe to an ideology based on the original faith professed by members. A theory of societal benefits is derived from this ideology, and according to this theory, society grants members permission (in the form of

licensure or certification) to be service-orientated within a recognised setting in which the profession is practiced. Practitioners are bound by the ethics of their profession. They can belong to a guild for those entitled to practice the profession. The review of the pharmacy profession taskforce revealed that, despite disagreement by scholars on the number of criteria, types of behaviour and characteristics of professions, three criteria consistently appear: i) service/altruism; ii) specialised knowledge; and iii) autonomy/ethics (Black, 2014:53). In conclusion, it therefore seems that the focus of the common characteristics is directed at professional capabilities (competence domain) and personal reliability (character domain) of the members of professions, with less emphasis on the connection domain referring to the ability of members of a profession to demonstrate interpersonal compatibility or having "people's skills" (Brown & Ferrill, 2009:5).

Kelly's criteria of a profession (1981)

Kelly is an influential nurse leader who was editor of the journal *Nursing Outlook* and President of Sigma Theta Tau International Society of Nursing. She compiled eight characteristics of a profession (Kelly, 1981:157) that brings to the fore the nurse's contract with society, education and training and legislation pertaining to nursing. The nurse enters into an unsigned *contract with society*, by pledging to provide services that are vital to humanity and the welfare of the society. Nurse practitioners are motivated by service (altruism) and consider their work an important component of their lives. The services involve intellectual activities, individual responsibility and accountability. Nurse practitioners are educated in institutions of higher learning. They are *educated and trained* over a long period of time. This training is unique to nursing because of the specialised body of knowledge that is continually enlarged through research. The profession has been given powers to regulate itself under the relevant *legislation*. Practitioners are given authority by law and their statutory body to function independently and control their own policies and activities (autonomy). There is a code of ethics to guide the decisions and conduct of practitioners. There is also an organisation (association) that encourages and supports high standards of nursing practice. In conclusion, it could be interpreted that Kelly's (1981) characteristics of a profession seems to emphasise the character domain, although a strong emphasis is not placed on honesty and integrity.

Professionalism framework for medical education

Brody and Doukas (2014) propose a professionalism framework to guide medical education. This framework includes precepts or guidelines which help students avoid common misunderstandings of professionalism and to jointly guide staff and students to address the

deeper issues related to successful professional identity formation. The guidelines for education in medical professionalism that the authors propose are: i) "profession" is a public, collective promise providing the basis for trust, based on an implied social contract which underlines the commitment to the patient's best interests; and ii) professionalism involves hard work that requires knowledge and technical competence, but more importantly, requires the application of ethics based on deeper attitudes (rather than mere behaviour) and practical wisdom.

2.5 PROFESSIONAL STANDARDS OF PRACTICE AS FRAMEWORK FOR PROFESSIONALISM

Standards are defined as "Benchmark of achievement which is based on a desired level of excellence" (Nursing Standards, 2010:1). Professional standards ensure that the highest level of quality nursing care is promoted. All standards of practice provide a guide to the knowledge, skills, judgment & attitudes that are needed to practice safely. Professional standards reflect a desired and achievable level of performance against which a nurse's actual performance can be measured (Nursing Standards, 2010:1). The main purpose of professional standards is to provide a framework to direct and maintain safe and clinically competent nursing practice. These standards are important to the nursing profession, because they promote and guide clinical practice. They may also be used to evaluate a nurse's quality of care if the employer suspects that the nurse has developed unsafe work habits or is not adhering to established organisational policies or widely accepted guidelines established by the laws of the country. Some of the ways in which professional standards assist nursing management and healthcare organisation is to develop safe staffing practices, delegate tasks to licensed and unlicensed personnel, ensure adequate documentation, and even create policies for new technology such as social media. Professional standards therefore guarantee that nurses are accountable for clinical decisions and actions, and for maintaining competence throughout the nurse's career. It is patient-centred; promote the best possible outcome, and minimise exposure to the risk of harm. These standards encourage nurses to continuously enhance their knowledge-base through experience and continuing education. The professional standards are utilised to identify areas for improvement in clinical nursing practice and work areas, as well as to improve patient and workplace safety. Nurses are expected to maintain the trust and respect of their patients and the community. The following international and national professional standards of practice, which serve as a framework for professionalism for nurses, are briefly discussed: i) British Columbia; ii) American; and iii) South African Professional Standards of Practice for Nurses.

Professional standards of practice for nurses in British Columbia

According to the College of Registered Nurses of British Columbia, professional standards provide an overall framework for the practice of nursing in British Columbia (CRNBC, 2012). The professional standards are statements about minimum levels of acceptable performance that nurses are required to achieve in their practice. These standards i) reflect the values of the nursing profession; ii) clarify what the profession expects of nurses; and iii) represent the criteria against which nurses' practice in British Columbia are measured by clients, employers, colleagues, the nurses themselves and others (CRNBC, 2012). Four standards fall under CRNBC's Standards of Practice: i) professional responsibility and accountability; ii) knowledge-based practice; iii) client-focused provision of service; and iv) ethical practice. These standards are all applied in clinical nursing practice, education, administration and research. CRNBC uses these standards to meet its legal responsibility to protect the public by regulating nurses' practice. These responsibilities include: recognising entry-level education programmes for RNs; clarifying to the public and other healthcare professionals what the profession expects of its members; providing guidance to the nurses regarding their professional obligations; providing a foundation for the assessment of professional performance; and addressing incompetent, impaired or unethical practice among nurses.

American Nursing Association: scope and standards of practice

This association outlines the expectations of the professional role within which all RN's must practice and delineates the standards of care and associated competencies for professional nursing. The goal of establishing standards is to improve the health and wellbeing of all recipients of nursing care and to establish the responsibilities for which nurses are accountable (Black, 2014:59). Each standard in this document have numerous competencies according to which nursing practice can be assessed. Although Black states that all the standards are important to the practice of nursing, the standards of professional performance are particularly relevant as it places emphasis on professionalism. In the ANA's Nursing, Scope and Standards of Practice (2004), the value of collegiality, an important aspect of professionalism, is specified as one of nine standards of professional performance. The fourteen points on professionalism serve as reminders of collegiality. The first point emphasises *civility* and that the nurse should treat people with respect. The second point is that the nurse must be *ethical* by committing to personal and professional standards. Third, nurses are required to be *honest*. Fourth, the nurse must be the best that she or he should strive to be better than before. The fifth point is that the nurse must be *consistent* and that her or his behaviour should coincide with values and beliefs of the profession. The nurse is required to be a *communicator* by inviting ideas, opinions and feedback from patients and colleagues, the sixth point. *Accountability* is the seventh point. Point

eight refers to the nurse being *collaborative* and working in partnerships with others for the benefit of the patients. Point nine stipulates that the nurse should be *forgiving* because everyone makes mistakes and therefore people must be given a fair chance. Point ten requires nurses to be *current* by keeping their knowledge and skills up to date. The nurse is expected to be *involved* and active at local and national levels in decision and policy making, point eleven. Point twelve stipulates that the nurse must be a *model*, because what a person says and does reflect on his or her profession. To be *responsible for self* is the thirteenth point that reminds nurses to take responsibility for their own learning and to be assertive in making this known to teachers and mentors. The last and fourteenth point highlights that the nurse, as a learner, must *be prepared*. Nurses should do assignments for classes and prepare for laboratories and clinical sessions in advance, brushing up on skills if needed.

South African frameworks of professionalism

Two important frameworks for professionalism in South Africa are highlighted, namely Searle's (1978) and Geyer, Mogotlane and Young's (2010) criteria of a profession.

- *Searle (1978)*

The origins of South African professionalism in midwifery dates back to 1652, and in nursing itself, professionalism dates back to 1891 (Searle, 1978:8). The *standards of practice* are laid down by the SANC, who controls the profession under delegated responsibility from Parliament. They establish the elements of professionalism, namely prescribing admission standards; prescribing syllabi in education; approving and inspecting nursing schools; examining competence; and registering and prescribing the regulations relating to professional practice and disciplinary control (Searle, 1978). It can thus be stated that the practice of nursing/midwifery is grounded in standards and ethical values and is supported by a system of professional regulation (SANC, n.d.). According to SANC, practice standards are authoritative statements describing the responsibility for which its practitioners in the nursing profession are accountable. These statements are agreed upon by the profession and are used in judging the quality of practice, service or education. They state what RNs are required and expected to do as professionals. Practice standards serve as benchmarks, provide guidance for achievable levels of best practice and professional performance, and reflect the values of the profession. They therefore clarify what the regulatory body expects of its RNs and in turn represent the criteria against which the practice of all RNs are measured by the public, clients/patients, employers and colleagues (SANC, n.d.). The criteria forming the framework of professionalism in South Africa, according

to Searle et al. (2009:8), relate to a body of knowledge, the legal and ethical foundation of nursing, the need for education and training, and autonomous practice.

The development of a *specialised body of knowledge* obtained through research and empirical experience is essential in nursing. The existence of a body of specialised knowledge and skills should be derived from the (i) sciences basic to medicine (the biological, physical, medical and pharmacological sciences); and (ii) the social sciences (sociology, psychology, cultural anthropology, philosophy and ethics). Nurses function *in legal and ethical foundations* on which their professional practice rests. They should be clear on the role and functions of the profession in society. The nurse therefore need *education and training* at institutions of higher education to become *autonomous* in making prudent and binding decisions consistent with the scope of practice; this *autonomy* is described in the dependent, interdependent and independent functions of a nurse (Searle et al., 2009:8).

- *Geyer, Mogotlane and Young (2010)*

The criteria by which the nursing profession have earned its professional recognition in South African are briefly contained as i) having a specialised body of theory; ii) enrolling students over a period of time; iii) testing or examining competence prior to admission to professional practice; and iv) registering nurses to practice autonomously under ethical and legal control, rendering service-orientated nursing practice and lifelong learning (Geyer et al., 2010:34).

The profession has a *specialised body of theory* and members develop knowledge drawn from the arts and sciences. The nurse, on entering the profession, *enrols* for a prescribed period of training and learning prior to qualification as a professional nurse. During this time, the nurse is equipped with skills based on theory. The nurse is therefore expected to master the knowledge and skills and to develop the capacity to internalise and express the norms and values of the profession. This mastery contributes to the exclusiveness of the nurse as a member of the profession. The *testing* of professional *competence* prior to admission to the ranks of qualified professionals is an important part of the education and training programme of the nurse who is still learning. *Registration or licensure* after the completion of a nurse training programme is a prerequisite for the practice of the competent nurse professional. When the nurse enters nursing practice as a trained professional, she or he is granted professional autonomy by the profession itself who exercises *ethical and legal control* of the profession to protect the public from unlawful practice. The nurse, who practices autonomously, should use discretion and judgement based on knowledge and experience. The profession is *service-orientated*. High *social status and social power* is given to the profession by the public. An overriding concern for the welfare of

others should be the first consideration of the nurse. The nurse is therefore required to render nursing services to the public or the community, which is based only on the needs of the patient. Nurses are responsible and accountable for all their professional acts. They should thus apply the learned theory to practice so that the results of their actions can be predicted. A constant thrive for excellence is regarded as a driving force behind the practice of nurses and depends on ongoing critical analysis of practice. The development of new methods in the light of new knowledge will therefore be achieved by the nurse's obligation to engage in *lifelong learning*.

2.6 MODELS OF PROFESSIONALISM

The models related to nursing professionalism to be outlined are The Wheel of Professionalism in Nursing by Miller (1984), Hall's Care, Cure and Core Model (1963), Hall's Professionalism Model (1967), The NPVS (2000) and Ochsner's Self-Report IPNV (1996).

2.6.1 The Wheel of Professionalism in Nursing (Miller)

Barbara Kemp Miller developed a model called The Wheel of Professionalism in Nursing in 1984 to explore the concept professionalism. It was created in response to nurses' need to recognise attributes and behaviours necessary for nursing professionalism (Alidina, 2013:129). According to Miller (1988:19), these attributes include: adherence to the code of ethics for nurses; community service orientation; professional organisation participation; autonomy and self-regulation; publication and communication; development and use of theory and research; and continuing education and competence. By exploring the concepts outlined in the model, it may help nurses to evaluate their own professionalism and may direct their professional growth (Alidina, 2013:131). Although several professional socialisation models explain how learner nurses are socialised into the professional role, not much is known about the process by which practising nurses continue to internalise, develop and sustain characteristics attributed to the nursing profession. Empirical research demonstrates that little is known about the role of practising nurses in maintaining and enhancing nursing professionalism (Alidina, 2013:128).

2.6.2 Hall's Care, Cure and Core model

Hall (1963) in Kubsch, Hansen and Huyser-Eatwell (2008:377) argues that nursing should be professional and that patients should be cared for only by professional RN's, who have the responsibility of caring and teaching. Hall's Care, Cure and Core Model, in Kubsch, Hansen and Huyser-Eatwell (2008:377) portray nursing as interlocking circles, each representing one aspect of nursing: care, cure and core. Although the care and cure circles are important and are taught in baccalaureate programs, Hall draws attention to the core circle and the professional values with

the emphasis on social, emotional, spiritual and intellectual needs of the family, community and world, as well as the therapeutic use of self (Hall in Kubsch, Hansen & Huyser-Eatwell, 2008:377). According to Hall, in the core circle the nurse works with the patient professionally rather than technically, as this is the essence of professional nursing practiced by the educated nurse. It can thus be concluded that the core circle of Hall's model focuses on the connection domain (Brown & Ferrill, 2009) – professionalism taxonomy that represents interpersonal compatibility and refers to the practitioner as having the "people skills" of compassion, empathy, kindness, influence and ability to connect with the patient by using the therapeutic self.

2.6.3 Hall's (1968) Professionalism Model

In 1968, Hall described a Professional Model and identified five attitudinal attributes that characterise professions such as law, medicine, nursing, social work, engineering and accounting: i) the use of a professional organisation as a primary point of reference; ii) belief in the value of public service; iii) belief in self-regulation; iv) commitment to a profession that goes beyond economic incentives; and v) a sense of autonomy in practice (Black, 2014:53). Hall (1968) argues that each profession needs to develop its own methods of measuring professionalism that recognise the uniqueness of that discipline (Black, 2014:53). The first attitudinal attribute is the use of professional organisations as referents. The second attitude is the belief in public service, which supports the idea that the profession is beneficial and indispensable to society. A third attitudinal attribute is the autonomy that allows professionals to make their own decisions and judgments about the services they provide, with minimal pressure from external sources such as employers, government legislators and regulators, other professionals, and non-professionals. According to Hall, independent practice is often associated with autonomy. The fourth attitudinal attribute of Hall's model is the belief in self-regulation that endorses control of work and the evaluation of work by colleagues who are fellow professionals. A sense of calling representing a commitment to the profession beyond economic incentives is the fifth attitudinal attribute. This attribute refers to professionals' idealistic dedication and devotion to their work and their clients. Wynd (2003) argues that although all five of Hall's attitudinal attributes of professionalism are important to nurses, there has been a shift in emphasis over the years. Wynd (2003)further believes that today's nurses place greater importance on autonomy and membership of professional organisations, whereas in 1968 nurses more readily identified belief in public service and a sense of calling as attributes of professionalism, putting the emphasis on personal reliability or the character domain of Brown and Ferrill (2009:2,3). A sense of calling, according to Brown and Ferrill (2009:3), compels one to provide an altruistic service of the highest quality.

2.7 THEORIES

Theory is the acknowledged foundation for methodology, professional identity and growth of formal knowledge (Halldorsdottir & Karlsdottir, 2011:806). The following theory incorporates nursing professionalism, specifically in the domain of midwifery.

2.7.1 Theory of professionalism in midwifery

Halldorsdottir and Karlsdottir (2011:806) suggest that the practice of midwifery should be theory-based. Theories, according to these authors, serve as a broad framework for practice and may also articulate the goals of a profession and core values. Halldorsdottir and Karlsdottir (2011:806) introduced the evolving theory on the empowerment of childbearing women, where the midwife's professionalism is central. According to this theory, the midwife's professionalism is based on five main aspects:

a) The professional midwife cares for the childbearing woman and her family. The caring within the professional domain is seen as the core to midwifery.

b) The professional midwife is professionally competent. This professional competency must always have primacy for the sake of the safety of the woman and the child.

c) The professional midwife has professional wisdom and knows how to apply it. Professional wisdom is a new concept that denotes the interplay of knowledge and experience.

d) The professional midwife has interpersonal competence, and is capable of facilitating communication and positive partnership with the woman and her family.

e) The professional midwife develops herself both personally and professionally, which is a prerequisite for true professionalism.

Halldorsdottir and Karlsdottir (2011:806) state that this evolving theory must be regularly reconstructed in the light of current knowledge within midwifery, since new knowledge will have implications for midwifery and nursing education and practice. The fundamental aspect of the theory is therefore that professional caring is at the core of midwifery, together with professional competence, interpersonal competence and professional development (Halldorsdottir & Karlsdottir, 2011:806). Halldorsdottir and Karlsdottir (2011:806) assert that midwifery must be theory-based because theories serve as a broad framework for practice and may also articulate the goals of the professions and core values. The authors agree that theory

development is important for professions because theories are meant to reveal a certain reality within the particular profession that include, among other things, increasing understanding and drawing attention to aspects which are important. The importance of caring in midwifery service is an example of a theory presented by Dickson (1997, in Halldorsdottir and Karlsdottir, 2011:808). The principle aspect of the theory is that by caring, women can have a positive birth experience. The theory also emphasises that communication, the presence of the midwife, her knowledge and understanding and her helping the woman to retain a sense of control in the birth are important. According to Halldorsdottir and Karlsdottir (2011:808) theories and models regarding professionalism in midwifery include professional caring, interpersonal competence and professional development, in addition to the professional competence required to provide safe practice. Special attention should thus be placed on these aspects in the curriculum, as well as on evaluating the attitudes of the student midwife and not only their cognitive and practical competences. This theory has significance for midwifery educators, indicating that they should use the theory as a framework for evaluating competence. On the other hand, student midwives can use the theory to gain understanding of what is required of a professional midwife and what qualities they need to nurture. The authors consider that midwifery as a profession has great influence on enhancing and humanizing women's experiences of maternity care. Mutual respect must be established and the importance of an ethical basis for the profession should be considered. One of the characteristics of a profession is autonomy, which means that the profession is entrusted with safeguarding the public from those who lack the necessary competence to work within it. A midwife's professionalism is therefore a key factor in empowering women during the childbearing process as presented in the International Code of Ethics for Nurses. However, individual midwives carry with them their own value system and moral standards that might be in conflict with the International Code of Ethics for Midwifes. Halldorsdottir and Karlsdottir (2011:816) conclude that midwives' associations have formulated professional standards, which must be constantly reviewed in accordance with the latest available knowledge within the profession.

2.8 PROGRAMMES AND GUIDELINES ON PROFESSIONALISM

2.8.1 The BEST Programme

BEST is a programme that incorporates core professional nursing values (CPNVs) as a framework to acculturate students more readily into the nursing profession. The idea is to assist students to apply the CPNVs to the student's academic practice and to integrate them into future clinical practice. Shaw and Degazon (2008:45) argue that by incorporating the CPNVs of altruism, autonomy, human dignity, integrity and social justice into baccalaureate nursing

programmes, the process of professional development and acculturation in a highly diverse student population can be enhanced. These CPNVs impart a shared foundation that gives meaning to the professional practice of nursing and unites students and nurses in a collective culture. Incorporating CPNVs was thus an intervention to bridge the cultural rift between learner nurses (Shaw & Degazon, 2008:45).

2.8.2 Best Practice Guidelines on Professionalism in Nursing (Ontario)

The Best Practice Guidelines (BPGs) was developed in 2003 by the Registered Nurses' Association of Ontario (RNAO) (RNAO, 2007:24). These guidelines were built on a conceptual model created to allow users to understand the relationships among the key factors involved in healthy work environments (RNAO, 2007:24). This document states that professionalism requires nurses to adhere to professional standards in all their roles and provides a comprehensive approach to professionalism. RNAO (2007:24) further states that nurses put into action their values and attributes when providing nursing care and collaborating with patients, nurse colleagues, other members of the healthcare team and student (learner) nurses. The guideline recognises that it is sometimes difficult to maintain professionalism in a changing healthcare setting and therefore provides the basis for a template that can be applied to assist practitioners with the complexities of daily practice. It was also written to help individual practitioners reflect on their own practice situation. The guideline is intended to assist educators to communicate the concept of professionalism to students in a comprehensive and meaningful way. It can furthermore guide nurse administrators in providing environmental support that reinforces the attributes of professionalism. The guideline furthermore provides a summary and recommendations of professional attributes, which include knowledge; a spirit of inquiry; accountability; autonomy; advocacy; innovation and visionary; collegiality and collaboration; and ethics and values. It could be interpreted that this guideline is comprehensive and focuses on professionalism in nursing. It also builds on a conceptual model that allows the understanding of relationships between the key factors involved in healthy work environments. The BPG was formed by the deliberations, perspectives and the development processes of an expert panel of nurses chosen for their expertise in the professional domains of nursing. The voice of the learner (student) nurse is therefore not included in the panel of experts, although the guideline is intended to be relevant to learner nurses. Although the guideline is applicable to all domains of nursing (e.g. clinical practice, administration, education (educators and learner nurses), research, those engaged in policy making and all practice and geographical settings), the guideline falls short of addressing contextual issues such as diversity, the new generation and its influence on

professionalism, and the academic context in which professionalism is acquired by learner nurses.

2.8.3 The International Council of Nurses (ICN)

The International Council of Nurses is dedicated to nursing professionalism (ICN updated 10 April 2015). The ICN's Code of Ethics for Nurses was revised in 2012 in response to the realities of nursing and healthcare in a changing society. It is a guide for action based on social values and needs. The code has served as the standard for nurses worldwide since it was first adopted in 1953. The code makes it clear that, inherent in nursing, is respect for human rights, including the right to life, to dignity and to be treated with respect. The ICN Code of Ethics for Nurses includes four principle elements that outline the standards of ethical conduct. These elements (nurses and people; nurses and practice; nurses and the profession; and nurses and co-workers) provide a framework for the standards of conduct (ICN, 2012:5). The first element addresses nurses and people. It states that the primary professional responsibility is to people requiring nursing care. In providing nursing care, the nurse promotes an environment in which the human rights, values and spiritual beliefs of the individual, family and community are respected. Personal information is held in confidence. The nurse demonstrates professional values such as respectfulness, responsiveness, compassion, trustworthiness and integrity (ICN, 2012:2).

The second element addresses nurses and nursing practice. Nurses carry responsibility and accountability for nursing practice and for maintaining competence by continuing learning. The nurse maintains standards of conduct that reflects positively on the profession and enhances its image and confidence in the public. While providing care, the nurse ensures that the use of technology and scientific advances are compatible with the safety, dignity and rights of the public. The third element under the code of ethics addresses nurses and the profession. This element stipulates that the nurse is active in developing and sustaining core professional values. The nurse, who acts through the professional organisation, participates in creating a positive practice environment and maintaining safe, equitable social and economic working conditions in nursing.

The fourth element relates to nurses and co-workers. The nurse sustains a collaborative and respectful relationship with co-workers in nursing and other fields, and takes appropriate action to support and guide co-workers to advance ethical conduct. The ICN Code of Ethics for Nurses can therefore be viewed as a guide for action, based on values, and will have meaning if applied to the realities of nursing and healthcare in a changing society. The ICN(2012) suggests that, in

order to achieve its purpose, the code must be understood, internalised and used by nurses in all aspects of their work, and it must be available to both students and nurses throughout their studies and work (ICN, 2012:4).

2.8.4 The Thai Nurses' Association Code of Ethics

The Thai Nurses'Association Code of Ethics (1985) provides guidelines for nursing practice and is considered a hallmark of professionalism. The code was analysed to identify professional nursing values. These values are conceptualised as the fundamental values providing standards and direction for nursing practice. They produce a corresponding shift in professional identity and provide a framework for evaluating a nurse's behaviour (Jomsri, 2005:585). The professional nursing values in Thailand were derived from the Professional Nursing and Midwifery Act (Nursing Council of Thailand, 1997). The ethical aspects of the Act were analysed by Pornwattanakul (in Jomsri, 2005:585) who identified eight attributes accepted as values for the nursing practice: faithfulness; politeness; kindness; respect for human dignity; discipline; unity; responsibility; and devotion. Jomsri (2005:585) presents these values as part of the Model of Moral Competence that consists of attributes derived from personal, social and professional values. The author obtained information about personal values from interviews with nurse educators and nurse practitioners. Social values were derived from the Buddhist religion as main source, but also from interviews with healthcare service clients who were Buddhists. The Thai Nurses' Association Code of Ethics (1985) and the Thai Professional Nursing and Midwifery Act (Nursing Council of Thailand, 1997) provided information in identifying professional values.

2.8.5 The code of ethics for nursing practitioners in South Africa: excellence in professionalism and advocacy for healthcare users

The Code of Ethics for Nursing in South Africa (SANC, 2013) serves as a declaration by nurses that they will provide due care to the public and healthcare consumers to the best of their ability. It serves as a guideline aimed at informing nursing practitioners of ethical and moral principles applicable to nurse practitioners in the performance of their duties. It reminds nursing practitioners of their responsibilities towards individuals, families and communities to protect, promote and restore health, prevent illness, preserve life and alleviate suffering, while supporting each other in the process. The code is a formal document published and used by the South African Nursing Council and binding upon all categories of nurse practitioners registered under the Nursing Act (Act 33 of 2005) (SANC, 2013). The Code of ethics forms the basis for moral and ethical decisions taken. Therefore, all nurse practitioners are required to familiarise

themselves with the content of the code because it has a bearing on their professional conduct towards healthcare consumers. SANC(2013) acknowledges that changes in the health practice environment can cause decision-making processes to be challenging and demanding, which implies that the code should be reviewed frequently. The nursing practitioner not only has the responsibility to remain aware of changes to the code, but should also be aware of the dynamics related to the application of the code, such as interpersonal relationships inherent in their professional practice.

Although the Code of Ethics (SANC:2013) provides a framework for ethical direction within which the nurse practitioner should practice, it still requires nurse practitioners to rely on their own personal integrity to make the right decisions. At the foundation of the Code of Ethics are the principles of respect for life, human dignity and the rights of other people, including cultural rights. However, when nurse practitioners apply the code, it should be done in conjunction with all applicable South African laws, as well as international policy documents such as the Universal Declaration of Human Rights, Code of Ethics of the ICN(2012), the Patient's Rights Charter and other nursing policy frameworks that provide direction for safe and professional nursing practice (SANC, 2013).

2.9 CONCLUSION

In Chapter 2, the researcher attempted to give the reader a short, though thorough, overview on important frameworks, models, theories, programmes and guidelines related to professionalism in nursing and health. An indication of what is already known in the field of study was provided at the same time. This chapter highlighted that professionalism is an ancient concept, not only in nursing, but also in other health professions such as medicine and pharmacy. In reflection on the chapter, the researcher became aware of the attributes related to the three domains of professionalism in practice. The overview confirmed that most of the professional values in the three domains of professional capability, interpersonal compatibility and personal reliability of Brown and Ferrill (2009:1) were essential in professionalism, although not included as a whole in one framework. The overview helped the researcher to understand what is already known about the topic (Houser, 2012:109). Chapter 2 is regarded by the researcher as important for the understanding of how the study relates to the larger field of the phenomenon of professionalism for undergraduate learner nurses. The methodological approaches followed in Chapter 2 seemed to include mostly qualitative approaches. Chapter 3 addresses the research methodology of this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The research methodology is an important part of the research process as it is a way of systematically solving a research problem (Gupta & Gupta, 2011:11). The research methodology not only deals with the research methods, but it also considers the logic behind the methods the researcher uses in the context of this study. Research methodology explains why the researcher is using a particular technique and enables others to evaluate research results (Gupta & Gupta, 2011). The main purpose of this chapter is to describe the process of inquiry, referred to as the research design, and the methods of data collection, analysis and interpretation in the paradigmatic perspective of the study (Creswell, 2014:31). The measures used to establish trustworthiness are presented along with the ethical principles followed in the study.

My research was aimed at developing a conceptual framework for nurse educationalists and professional nurses for facilitating professionalism among undergraduate learner nurses in the nursing practice in the Western Cape by describing the essence of the experiences of the participants with regards to professionalism. This concept arose in the practice of a human service profession (nursing) and could be placed in the field of professional research (De Vos, Strydom, Fouche & Delport, 2011:44; Creswell, 2014:185). According to De Vos et al. (2011:46), professional research is a scientific inquiry about a professional problem, such as concerns about nursing professionalism that provides an answer and contributes to an increase in the body of knowledge in e.g. Nursing Sciences. The researcher's intend in this study was the development of scientific knowledge within a professional context. Therefore, the scientific process applied by the researcher was built on the epistemology (philosophy of knowing) of inquiry around the experiences of nursing participants involved in the undergraduate programme for learner nurses.

The overall approach in this study was qualitative, using a case study method. In this qualitative inquiry, the researcher explored and described the experiences of three cases, namely learner nurses, nurse educationalists (nurse educators and clinical supervisors) and professional nurses, to facilitate professionalism among undergraduate learners in a nursing programme at a higher education institution in the Western Cape. The researcher was the main instrument for data collection, analyses and interpretation of the data during the qualitative research inquiry. The

researcher avoided any personal bias that could have inhibited the research participants from sharing their experiences about the phenomenon under investigation.

The chapter starts with a brief discussion of the paradigm for situating the study in a qualitative paradigm.

3.2 PARADIGM

Philosophical worldviews, although hidden, influence the practice of research and explain why a certain approach was employed by the researcher. Creswell (2014:32) uses the term "worldview" as meaning "a basic set of beliefs that guide action", whereas Lincoln, Lynham and Guba (2011) call it "paradigms". In this study, a constructivist worldview or paradigm was used. Constructivism or social constructivism, often combined with interpretivism, is an approach to qualitative research. Individuals develop subjective meanings of their experiences, and in this study, meanings with regard to how professionalism is experienced by undergraduate learner nurses, nurse educationalists and professional nurses in the clinical learning environment were explored. These meanings are multiple and lead the researcher to look for the complexity of views rather than narrowing the meanings down to a few categories or ideas. The goal of this research was thus to rely as much as possible on the participants' views of the phenomenon being studied (Creswell, 2014:37).

3.2.1 Qualitative versus quantitative paradigms

A distinction is made between qualitative and quantitative paradigms. In qualitative studies, the aim is for depth, rather than to quantify an understanding. Qualitative researchers want to understand and explain by using evidence from the data and from the literature about the phenomena being studied (Henning, 2004:3). Qualitative studies capture data from the natural development of interaction of the participants with minimal control from the researcher, data that cannot be obtained by predetermined instruments controlled by a quantitative researcher (Hennink et al., 2011:3).

Unlike quantitative paradigms where components (variables) are controlled, the researcher in this study chose to use a qualitative paradigm in which the aim was to understand, explore and describe participants' experiences of professionalism. The researcher wanted to understand the perspectives of three cases of participants by using methods such as focus groups and unstructured interviews that allowed the participants to demonstrate what was important to them, rather than collecting data that focused on the concerns of the researcher (Harding, 2013:10; Bryman, 1988:50). A general distinction between qualitative and quantitative research is that

qualitative studies use words and open-ended questions rather than numbers or close-ended questions (quantitative studies) (Creswell, 2014:32). Qualitative research is an approach for exploring and understanding the meaning individuals or groups ascribe to a problem. Creswell (2014:32) explains that the qualitative process involves emerging questions and procedures, collecting data in the participant's setting, inductively building data from particular to general themes and making interpretations about the meaning of the data. By engaging in the qualitative research design, the researcher indicated that she was looking at the research from an inductive point of view, with a focus on individual meanings and the importance of delivering an understanding of the complexity of the situation (Creswell, 2014). On the other hand, quantitative research is an approach that would have tested theories by examining the relationship among variables, which in turn could have measured the phenomenon through instruments, so that numbered data could be analysed using statistical procedures (Creswell, 2014).

The purpose of qualitative studies is therefore to produce information — rich data from a sample chosen for its ability to speak to the research issue (Ulin, Robinson & Tolley, 2005:54). These studies emphasise depth and insight rather than making generalisations, and enlighten meaning of human behaviour. On the other hand, the goal of quantitative research is to generalise findings to larger populations. In contrast to quantitative designs in which researchers rarely depart from that design when the study is underway, the study design in qualitative research evolves over the course of the research. In this study, for example, considerable advanced planning was done, which provided the researcher with the flexibility to develop an emergent qualitative design. The qualitative study therefore uses an emergent design. Polit and Beck (2012:487,726) claim that qualitative studies use emergent designs that allow the researcher to reflect on the decisions made as the study unfolds. According to Lincoln and Cuba (1985) in Polit and Beck (2012:487) an emergent design is a reflection of the researcher's desire to have the qualitative inquiry based on the realities and viewpoints that are not known or understood at the outset of the research study. The researcher chose purposive sampling, choosing those members (learner nurses, nurse educationalists and professional nurses) who could best respond to the research question because of their experiences and involvement in the undergraduate nursing programme over time. The researcher initially planned on only conducting focus group interviews (FGIs) as methods of data collection, but in one setting the healthcare authorities were not comfortable with focus group interviews, and therefore unstructured individual interviews had to be conducted. The researcher was the main instrument for data collection in this study. The researcher collected data during February 2013 to October 2013 from three cases — the undergraduate learner nurses, nurse

educationalists and professional nurses — through the methods of FGIs, unstructured interviews and field notes, and analysed and interpreted the data (Polit & Beck, 2008:219).

3.3 RESEARCH DESIGN

Research design in any study is created by the researcher; it is moulded by the method and is responsive to the context and the participants. Research design refers to the logical sequence that connects the empirical data (primary data collected) to a study's initial research questions, and ultimately to its conclusions (Green & Thorogood, 2005:34; Yin, 2003:20, in Tappen, 2011:69). Researchers then select a research design for a research study that must be suitable to adequately address the research question(s) (Burns & Grove, 2011). In this study, a qualitative, explorative, descriptive and contextual design with a case study method was used.

3.3.1 Qualitative design

As mentioned under Point 3.2.1, a qualitative design was followed. It is a flexible method used to gain an understanding of participants' experiences and the significance thereof (Polit & Beck, 2012:487). Qualitative studies are interpretive (Creswell, 2009:4). They thus allow the researcher to meaningfully explore and understand the experiences of the learner nurses, nurse educationalists and professional nurses on professionalism among undergraduate learner nurses.

3.3.2 Exploratory design

Exploratory research begins with a phenomenon of interest, such as professionalism in nursing. Instead of just observing and describing the phenomena of professionalism, exploratory research investigates the full nature of the phenomenon, the manner in which it is manifested and other underlying factors to which it is related (Polit & Beck, 2008:20). The researcher in this study asked: What is the full nature of professionalism among undergraduate learner nurses? What is really going on in the nursing profession pertaining to professionalism? What is the process by which professionalism evolves and what is the process by which it is experienced by members in the nursing profession?

3.3.3 Descriptive design

Qualitative researchers study phenomena about which little is known. Rubin and Babbie (2011:125) and De Vos et al. (2011:96) refer to descriptive research as an intense examination of the phenomenon (nursing professionalism) and its deeper meaning, thus leading to a thicker description. The researcher presented a picture of the phenomenon professionalism as it was experienced by learner nurses, nurse educationalists and professional nurses in the academic and

clinical practice environment. It was also appropriate to choose a descriptive design because the research study was non-experimental in nature and designed to discover new meaning and provide new knowledge about nursing professionalism among undergraduate learner nurses in an institution of higher education who were also placed in nursing practice (Dempsey & Dempsey, 2000:364). The researcher then describes how professionalism can be facilitated in the undergraduate learner nurse, through the support of nurse educationalists and professional nurses in theoretical and clinical placement facilities in the Western Cape.

3.3.4 Contextual design

Qualitative research is conducted in the context of a cultural, physical or geographical setting (Holloway, 2005:275). Contextualisation is important and critical for understanding the reality of the participants and how things work in a particular context. The researcher aimed to grasp the whole picture of how nursing professionalism was experienced within the context of the nursing education and practice environment in a changing socio-economic and cultural environment of South Africa. Context is a complex term that does not merely indicate a physical environment, but is rather produced in the social practice of asking questions about meaning (Schwandt, 2001:37).

3.3.5 Case study research method

Yin (2009), in Creswell (2013:97), discusses explanatory, exploratory and descriptive qualitative case studies. In this qualitative study, the researcher used the case study (with a variety of data sources) as a method to explore and describe nursing professionalism. Rigorous qualitative case studies afford researchers opportunities to explore and describe a phenomenon (such as nursing professionalism) in context (for example nursing practice, socio-economic and cultural environment, and the next generation). In this study the data sources were focus groups and unstructured individual interviews with three cases, namely learner nurses, nurse educationalists and professional nurses (Baxter & Jack, 2008:544). This was done to ensure that professionalism is not explored through one lens, but rather a variety of lenses that allows for multiple facets of the phenomenon to be revealed and understood. Baxter and Jack (2008:544) are of the viewpoint that this approach is valuable in health science research for developing theory and interventions or recommendations because of its flexibility and rigor. According to Yin (2014:4), the case study as a research method contributes to knowledge of individual, group, organisational, social, political and related phenomena. Yin (2014:4) explains that a distinctive need for case study research arises out of the desire to understand complex social phenomena. The researcher's choice for using the case study as a research method in this study was largely

dependent on the research question. Yin (2014:4) and Baxter and Jack (2008:545) state that the more the research questions seek to explain present circumstances, such as how professionalism can be facilitated among undergraduate learner nurses, the more relevant the case study will be. The case study is also relevant in this study because the research questions require a description of nursing professionalism from the perspectives of three distinct cases, namely those of learner nurses, nurse educationalists and professional nurses. The researcher in this study is thus able to focus on nursing professionalism and obtain a holistic and a real world perspective of the phenomenon through a variety of lenses, which allows for multiple facets of professionalism to be revealed and understood (Baxter & Jack, 2008:544; Yin, 2014:4). Case studies as a form of qualitative research can be used to inform professional practice in both clinical and policy fields (Baxter & Jack, 2008:544). Another rationale for using a case study was that the researcher wanted to cover the relevant contextual conditions and beliefs about professionalism, as the case cannot be considered without the context. The contexts in this case were nursing education where nursing professionalism is taught in the academic environment in a classroom, and professional practice where learner nurses are placed in accredited healthcare facilities. Without considering the context, it would be difficult for the researcher to get a picture of how professionalism is experienced in both the theoretical and clinical practice learning environments. To ensure that the study's scope remained reasonable, it was necessary to limit the contexts to the facilitation of nursing professionalism of undergraduate learner nurses at a higher education institution and nursing practice in the Western Cape Metropole (Baxter & Jack, 2008:546). Setting boundaries indicate "what" will be studied. In qualitative studies, the establishment of boundaries according to Baxter and Jack (2008:547) is similar to the development of inclusion and exclusion criteria. Boundaries also indicate the breadth and depth of the study and not simply the sample/cases to be included. The contexts of each of the three cases (undergraduate learner nurses, nurse educationalists and professional nurses) in this study as well as the settings differed, and therefore the researcher analysed and then described the findings within the specific contexts (Chapter 4) and then conceptualised it as an overall case (Chapter 5).

A multiple case study method was employed as the type of qualitative case study (Creswell, 2013:99) (see Figure 3.1). Themes were identified in each case (within-case analysis in Chapter 4 and 5). In the final interpretive phase, the researcher report on the meaning of professionalism in the undergraduate nursing programme at a higher institution of learning in the Western Cape (overall case 5.4). Case studies end with conclusions formed by the researcher about the overall meaning derived from the cases, called building "patterns" or "explanations" (Yin, 2009, in Creswell, 2013:99). The individual cases, learner nurses, nurse educationalists and professional

nurses in Chapter 4 and 5 comprised of conclusions (see Annexures R, S, T) also called "assertions" by Stake (1995) and building "patterns" by Yin (2009) in Creswell (2013:99), which were formed about the overall meaning derived from the cases. The cross-case findings followed in Chapter 6.

The final themes were presented as one framework in Chapter 7. The application of a conceptual framework is required as one of the components of designing and implementing a rigorous case study (Miles & Huberman, 1994, in Baxter & Jack, 2008:550). A framework was developed as the study progressed. The final conceptual framework included all the themes that emerged from the data analysis (Baxter & Jack, 2008:553).

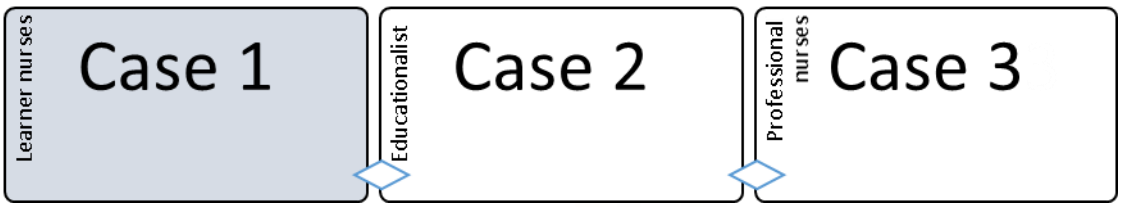


Figure 3.1: Multiple case

3.3.6 Study setting

Clinical practice

The setting was the academic HEI offering the undergraduate programme for nurses, as well as the nursing practice environment where the undergraduate learner nurses are placed for clinical learning in the Western Cape, specifically the Cape Town Metropolitan area. The training of the professional nurse takes place in the Western Cape at a university with a diverse student population. Learner nurses interact with fellow students and nurse educationalists (lecturers and clinical supervisors) in the academic environment where they are taught theory in a classroom setting. Integrated with the theory in the academic environment is the practical component, which extends into the clinical practice environment in the healthcare facilities where these learner nurses integrate their knowledge and obtain practical skills under the guidance of professional nurses. Professional nurses are employed by the Department of Health in the City of Cape Town Metropole. Professional nursing practice in South Africa is rendered within the context of the South African National and Provincial Health sectors.

More than 5.4 million people live in the Western Cape on 129 370 km² of land (Western Cape Government, 2011). Forty-nine percent of the people in the Western Cape are "Coloured", while 33% described themselves as "Black African", 17% as "White", and one (1) percent as "Indian or Asian". Afrikaans is spoken by the majority, with isiXhosa and English being the other main

languages.Afrikaans is spoken as the first language by 50% of the province's population. IsiXhosa is the first language of 25% of the population, while English is the first language of 20%. Roughly 16% (894 289 people) of the Western Cape's population in 2011 were born in the Eastern Cape, 3% (167 524) in Gauteng, and 1% (61 945) in KwaZulu-Natal. People born outside of South Africa amounted to 4% of the province's population or 260 952 people.

The City of Cape Town Metropole in the Western Cape is a large urban area with a high population density, an intense movement of people, goods and services, extensive development and multiple business districts and industrial areas (Western Cape Government, 2016). The City of Cape Town is South Africa's second-largest economical city in South Africa. It is the provincial capital and primate city of the Western Cape, as well as the legislative capital of South Africa, where the National Parliament and many government offices are located. The Khayelitsha health sub-district remains the district with the highest HIV prevalence rate in Cape Town and the Western Cape. Healthcare is rendered to patients in certain main areas of the City of Cape Town municipality (Table 3.1).

According to the State of Cape Town Report (2014:14), Cape Town is regarded as an international, culturally diverse and dynamic city. Local government in the Western Cape takes the form of one metropolitan municipality, the Metropole (City of Cape Town municipality), and four district municipalities (West Coast, Cape Winelands, Eden and Central Karoo, and Overberg) (see Figure 3.2), subdivided into 24 local municipalities.

South Africa

South Africa is divided into nine provinces (Figure 3.1).

Figure 3.1: Location of the Metropole (City of Cape Town Municipality area) in the Western Cape Province within South Africa (Source: *City of Cape Town Metropole in the Western Cape, Google Maps*).

Table 3.1: Main places of the City of Cape Town Metropolitan Municipality area

Place	Population	Most spoken language	Place	Population	Most spoken language
Atlantis	53 820	Afrikaans	Langa	49 667	Xhosa
Bellville	89 732	Afrikaans	Lekkerwater	1 410	Xhosa
Blue Downs	150 431	Afrikaans	Lwandle	9 311	Xhosa
Brackenfell	78 005	Afrikaans	Mamre	7 276	Afrikaans
Briza	1 959	English	Masiphumelele	8 249	Xhosa
Cape Town	827 218	Afrikaans	Melkbosstrand	6 522	Afrikaans
Crossroads	31 527	Xhosa	Mfuleni	22 883	Xhosa
Du Noon	9 045	Xhosa	Milnerton	81 366	English
Durbanville	40 135	Afrikaans	Mitchell's Plain	398 650	Afrikaans
Eerste River	29 682	Afrikaans	Nomzamo	22 083	Xhosa

Elsie's River	86 685	Afrikaans	Noordhoek	3 127	English
Excelsior	189	Afrikaans	Nyanga	58 723	Xhosa
Fisantekraal	4 646	Afrikaans	Parow	77 439	Afrikaans
Fish Hoek	15 851	English	Pella	1 044	Afrikaans
Goodwood	48 128	English	Robben Island	176	Afrikaans
Gordons Bay	2 751	Afrikaans	Scarborough	723	English
Guguletu	80 277	Xhosa	Simon's Town	7 210	English
Hottentots Nature	18	Xhosa	Sir Lowry's Pass	5 766	Afrikaans
Hout Bay	13 253	English	Somerset West	60 606	Afrikaans
Imizamo Yethu	8 063	Xhosa	Strand	46 446	Afrikaans
Joe Slovo Park	4 567	Xhosa	Witsand	2 405	Xhosa
Khayelitsha	329 002	Xhosa	Kuilsrivier	44 780	Afrikaans
Kraaifontein	57 911	Afrikaans	Remainder	14 498	Afrikaans

(Source: Census 2011 Municipal Fact Sheet, published by Statistics South Africa:2016)

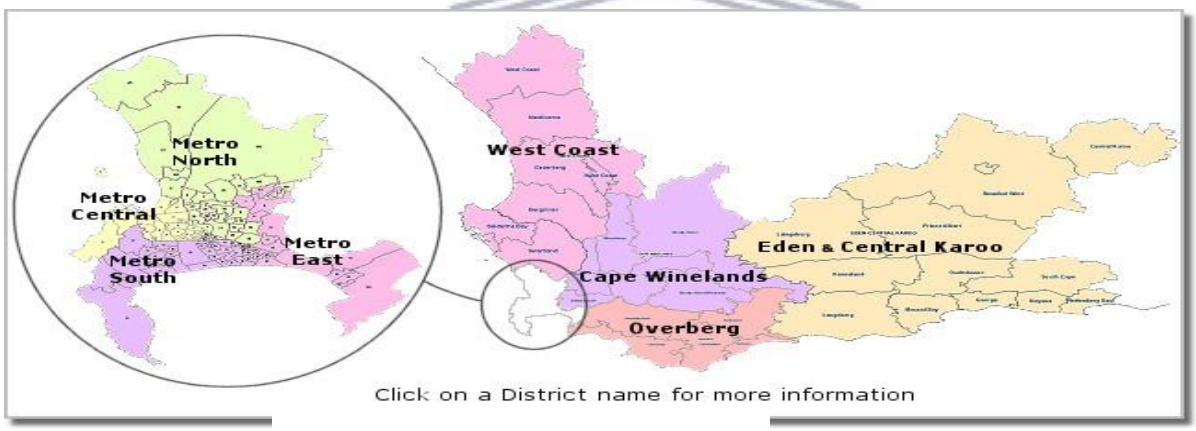


Figure 3.2: Adjacent district municipalities with the City of Cape Town Metropole and its sub-districts
(Source: The Local Government Handbook 2012-2016)

In this study the professional training of the four-year undergraduate programme takes place in the Western Cape Province in the City of Cape Town Metropole municipality where the head office and main administration of the Western Cape Department of Health is located. The Cape Town Metro Municipality area also provides health services to communities ranging from Cape Point in the South-West; Somerset West and Gordon's Bay in the south-east (including the suburbs of Khayelitsha and Mitchells Plain); and Atlantis in the north, including Robben Island (Figure 3.3).

Figure 3.3: City of Cape Town Metropolitan Municipality (also refered to as the Western Cape Metropole)
(Source: The Local Government Handbook, 2012-2016)

The hospital settings included in this study were:

- Hospital 1: District (secondary) hospital (one), in Bellville (Metro Eastern Health District);
- Hospital 2: Psychiatric hospital (one), in the Mitchell's Plain District (Metro Eastern Health District); and
- Hospitals 3 and 4: Two academic (tertiary) hospitals, which include a hospital in Observatory (Metro Central Health District) and a hospital in Bellville (Eastern Health District).

All four hospitals are accredited by the SANC for clinical placement of undergraduate learner nurses registered at a higher education institution in the Western Cape Metropole. Students are not placed in Metro North and Metro South for clinical practice. The study focused on urban areas and not on the five rural districts and four sub-structures in the district of Metropolitan Cape Town. The service delivery improvement plan implemented in these hospitals is aligned to a patient-centred care approach, which is core area of focus in Healthcare 2030 and is encompassed in the Department's value-driven vision (Western Cape Department of Health, 2013:32).

Higher education institution in Bellville

A university in the Western Cape, founded in 1960 by the South African government as a public university for Coloured people only, was included for the study. The university is based in the

northern suburbs, Bellville, Cape Town, South Africa. It currently has about 22 000 namely 15 840 undergraduate and 6 160 postgraduate students, providing education to a diverse and dynamic demographic (Eu-Saturn, 2016). In the SoN at this university, the number of students has grown to approximately an intake of 350 undergraduate first-year learner nurses per year. Among academic higher education institutions, this university has been at the forefront of South Africa's historic change, playing a distinctive academic role in helping to build an equitable and dynamic nation (University of the Western Cape, 2016).

The university is diverse in terms of culture, language and nationality. It offers tertiary opportunities not only to the prospective learners residing in the Western Cape Province, but also to learners from other provinces across South Africa and beyond its borders, accommodating international students from neighboring African countries.

3.3.7 Research population

Christensen, Batterham, Grant, Griffiths and Makinnon (2011:505) define a research population as a group of interest from whom the sample is selected and to whom the findings and the conclusions of the research would be applied. In this study, the target population was:

a) The 1058 undergraduate learner nurses (1st to 4th year levels) registered for the four year Bachelor of Nursing degree programme (BNUR) at a HEI in Bellville in the Western Cape in 2013.

b) Nurse educationalists (all nurse educators, (N=26) and clinical supervisors (N=34)) employed by the higher education institution for teaching and learning in a SoN, to be involved in the theoretical and clinical training of the learner nurses.

c) Professional nurses employed by the Western Cape Department of Health, working at the four public hospitals (tertiary hospital in central district (N=978), tertiary hospital in the eastern district (N=1215), secondary hospital in the eastern district (N=180) and psychiatric hospital in the eastern district (N=265)). These hospitals address the disciplines of general nursing, midwifery, psychiatry and community health (day clinics).

3.3.8 Sampling technique and sample

Sampling is the process whereby the participants are selected from a target population to ensure that the participants are representative of the total population. In qualitative research, this process is referred to as non-probability sampling (Jooste, 2017:303). A sample comprises elements of the population considered for actual inclusion in the study and therefore sampling is studied to

understand the population from which it was drawn (Unrau, Gabor & Grinnell, 2007:279). The researcher selected the research participants (sample) who would fit the criteria of desirable participants using purposive sampling (Marshall & Rossman, 1995, in Henning, 2011:71). The researcher chose participants for FGIs and unstructured individual interviews in Phase 1 (Objective 1 and Objective 2) who would be able to provide relevant information for the study. The researcher sampled for three cases: i) *learner nurses* from first to fourth year who were registered for the undergraduate nursing programme at the specific higher education institution (HEI); ii*) nurse educationalists* (nurse educators and clinical supervisors involved in the theoretical and clinical facilitation of the learner nurses in the undergraduate programme at the HEI); and iii) *professional nurses* working at the hospitals where the learner nurses were placed for clinical learning. Inclusion criteria for selecting participants were set by the researcher.

3.3.9 Sampling criteria

Inclusion criteria, according to Jooste (2017:303), outline the characteristics that the researcher wants in the participants. More specifically, it should specify attributes that cases must possess to qualify for the study (Robinson, 2014:2). Exclusion criteria stipulate attributes that disqualify a case from the study (Robinson, 2014:2). Any participant who did not give consent to partake in the study or who did not meet the inclusion criteria, were excluded from the study. Participants had to speak English or Afrikaans.

Learner nurses

To be included in the FGIs, learner nurses had to be:

a) *Students* in nursing at the higher education institution (HEI) in the Bellville area in the Western Cape Metropole; and

b) Males and females from diverse cultures and backgrounds.

c) They furthermore had to be in one of the following categories:

a) First years placed in general-, medical-surgical and paediatric wards, as required by their course; or

b) Second-year learner nurses placed in general wards, medical and surgical wards as well as speciality areas such as intensive care units, trauma units, theatre, paediatrics, outpatient departments and community health clinics; or

c) Third-year learner nurses placed at healthcare facilities for community nursing/day clinics at hospitals or midwifery, of which these two modules are being offered concurrently over a period of 6 months; or

d) Fourth-year learner nurses, completing the last year of their training in psychiatric nursing.

The criteria for exclusion were:

a) Learner nurses registered for post graduate studies (e.g. Masters and Doctoral students) at the HEI where the study was conducted; or

b) Learner nurses at other nursing colleges and nursing schools in the Western Cape Metropole.

Nurse educationalists

Nurse educationalists refer to nurse educators and clinical supervisors who partook in FGIs.

To be included, *nurse educators* had to be:

a) Registered with the SANC as professional nurses and employed in the SoN at the HEI that offered the undergraduate nursing BNurs degree programme in the Western Cape Metropole;

b) Involved in the theoretical and clinical training of first to fourth year learner nurses in at least one of the following modules: Fundamental Nursing Science, General Nursing Science, Midwifery, Community Health Nursing and Psychiatry; and

c) In possession of an additional post basic qualification in nursing education.

Clinical facilitators had to be:

a) Registered as professional nurses with the SANC for a minimum of two years;

b) Employed in the SoN the HEI that offers the undergraduate nursing degree programme in the Western Cape Metropole;

c) Involved in the clinical training of undergraduate learners for at least one year; and

d) Involved, as a clinical facilitator, in the accompaniment of learner nurses during their clinical placements at public hospitals accredited by SANC for at least a year.

The criteria for the exclusion of clinical facilitators are:

Clinical supervisors who also accompany learner nurses at other nursing education colleges and nursing schools in the Western Cape Metropole.

The focus groups held with the nurse educators and clinical supervisors included representation of all year levels, including the disciplines from first to fourth year per focus group.

Professional nurses

For *professional nurses* to partake in the FGIs with the researcher, they had to be:

a) Registered with the SANC as a professional nurse;

b) Employed part-time or fulltime by the Western Cape Department of Health; and

c) Working in the public hospitals where the learner nurses were placed for clinical learning in the Western Cape Metropole.

The criteria for the *exclusion* of professional nurses were professional nurses who were practising in nursing and employed at healthcare clinics and community centres of the Department of Health in the Western Cape.

Sample

Generally, the number of participants in a focus group is 8–12, but smaller groups (less than six) have also been used (Strong, Ashton, Chant & Cramond, 1994). De Vos et al. (2011:366) state that small groups of four to six people are preferable when participants have a great deal to share about a topic or have lengthy and intense experiences related to the topic of discussion. The use of very small focus groups (three or four participants) is referred to as "mini-focus groups" (Onwuegbuzie, Dickinsin, Leech & Zoran, 2009:3). In a study by Winlow, Simm, Marvell and Schaaf (2013:295), two focus groups consisted of two participants only. Small focus groups were used in this study because the researcher believed that this would ensure that more in-depth information could be obtained about the phenomenon related to nursing professionalism (Onwuegbuzie, Leech & Collins, 2010: 711). Another reason for the inclusion of a small number of participants (learner nurses in the FGIs) was due a very full timetable of the undergraduate

four-year nursing programme. This meant that, on the day of the FGIs, fewer participants attended the appointment than initially indicated.

Objective 1

Case 1: Learner nurses

The researcher conducted eight FGIs (including the two pilot interviews) with learner nurses across the entire four-year undergraduate programme (Table 3.2). The number of participants varied between three to eight participants. The researcher grouped the learner nurses according to their year level, since it was anticipated that learner nurses would be more comfortable discussing issues with other learner nurses who were in the same year level.

Table 3.2: FGIs of learner nurse according to their year level in the undergraduate programme

Year level	Learning area	Clinical placement area	Number of focus groups	Size of group
Year Level One	Fundamental Nursing Science	General Nursing	1	7
			2	8
Year Level Two	General Nursing Science	Medical-Surgical Intensive care Theatre Trauma Paediatrics	1	5
Year Level Three	Community Nursing Science Midwifery	Community Midwifery and Obstetric Units	1 (pilot= data included in study)	3
			2	4
Year Level 4	Psychiatry	Mental Health Facilities	1 (pilot= data included in study)	3
			2	7
			3	6
Total			8	42

Objective2

Case 2: Nurse educationalists

Three FGIs were conducted with nurse educationalists at the HEI in the Western Cape where the undergraduate learner nurses were registered for the four-year undergraduate nursing programme. Nurse educationalists included (i) nurse educators (two FGIs); and (ii) clinical supervisors (one focus group interview) with respectively seven and six participants (Table 3.3).

One unstructured individual interview (Table 3.4) was also conducted as a pilot study with a clinical supervisor involved in the accompaniment and supervision of learner nurses in the discipline of midwifery at the university, and the data were included in the findings. It seemed to be important to elaborate on some of the data obtained in the FGIs, as no other midwifery clinical supervisor was available to attend the FGIs.

Table 3.3: FGIs of nurse educationalists

Category of nurse educationalists	Number of focus group interviews	Size of group
Nurse educators	1	7
	2	7
Clinical supervisors	1	6
Total	3	20

Table 3.4 Unstructured individual interviews (pilot interview)

Clinical Supervisor (Midwifery)	1

Case 3: Professional nurses

Five FGIs (with between four to nine participants) were conducted with the professional nurses at three hospitals, which included an academic (tertiary), psychiatric, and secondary hospital (regarded as a training hospital) in the Western Cape Metropole (Table 3.5).

Table 3.5: FGIs of professional nurses at healthcare institutions where learner nurses were placed for clinical learning

Healthcare facilities	Healthcare services rendered	Number of focus groups	Size of group
Hospital 1	Psychiatric hospital	1	9
Hospital 2	District (secondary) hospital	1	4
		2	5
Hospital 3	Academic(tertiary) hospital offering general and speciality healthcare services	1	5
		2	6
Total		5	29

In addition to the FGIs conducted with professional nurses, the researcher was also granted permission to conduct unstructured individual interviews with five professional nurses at the second academic (tertiary) hospital (although focus groups were requested) (Table 3.6) (see Annexure J). On reflection of this particular method of data collection, new data emerged from individual interviews that complimented the data from the focus groups.

Table 3.6: Individual interviews with professional nurses at healthcare institutions where learner nurses were placed for clinical learning

Healthcare facilities	Healthcare services rendered	Number of individual interviews
Hospital 4	Academic (tertiary) hospital offering general and speciality healthcare services	5
Total		5

The sample sizes of the three cases (learner nurses, nurse educationalists and professional nurses) were determined by reaching data saturation. Data saturation was detected during the interviewing process at the point where no new information was provided by participants (Burns & Grove, 2011:317; Polit & Beck, 2012:62). In Phase 1, no new information was generated at the 8th focus group of learner nurses, the 3rd focus group of nurse educationalists and the 5th focus group interview of professional nurses.

3.4 RESEARCH METHOD

3.4.1 Preparation for the study field

After approval of the research study by the Senate Research Committee, ethical clearance was obtained by the Research Ethics Committee of a university in the Western Cape, South Africa. The researcher then contacted the Western Cape Government of Health in the Western Cape Metropole to gain access to the healthcare facilities where learner nurses were placed for clinical learning (see Chapter 1). Once permission was obtained, the researcher sent out letters to each of the hospitals to obtain permission to conduct the FGIs. One of the academic hospitals was also affiliated to another HEI and required a separate process that the researcher had to follow to get ethical clearance for access to the academic hospital (Annexures L and M). This process lasted more than eight months, after which the researcher could arrange for information sessions with the nursing services managers at the four hospitals where the focus groups were planned to be conducted.

The researcher then sought approval from the relevant SoN to interview learner nurses and the nurse educationalists. This was followed by emails to the nurse educators informing them about the study and asking permission to speak to *learner nurses* during the last 10 minutes of the theoretical class sessions on a specific day. The learner nurses then voluntary signed up to indicate their interest in the study. After information sessions with learner nurses, suitable days and times to conduct the FGIs, were established with participants with the aim of minimal interference with any theoretical work or assessments planned for the learner nurses. It could

have been advantageous to bring together a diverse group of all the learner nurses of the different year levels to maximize exploration of the different perspectives within the group setting (Holloway, 2005:61). However, due to clashes in the group timetables of the undergraduate programme and the different times the learner nurses of the respective year levels were available, interviews of each year level of learner nurses were conducted separately.

Nurse educationalists were informed via email about the study, and the researcher also personally asked individual educators and clinical supervisors if they would be interested to partake in the study. Several options of dates and times were sent to allow educationalists to choose times for the focus group suitable to them.

For the clinical supervisors the researcher first had to obtain a schedule from the main clinical coordinator who oversees the placements and roster for clinical accompaniment of all the supervisors in their respective year levels (first to fourth years). With this schedule, the researcher could ascertain when a certain group of clinical supervisors for a particular year level would be on campus and be available for demonstrations in the skills laboratory with the students. All these FGIs had to be conducted during the lunchtime period to prevent interference with the academic programme.

For the interview sessions with *professional nurses*, the researcher made initial telephonic contact with the healthcare institutions to set up a meeting with the Director of Nursing services or the nursing services personnel manager. At this meeting, an overview of the research study was provided and it was agreed that the ward managers would free up one professional nurse for an hour on the pre-arranged date for the focus group interview. The venue and time for all interviews were arranged by the Chief Nursing Services Manager at the relevant facility. On the day of the arranged FGIs, which took place at the institution where the professional nurses were stationed, the researcher informed the participants about the nature of the study.

All the participants were reminded three days before the data gathering via email about the focus group, the time and the venue. Good organisational skills were required to coordinate the times of the different groups, choosing and booking a venue on campus and getting members to volunteer and participate in the study (Harding, 2013:45). An information sheet containing the objectives and purpose of the study was given to the participants. Only after the researcher ensured that nothing was unclear and that the participants understood their rights and were willing to participate voluntarily, an informed consent form was signed. Prior to the FGIs and the unstructured individual interviews, the researcher made sure that the voice recorder was in good working order. As a backup measure, the researcher also activated the voice recorder on her cell

phone. Permission for making the recording was obtained from the participants prior to conducting the interviews. The researcher thanked them for partaking in the study and informed them of their right to withdraw at any point during the interview or the study.

3.4.1.1 *Pilot interviews*

In any study, the pilot study is an important part of the research because it can identify difficulties and reduce the danger that flawed data is collected (Harding, 2013:48). In this study, three pilot studies (two FGIs and one unstructured individual interview) were conducted to assess whether the questions were understood, the words used appropriate to the context of the participant, any questions needed to be rephrased and the research objectives could be met with the information gathered from the interviews. The research questions seemed to be clear and thus required no changes, and the data collected from the pilot interviews were included in the main study.

3.4.2 Phase 1: Data collection

Qualitative researchers use a variety of data collection methods, known as data triangulation (Henning, 2004:102). Triangulation in qualitative research, according to Polit and Beck (2012:175), involves attempting to understand the full complexity of a phenomenon (such as nursing professionalism), by using multiple means of data collection to converge on the truth or reality. Richardson (2000:934) refers to a process of crystallisation that provides qualitative researchers with a complex and deeper understanding of phenomenon. The author suggests that reality emerges from the data gathering techniques and data analysis and represents our own reinterpreted understanding of the phenomenon. The methods used for data collection in this study were FGIs, unstructured individual interviews and field notes.

3.4.2.1 *Focus group interviews (Phase 1, Objectives 1 and 2)*

FGIs allowed the participants to verbalise their views in a safe forum with other participants without feeling intimidated. The researcher chose FGIs for several reasons. First, because the researcher wanted to examine shared understandings of professionalism in the undergraduate nursing programme within a group of learner nurses, nurse educationalists and professional nurses. Second, the researcher wanted to encourage the interaction among participants from diverse backgrounds. According to Harding (2013:22), FGIs can elicit collective voices from groups of participants. Furthermore, the researcher believed that individual participants could also provide insight into the topic of discussion. This format also allowed participants to explain why they hold a certain view, which provided greater insight into the reasoning behind their

opinions. Disagreements between the participants in the focus groups interviews can demonstrate the strength with which participants hold their views (Barbour, 2007:35; Oates, 2000:187). The purpose of focus groups are to promote self-disclosure among participants and to know what people think and feel about a topic, which in this study was professionalism in an undergraduate nursing programme (Krueger & Casey, 2000:7). The key feature of using focus groups is that the interaction among participants stimulate the generation of data that might not emerge in the case of for example single-respondent or unstructured interviews (Webb & Kevern, 2001:802). FGIs, therefore, through group interaction, allow participants to ask questions from one another and to debate issues in the group (Alireza, Tate, Johnstone & Gable, 2014:1). Other advantages of FGIs that the researcher considered for this study were that they provide a safe forum for the expression of views and experiences. FGIs are used to achieve understanding among a group of individuals who are assisting with the initial conceptualisation of a research area. FGIs have been found to be a valuable method of obtaining rich data and answer research questions of studies in social contexts (Alireza et al., 2014:1).

In Objective 1 of Phase 1, FGIs were used to explore the views of learner nurses on their experiences of professionalism in the undergraduate nursing programme at the HEI. On the other hand, Objective 2 of Phase 1 was to ask the nurse educationalists, who were the lecturers and the clinical supervisors, and the professional nurses about the way in which they could facilitate professionalism among undergraduate learner nurses professionalism for nursing practice in the Western Cape. The FGIs with nurse educationalists were conducted in the academic environment at the university, more specifically, in the boardroom of the nursing school. All felt at ease because the venue was familiar, accessible and proved to be a convenient location on campus. The FGIs were held during the students' lunch hour, which followed nursing theory classes or practical sessions in the clinical skills laboratory in their respective modules relevant to their level of study. Data collection with the professional nurses took place in the healthcare settings where the professional nurses were employed so that they could be easily contacted and return to their clinical areas should they be needed for any kind of emergency.

The group discussion sessions lasted for not longer than 60 minutes, with the researcher introducing herself and giving an overview of what the research study entails and what the research objectives are. During this time, participants were encouraged to ask questions about the study. The interview guide (Annexure P) was used to pose the questions. The participants were encouraged to respond freely to the questions at any time they felt ready to do so. The initial question asked to learner nurses was: *"What are your experiences about professionalism in the undergraduate nursing programme at this institution?"* Nurse educationalists and professional

nurses were asked about their experiences about professionalism and how they could facilitate professionalism in learner nurses in the undergraduate nursing programme at a HEI for nursing practice. The researcher sometimes varied the order or the wording of the questions to make it more clear to the participants at the start of the interviews. This is allowed in qualitative interviews, in contrast to structured, inflexible interviews in quantitative research (Harding, 2013:31).

3.4.2.2 *Unstructured individual interviews (Phase 1 Objective 2)*

Unstructured individual interviews were conducted to support the data that emerged from the FGIs (Maree, 2007:87). The researcher acted as the facilitator of the FGIs and individual interviews. The facilitator directed the discussions with the purpose of collecting in-depth qualitative data about professionalism in the undergraduate nursing programme at a HEI in the Western Cape.

Unstructured interviews, also referred to as in-depth interviews, formalise conversation and is also referred to as a conversation with a purpose. However, the purpose is not to get answers to the research question, but rather to gain understanding of the experience of other people and the meaning they make of that experience (De Vos et al., 2011:348). The interviews with the participants were focused and conversational in nature and allowed the researcher to explore the issue of nursing professionalism from the experiences of the participants.

One unstructured individual interview took place with a clinical supervisor who was involved with the clinical training of the midwifery learner nurses. The interview took place in the office of the researcher, who conducted the interview at a SoN at a HEI as it was a convenient environment familiar to the participant. All interviews were recorded and the researcher made field notes immediately after the sessions. Participants were encouraged to respond in the language they felt most comfortable with and were encouraged to ask questions when they wanted more clarity or did not understand the questions posed to them by the researcher. The professional nurses were asked: *"What are your experiences as a professional nurse of professionalism in dealing with undergraduate students at this facility?"* and *"How can professional nurses assist and support the students to become more professional?"* Probing questions based on the responses of the participants were asked to explore their opinions. Participants were allowed to freely express themselves. Interviews lasted 30–40 minutes. The researcher maintained the ethical standards in the same way as during the FGIs. The researcher reflected upon the process of conducting the individual interviews and the value of gaining additional empirical information about the social world of the participants with regards to

nursing professionalism by asking participants to speak about their experiences (Holstein & Gubrium, 2003, in Maree, 2011:296). The unstructured interviews were beneficial because the participants gave an in-depth description of their experiences.

3.4.2.3 *Field notes of interviews*

Field notes are the researcher's notes made during fieldwork and may vary from jottings to formal narratives. It can also include drawings (Yin, 2014:239). Polit and Beck (2012:548) state that field notes represent the researcher's efforts to record, synthesise and understand the data. Writing down field notes allowed the researcher to reflect and think about what actually happened, where and when events took place, who the participants were and how they experienced the events, and what the behaviour of the participants and the thoughts and feelings of the researcher were (De Vos et al., 2011:316; Myers, 2013:144). In this study, the researcher jotted down contextual notes about the place, time and participants to sketch and give a glimpse of the events of the focus group and unstructured individual data collection sessions. The goal of the field notes was to get a thick description of the data (Polit & Beck, 2012:548). The field notes were written immediately after a data collection session as the researcher wanted to avoid the risk of forgetting or distorting the data as a result of time delay. Druckman (2005:247) states that the greater the time lapse between the session and the making of field notes, the less accurate the data will be. Moreover, memory of what was observed may be biased by things that happened subsequently (Polit & Beck, 2008:208). The researcher wrote the field notes after each session with the participants to avoid distraction from and interference with the natural flow of the discussion (Jacob & Furgerson, 2012:7). The recording of the field notes immediately after the session enabled the researcher to remember important matters discussed during the interviews on that particular day (Myers, 2013:144). The writing up and analysis of the field notes served as a backbone of the internal audit of the research process (De Vos et al., 2011:316).

To make meaning out of the data, the researcher had to see the bigger picture of the phenomenon of nursing professionalism and had to convert the raw empirical data into a thick description. Thick descriptions give a coherent account of a concept, such as professionalism in nursing, and aid the researcher in interpreting the information from the basis of the theoretical framework of a study (Dickoff et al., 1968:416). The researcher was the main instrument of data collection in this research study and obtained meaning from engagement with the research data.

3.4.3 The role and skills of the researcher during data gathering

In qualitative studies, unlike in quantitative research where objectivity is the aim, researcher subjectivity is accepted. Subjectivity cannot be eliminated and the researcher is seen as the

"research instrument" (Maree, 2011:79). In this study, the researcher's involvement required effective communication skills between herself and her participants during the data collection process. The techniques and skills used by the researcher during the data collection process are discussed in more detail below.

3.4.3.1 *Active listening*

Active listening is a communication skill which the researcher should have so as to be fully attentive to responses of the participants (De Vos et al., 2011:345). In order to successfully collect information, the researcher first had to ensure adequate preparation of the setting by minimising noise in the venue where the interviews took place. The researcher put a notice on the door that informed outsiders that FGIs and unstructured interviews were in progress. The choice of venue was either a boardroom or a lecture venue, which did not have telephones that could disturb or interrupt the data collection process. In most instances, except where the researcher was dependant on the resources made available by the healthcare facilities, the environment was conducive, as it was well-lit and had ample ventilation. By eliminating all distractions, the researcher could give her undivided attention to the participants.

3.4.3.2 *Minimal verbal response*

The researcher used minimal verbal response to avoid distraction and interruption in the thought processes and the discussion of the participants (Kadushin & Kadushin, 2013:158). These authors further suggest that the interviewer should use head-nodding and verbal responses such as "hmm" or "uh-huh", as minimal non-verbal encouragers, preferably at the end of a sentence to avoid interruption. The participants were given enough time to verbalise their responses to the questions. Silence was effectively used to encourage the participants to think about the question before responding. The researcher used the verbal response "Mmm, yes, I see", which correlated with occasional nodding, to demonstrate to the participants that the researcher was listening (De Vos et al., 2011:345).

3.4.3.3 *Clarifying*

Clarifying helped the researcher to understand and the participant to communicate more clearly (Uys, 1999:36; De Vos et al., 2011:345). The researcher sought clarification from the participants when their verbal responses were unclear or vague. The goal was to understand the meaning of their thoughts, feelings and actions by for example asking participants to clarify using: "Could you tell me more about…".

3.4.3.4 *Paraphrasing*

Paraphrasing is a verbal response in which the researcher will enhance meaning by stating the participant's words in another form with the same meaning (De Vos et al., 2011:345). The researcher in this study used paraphrasing as a technique to sum up the accounts of experiences and feelings of the responses of the participants. Paraphrasing therefore conveys an understanding of the basic message of the participants (Uys, 1999:36).

3.4.3.5 *Probing*

Probing is a technique used in qualitative data collection to support the discussion process and assist the researcher with clarifying issues and getting more details or information about the matter under discussion (De Vos *et al.*, 2011:345; Hennink et al., 2011:161). De Vos et al. (2011) mention that the purpose of probing is to deepen the response to a question, to increase the richness of data being obtained and to give cues to the participant about the level of response desired. The researcher, in her role as moderator of the FGIs, took an active role when she had to ask probing questions to elicit a deepened response to the question and to encourage interaction among participants (Krueger, 1998:46).

3.4.3.6 *Summarising*

The participant's verbalised ideas, thoughts and feelings are summarised to see if the researcher really understood what he or she was saying ("What you are saying is …"). The summary encourages the participant to give more information (De Vos et al., 2011:345). In this study, the researcher summarised the responses of the participants at the end of each interview session to emphasise the important issues raised during the interview as accurately as possible. This was done to allow the participants to reflect on the key issues that they had communicated and to confirm and check whether the researcher correctly grasped the information provided by the participants.

3.4.4 Data analysis of the cases in Phase 1

Case analysis, according to Patton (2002:447), involves organising the data by specific cases for in-depth study and comparison. Patton indicates that in qualitative research, well-constructed case studies are holistic and context sensitive. The author states that cases can be individuals, groups, neighbourhoods, organisations, cultures or regions. Cases are units of analysis and anything that can be defined as a specific, unique and bounded system (Patton, 2002:447; Stake, 2000:436). What makes up the case or unit of analysis is determined during the design stage and becomes the basis for purposeful sampling in qualitative research (Patton, 2002:447). The case

study approach to qualitative analysis constitutes a specific way of collecting, organising and analysing data. In this sense, according to Patton, it represents an analysis process. The purpose is to gather comprehensive, systematic and in-depth information about each case of interest. The analysis process results in a product called a "case study". Patton (2002:447) states that the term 'case study' can thus be referred to as either the process of analysis, or the product of analysis, or both.

3.4.4.1 *Collecting the data*

The first step in the process was to assemble all the information collected about the individual cases that referred to undergraduate learner nurses, nurse educationalists and professional nurses and then to condense the data into a holistic picture, presented with context, for understanding the overall case (Patton, 2002:450). An inductive approach was used because the researcher analysed the data before considering its relationship to existing knowledge about nursing professionalism (Moses & Knutsen, 2007:22). In an inductive approach or conventional analysis, themes and categories are included inductively from the transcriptions and/or field notes (i.e. raw data). In this approach, direct data is gained from raw data without preconceived categories or perspectives. The researcher believed that using the inductive approach could lead to the emergence of new insights and a richer understanding of the phenomenon of nursing professionalism (Alireza et al., 2014:1). As soon as the transcribed data were available, the researcher analysed the data for each case separately, engaging in a process of moving in analytic circles, touching on several facets of analysis in-between the data text and the account of findings in the end (Creswell, 2013:182).

The researcher analysed the data of Objectives 1 and 2 in Phase 1 separately for each case according to Creswell's (2013:179) data analysis spiral step in the data analysis process in qualitative research. The focus groups and individual interviews in Phase 1, Objective 2, were analysed separately, using the technique of organising the data, as set out below. Although the key steps below are in a linear form, it should be kept in mind that these main activities also move in circles or a spiral (De Vos et al., 2011:403).

3.4.4.2 *Organising the data*

Managing the data is the next step of the spiral and the beginning of the analysis process. The researcher organised the data for Case 1 (learner nurses), Case 2 (nurse educationalists) and Case 3 (professional nurses) into computer files and named them so that the data could be easily located. This was an important step in the research process, because the large amount of data were overwhelming. The researcher first organised the voice (audio) data of each case into

separate files on the computer. Then she listened to the tape recordings several times after each focus group interview and unstructured individual interview session, before the recordings were transcribed verbatim. The researcher, subsequent to the transcribing process, read through the transcriptions while listening to the recording (Henning, 2004:76). The transcriptions were also organised into separate files for each case. The researcher went through the field notes several times as well. Transcribing is an important aspect of qualitative research. It involves close observation of data and opportunities to listen to the participant's words, pauses, silences and non-verbal expressions. It is therefore vital to have an in-depth understanding of the collected data. Analysis and understanding is derived from listening and re-listening to the audio tape, hence transcribing facilitates interpretive thinking, which was needed in this study to make sense of the data (Zakaria et al., 2015:3). Zakaria et al. (2015:3) state that transcribing helps the researcher to cycle back and forth between thinking about the existing data and generating strategies for collecting new data. It provides opportunities to researchers to critique their own work and to potentially improve their interviewing skills (Johnson, 2011, in Zakaria et al., 2015:2). No names were used in any of the transcripts because the researcher wanted the best way to present the findings, which was to transform the voice data to text for reporting purposes (Zakaria et al., 2015:3).

3.4.4.3 *Reading and memoing*

After managing the data, the researcher continued to get a sense of the whole database by reading the individual transcripts several times in their entirety (Agar, 1980, in Creswell, 2013:183). This entailed that the researcher immersed herself into the details of the text, trying to get a sense of the interview as a whole before it was broken up in parts. Notes were written in the margins of the transcripts to assist the researcher in the initial process of exploring the data. The notes or memos were short phrases, ideas and key concepts that occurred to the researcher.

3.4.4.4 *Describing, classifying and interpreting data into codes and themes*

In this loop of Creswell's (2013:179) spiral of analysis, the researcher built a detailed description of the multiple sources of data (the three cases) and methods of data collection (FGIs and unstructured individual interviews) within the context of the setting, formed codes or categories (used interchangeably), developed themes and made a subjective interpretation. The coding process involved organising the text into small categories of information, looking for evidence for the code from different databases and then assigning a label to the code. The researcher then moved beyond codes to classifying and looking for categories or themes. Themes are the broad

units of information that consist of several codes (categories) grouped together to form a common idea.

3.4.4.5 *Interpreting the data*

Interpretation involves making sense of the data, as described by Lincoln and Guba (1985), in Creswell, 2013:187). It involves abstracting out beyond the codes and themes to a larger meaning of the data. The researcher linked her interpretation to the larger research literature.

3.4.4.6 *Representing and visualising the data*

In the final process of the spiral, a visual image of the information is presented in a table to show the levels of abstraction in the separate cases. The tables illustrate inductive analysis, which began with the raw data (consisting of multiple sources of information) being broadened to several specific themes and then to general themes. As an analytic technique, a cross-case synthesis was used because the researcher studied two or more cases (Yin, 2009, in Creswell, 2013:199). Table 6.1 was created to illustrate both the common themes and differences among the cases (multiple sources of data) (cross-case analysis) of professionalism. A description has been added to the analysis of each case. The data of the major role players, as portrayed in the individual cases (within-case analysis), was grouped into thirteen themes and collapsed into six common themes in the cross-case analysis (Annexure Q). In the final stage of the research study, the researcher developed interpretations about the common themes and linked them to the larger research literature.

3.4.4.7 *The use of a "thick description"*

A thick description is "a rich and thorough description of the research context in a qualitative study" (Polit & Beck, 2012:526). The authors state that: "when developing thick descriptions, the researcher is able to think conceptually rather than only thinking descriptively about the study contexts." The goal in this study was to have a conceptual framework in that the researcher decided on the descriptive information to share. In this study, the researcher used verbatim quotes of the study participants. The researcher also provided a clear description of the participants who participated in the study, their experiences during the research inquiry and the context in which the research was conducted. The researcher's field notes added to the description of the time, place and participants of the study. Lincoln (2002), in Henning (2004:143) suggests that the study methods used in the research should lead to interpretation and to clarifying the topic by means of a thick description and by giving more than only categories of

data as findings. In this study, the researcher confirmed the findings with findings from broader literature (Henning, 2004:143) (see Chapter 5).

3.4.5 Phase 2: Development of the conceptual framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses

Phase 2 of this study focused on the construction of the conceptual framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape.

3.4.6 Identifying and naming themes and categories

Identifying and naming themes and categories involved a thorough analysis of the data from Phase 1 to discover themes and categories which described the data most accurately**.**

3.4.7 Deconstructing and categorising the concepts

This process encompassed a critical re-look at the themes, categories and their concluding statements to identify its characteristics and role with regards to the survey list of the Practice Oriented Theory of Dickoff et al. (1968).

3.4.8 Integrating concepts

The concepts of the findings of undergraduate learner nurses, nurse educationalists and professional nurses were integrated into one framework. The Practice Oriented Theory of Dickoff et al. (1968) was used in the organisation of the concepts.

3.4.9 Synthesis, re-synthesis and clarification of the concepts

Synthesis, re-synthesis and clarification of the concepts involved the description of the framework with the purpose of providing a comprehensive understanding of professionalism as it is experienced by the participants in this research study. The survey list of the Practice Orientated Theory proposed by Dickoff et al. (1968:423) provided the reasoning map in this study for describing the conceptual framework (see 1.8.2.1) by asking the following six questions:

a) Who or what performs the activity (agent)?

b) Who or what is the recipient of the activity (recipient)?

c) In what context is the activity performed (framework)?

d) What is the endpoint of the activity (terminus)?

e) What is the guiding procedure, technique or protocol (procedure)?

f) What is the energy source for the activity (dynamics)?

Table 3.7: The thinking map adopted in the study

Concept	Meaning of concept in this study
Agents	Nurse educators, clinical facilitators and professional nurses – they were responsible for performing the activity of facilitating professionalism among undergraduate learner nurses in nursing practice
Recipients	Undergraduate learner nurses who are registered for the four-year Bachelor's in nursing programme at a HEI
Context	A HEI and nursing practice at the healthcare facilities in the Western Cape Metropole region in the Western Cape Province of South Africa
Dynamics	The motivating factors required for supporting undergraduate learner nurses to facilitate professionalism for nursing practice
Procedure	Guiding procedures/strategies for facilitating professionalism among undergraduate learner nurses for nursing practice in the Western Cape
Terminus	The conceptual framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learners for nursing practice in the Western Cape Province of South Africa

3.4.10 Validation of the conceptual framework

Validation includes continually checking, questioning and theoretically interpreting the findings throughout the research process, from design to presenting the findings (Henning, 2011:148). In this study, the researcher and the supervisor assured the quality throughout the research study, not just of the findings, but also in terms of the research management decisions made. The conceptual framework was checked for bias, neglect and lack of precision. The supervisor questioned all the procedures and decisions critically throughout the study. In addition, the researcher and the supervisor theorised the research by looking for and addressing theoretical questions that arose throughout the process. As part of the validation process, the researcher discussed and shared research actions with five peers as critical in-process reviewers. Furthermore, the researcher made use of a discourse platform at a conference to communicate the research findings and enhance rational thought in the public view. In addition, the framework was given to experts in the field of nursing that included a nurse educator, clinical supervisor and professional nurse at one of the healthcare facilities that formed part of the study. The individual sessions with the experts lasted between 30–45 minutes. The researcher adapted the criteria of Chinn and Kramer (2008:183), which included questions around clarity, simplicity, generality, accessibility and the importance of the framework. Questions were posed around the framework.

The researcher first gave a brief description to the experts as an orientation to the purpose of the study, which consequently led to the conceptual framework for nurse educationalists and professional nurses, before they answered the following questions:

Does the framework provide in the need to support the facilitation of professionalism for learner nurses? Is it clear?

The developed conceptual framework is offered to be used by nurse educationalists and professional nurses to facilitate professionalism among learner nurses. Will the developed strategies be sufficient for the purpose it sets out to achieve?

Is the conceptual framework useful to nursing education and nursing practice?

Does the conceptual framework make an important contribution to nursing practice and nursing education?

The design of the research study also builds in the possibility for action. The findings will be communicated as the conceptual framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses. The researcher will use the research to contribute to social change, as the researcher foresees that nursing education as well as nursing practice will benefit from the study when the conceptual framework is implemented into everyday practice. This focus of the researcher on the usability of the findings and the empowerment of the research participants is called pragmatic validity (Henning, 2011). The pragmatic concept of validity goes further than communication, representing a stronger knowledge claim with the commitment of the researcher to put the study findings or interpretations into action and thus in the domain of the ethics of research that could be used as a criterion for quality (Lincoln, 2002, in Hennink, 2011:150).

3.5 REASONING STRATEGIES

Reasoning is a problem solving method that combines experience, intellect and formal systems of thought (Polit & Beck, 2012:11). The researcher's choice of engaging in a qualitative approach in this study was to allow experiences of professionalism from the perspectives of undergraduate learner nurses, nurse educationalists and professional nurses in nursing practice within the current socio-political and economic context of healthcare service delivery in which nursing care is rendered. One of the strengths of qualitative research is the inductive, naturalistic strategy of approaching a setting (Patton, 2002, in De Vos et.al., 2011:5). The reasoning

strategies used in this research study were inductive reasoning, deductive reasoning, analysis, synthesis and bracketing.

- Inductive reasoning

Qualitative researchers build themes and categories by organising the data inductively into abstract units of information. The inductive logic process involves working back and forth between the themes and the database until a comprehensive set of themes is formed. This means that the qualitative researcher uses complex reasoning skills throughout the research process (Creswell, 2013:45). Inductive reasoning moves from the particular to the general (Babbie, 2007:49; Harding, 2013:13). With inductive reasoning, the researcher begins with a general topic (professionalism in this study), which is then developed into more theoretical concepts (De Vos et al., 2011:49). The researcher in this study started with data collection and analysis instead of what is already known about professionalism (Harding, 2013:13), and because of the interpretive (naturalistic) paradigm in which this study is situated, an inductive data analysis was applied, which assisted her to identify the multiple realities present in the collected data. It was only at a later point that the researcher tried to build general truths by thinking about the relationship between the findings and existing knowledge (Moses & Knutsen, 2007, in Harding, 2013:13). The research was carried out in real life situations and in a natural setting.

Deductive reasoning

Polit and Beck (2012:11,725) describe deductive reasoning as the process of developing specific predictions from general principles and a means of understanding and organising phenomena. According to Neuman (2006:59), deductive reasoning begins with abstract concepts that outline the logical connection among concepts and then move towards concrete empirical evidence. Deductive reasoning was used in Phase 2 of the study.

Analysis

Qualitative data analysis is, according to De Vos et al. (2011:399), a process of inductive reasoning, thinking and theorising, which is far removed from structured, mechanical and technical procedures to make inferences from empirical data. Babbie (2007:378) describes qualitative analysis as the "non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships". Gibbs (2007:1), on the other hand, states that the idea of analysis implies some kind of transformation where a researcher starts with the collection of qualitative data and then, through analytic procedures, processes it into a clear, understandable, insightful, trustworthy and original analysis. The

researcher and her supervisor analysed the data gathered for the study in order to obtain an in-depth understanding of professionalism as it was described by the study participants. An independent coder assisted with the analysis of the data collected from FGIs and unstructured individual interviews.

Synthesis

Synthesising is the "sifting" part of the analysis. In qualitative research, the process of analysis facilitates synthesising, whether a computer programme is used or "cuts and pastes" is made by hand by the researcher (Morse & Field, 1996:105). Data analysis assumes two forms: i) inter-participant analysis; and ii) analysis of categories sorted by commonalities. Morse and Field (1996:105) state that each form of analysis facilitates cognitive processes that enable the researcher to synthesise, and as the research process continues, to interpret, link, see relationships, make inferences and verify findings.

Bracketing

Bracketing is the process in phenomenological studies of identifying any preconceived beliefs and opinions about the phenomenon under study (Polit & Beck, 2012:495,721). Burns and Grove (2011:533) and Brink, Van der Walt and Van Rensburg (2012:122) describe bracketing as a technique used in qualitative research where the researcher sets aside what is known about the phenomenon under study. In this study, the researcher used bracketing through making notes in a reflexive journal. After data analysis, for example, the researcher reflected on how the findings were written up. The researcher also reflected on whether the literature is truly supporting the findings, and whether it is expressing a cultural background similar to that of the researcher (Polit & Beck, 2008:228).

Reflexivity

Reflexivity is the process of reflecting critically on the self and analysing and making note of personal values that could affect data collection and interpretation. It concerns acknowledgement that the researcher is part of a setting and involves a critical self-reflection about the qualitative researcher's own biases, preferences and preconceptions (Polit & Beck, 2012:495). In this study, the researcher reflected on every decision made during the study. The researcher was conscious about how her values and experiences may shape the findings, the conclusions as well as interpretations drawn in the study (Creswell, 2013:126). During the focus group and unstructured individual interviews, it was important to capture the participants` (three cases) own sense of reality. The researcher thus needed to be aware of minimizing a methodological threat that could

be created by the conversational nature of the interviews. Yin (2014:112) refers to reflexivity when he cautions that the conversation can lead to a mutual and subtle influence between the researcher and the participants.

3.6 MEASURES TO ENSURE TRUSTWORTHINESS

Lincoln and Guba's (1985) framework for quality and integrity of qualitative research identifies five criteria for evaluating the trustworthiness of data and interpretations. Trustworthiness encompasses credibility, transferability, confirmability and dependability, as well as authenticity, which was added to the framework at a later stage (Polit & Beck, 2012:484). Trustworthiness is used synonymously with validity (Henning, 2004:103). Various strategies to enhance validity are required in qualitative research. Validity in qualitative research refers to whether the findings of a study are true and certain — 'true' in the sense that research findings accurately reflect the situation, and 'certain' in the sense that research findings are supported by the evidence (Guion, Diehl & McDonald, 2011:1). **Credibility** is achieved to the extent that the research methods engender confidence in the truth of the data and in the researcher's interpretations of the data. It is sometimes referred to as the equivalent of internal validity. The purpose for using multiple sources was to enhance data credibility. The data sources contributed to the researcher's understanding of phenomenon of nursing professionalism. According to Baxter and Jack (2008:554), a voluminous amount of data, a result of multiple data sources, requires effective management and analysis.

Dependability refers to research evidence that is consistent and stable over time and conditions. It can be compared to reliability in quantitative studies. **Transferability**, which is equivalent to external validity, is the extent to which findings from the data can be transferred to other settings or groups. **Authenticity** refers to the extent to which researchers fairly and faithfully show a range of realities and convey the experiences of participants. In this study, trustworthiness of the data were demonstrated by confirming that the findings accurately reflected the experiences and viewpoints of the participants rather than the perception of the researcher. The researcher also shared the preliminary interpretations with the participants, so that they could evaluate whether the researcher's interpretations were consistent with their experiences. Furthermore, strategies for enhancing the quality of the data, as collected by the researcher, included prolonged engagement with participants. This was done because the researcher strived for adequate scope of data coverage, triangulation and member checking.

Confirmability is the degree to which study results are derived from characteristics of participants and the study context. It is referred to the objectivity or neutrality of data. The

findings in this study reflected the participants' voice and not the researcher's perspective (Polit & Beck, 2012:585).

Furthermore, the researcher in this study used triangulation to reveal the complexity of nursing professionalism as a phenomenon by using multiple means of data collection to converge on the truth. Triangulation is the process of using multiple referents to draw conclusions about what constitutes the truth (Polit & Beck, 2012:175). Guion et al. (2011) distinguish between five types of triangulation: data triangulation, investigator triangulation, theory triangulation, methodological triangulation and environmental triangulation. In this study, data triangulation and methodological triangulation were used. Polit and Beck (2008) categorise triangulation during the process of data collection and data analysis. During data collection, key forms of triangulation include data triangulation, which is the use of multiple data sources (in this study the three units of cases) to validate conclusions. Methodological triangulation uses multiple methods to collect data (in this study FGIs and unstructured individual interviews were used) about the same phenomenon. Information was further increased by the writing of field notes. Triangulation in facilitating interpretive validity and establishing data trustworthiness is extremely important (Maree, 2007:39). Maxwell (2013:93) states that it relies on information collected from a range of individuals, teams and settings, using a variety of methods. Strategies for enhancing the quality during the analysis of qualitative data included investigator triangulation. In this study, the researcher obtained the services of an independent (external) coder and her supervisor (a research expert) to verify the qualitative results. Reliance on the input of an expert is valuable to the validity of the information provided. The combination of literature and the use of experts, according to RNAO (2007:22), strengthen the rigour of discussion.

3.7 ETHICAL CONSIDERATIONS

Since human subjects are involved in research about nursing, it is necessary to put procedures in place to ensure that the study adheres to i) ethical principles and ii) that participants are protected (Polit & Beck, 2008:67). Institutions require that all research involving human subjects should be approved by their institutional review board or ethics review committee. Qualitative research must be reviewed and given ethical clearance before the researcher may proceed. In this study, the letter from the chair of the review committee served as verification that the study had been approved. This review is for the protection of human subjects and not for scientific merit (Morse & Field, 1996:47). The South African law that regulates ethical research is the National Health Act No. 61 (2003). A research proposal that included the problem statement, purpose, design and

methodology of the research was first presented for critical review to a panel of academics and postgraduate students at a SoN at a university in the Western Cape. Ethical approval for conducting the study was received from both the ethical committees of the Faculty of Community and Health Sciences (CHS) and the Senate Research Committee of a university in the Western Cape, South Africa. The registered ethical clearance registration number 12/10/18 was allocated to this research project. Thereafter, further permission was sought from another university (Annexures L and M) and the Provincial Department of Health in the Western Cape. The ethical principles of the *Belmont Report* (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978) and the ICN Code of Ethics for Nurses (ICN, 2012) directed the ethical approach of this research study.

Respect for persons**:** The principle of *respect for persons* implies that individuals are autonomous and that they have the right to decide whether they want to participate in a study or not, withdraw from a study at any stage, refuse to provide information and ask questions relating to the study. This freedom of choice was augmented in that the researcher of this study provided all the information the participants needed in order for them to make an informed decision whether to participate in the study or not. This meant that the participants were free from coercion and that nobody was forced to participate against their own will (Mulaudzi et al., 2001:26).

Beneficence*:* *Beneficence* refers to the rights of participants to be protected from every form of physical, psychological, emotional, spiritual, economic, social and legal discomfort or harm and even includes harm to a person's dignity (Pera & Van Tonder, 1996:23).

Justice: The principle of *justice* encompasses the participants' rights to fair selection and treatment. These three principles (respect for persons, beneficence and justice) are anchored in the human rights perspective that acknowledges the protection of all human research participants' rights (Brink, Van der Walt & Van Rensburg, 2012:35). These rights are discussed in more detail below.

g) Protection of participants: *Informed consent* is based on the principle that individuals should not be coerced, persuaded, or induced into participating in a research study against their will, but should rather participate voluntarily with a complete understanding of the implications of participation in the research study (Mulaudzi et al., 2001:26; Green &

Thorogood, 2009:68; Yin, 2014:78). Informed consent requires the researcher to disclose information to all prospective participants. When a prospective subject willingly decides to take part in a research study on his or her own volition, without coercion or any undue influence and after receiving complete information about the research study, it is regarded as voluntary informed consent. The participants in this study were also told that they were welcome to contact either the researcher or the research supervisor at any time when they had further questions about the study. The researcher furthermore provided a verbal explanation to all the potential participants about the aims, objectives and benefits of the study; anonymity and confidentiality; and the option to withdraw at any stage. All their questions were also answered. Additionally, information sheets with the same information were distributed to all the potential participants. All participants were above the age of 18 and signed a consent form.

h) Right to privacy: *Privacy* is the freedom people have to determine the time, extent and general circumstances of sharing or withholding their private information from other people (Burns & Grove, 2011:114). Oftentimes, social research requires that participants reveal private information about themselves. It is important that their privacy is respected and that they are not forced to participate in a research study (Babbie, 2010:64). The participants' privacy is considered to be protected when they are informed about the study, voluntarily give their consent to participate in the study and share private information with the researcher (Burns & Grove, 2011:114). The researcher must protect the privacy of the participants so that they will not be put in an undesirable position, such as being on a roster or data base to receive requests to participate in some future research, whether conducted by the researcher or anyone else (Yin, 2014:78). In this study, the participants voluntarily consented to participate in the study. They were not coerced into disclosing information to the researcher.

i) Right to anonymity and confidentiality: In qualitative research, anonymity requires the removal of all information that identifies or traces the research participants. A researcher has to exclude any information from the interview transcripts and research report that could possibly identify a participant (Hennink et al., 2011:71). Confidentiality is assured when a researcher who can identify the participants' responses chooses not disclose such information (Babbie, 2010: 67). In this study, the researcher protected the identity of the participants by using numbers instead of names to ensure their anonymity. Number cards were randomly selected by the participants. Their names were not mentioned during the focus group and voice recorded unstructured individual interviews, neither were they

written on the transcripts and field notes. To maintain confidentiality, the researcher made sure that the data collected from the participants was strictly kept confidential and not disclosed to other people. No other person except the researcher and her supervisor had access to the confidential information about the participants. Only they had access to the transcripts and voice recordings of the interviews that were securely protected by using password-protected files. The independent coder was given a copy of the transcripts without any details or information about the participants and had to sign a confidentiality agreement to not reveal any information about the research project. The researcher committed to destroy these records five years after the publication of the research report. The participants were also informed that the study would be analysed and reported anonymously and that all information provided by them would be kept confidential.

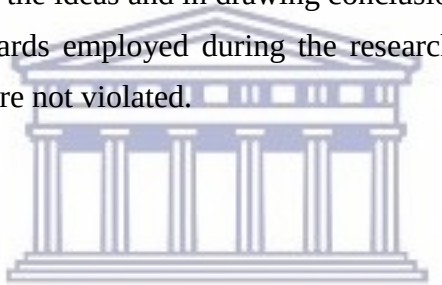
j) Right to fair treatment: This right is based on the ethical principle of justice. According to this principle, research participants must be treated fairly (Burns & Grove, 2011:114). In this study, the research participants were selected fairly and were all treated with utmost dignity and respect. The findings from the study will also be shared with the participants prior to its publication in an accredited peer-reviewed journal. Participants were selected equitably and the researcher made sure that none of the separate cases were unfairly included or excluded from the research (Yin, 2014:78).

k) Right to protection from discomfort or harm: The right to be protected from discomfort or harm in a research study is based on the ethical principle of *beneficence* which states that no participant should be harmed. It is recommended that human research should never injure or cause damage in any form to the study participants, regardless of the fact that they volunteered to participate in the study (Burns & Grove, 2011:114; Babbie, 2010:65). To ensure this, the participants in this study were not subjected to injury, stress, or discomfort. Arrangements were made with a counsellor for prompt management of any participant who experienced psychological discomfort due to the study.

3.8 CONCLUSION

This chapter presented the research methodology of the study. The researcher stated the purpose and objectives of the study, thereby reflecting on what the study aims to achieve. The methodological approach was selected before it was presented and described systematically. Instead of using a quantitative design for this study, the researcher selected a qualitative, exploratory, descriptive and contextual design with a case study approach. The selected research design was congruent with the objectives and the research questions of the study. The researcher

proceeded to the research field with the theoretical framework of Brown and Ferrill's (2009) taxonomy of professionalism. The preparation of the research study field, pilot interviews, methods used for data collection (FGIs, unstructured individual interviews and field notes), phases of the study and the data collection procedure were discussed to give a rich representation according to appropriate theoretical and methodological sources. The researcher described and reflected on the study setting, research population, sampling technique and sample used to convey all the characteristics of the research context and the study participants as clearly as possible and without any ambiguity. The procedure for data analysis was clearly described. The researcher conducted within-case and cross-case analysis and used Creswell's (2013) data analysis spiral of steps to illustrate how the main activities move in circles or a spiral even though they are presented in a linear format. The researcher found that, as multiple sources were used during data collection, this technique of qualitative data analysis was the most appropriate. Trustworthiness was addressed and appropriately described in this chapter according to measures that are acceptable in qualitative research. Also, the researcher describes the reasoning strategies used in processing and organising the ideas and in drawing conclusions in the study. This chapter concluded with the ethical standards employed during the research process to ensure that the rights of the study participants were not violated.



CHAPTER 4

DISCUSSION OF RESULTS OF THE LEARNER NURSES IN PHASE 1

4.1 INTRODUCTION

Chapter 3 presented a detailed description of the methodology used in conducting this research study. In this chapter, findings from the first phase of the study with regard to nursing professionalism, leading to a framework for nurse educationalists and professional nurses to facilitate professionalism is discussed. The objectives of the first phase were:

- To explore and describe the experiences of learner nurses of professionalism during their undergraduate nursing programme at a university in the Western Cape.

- To explore and describe how nurse educationalists and professional nurses could facilitate professionalism among undergraduate learner nurses in nursing practice in the Western Cape.

The findings are described as a multiple case (see Point 1.8.2), consisting of learner nurses, nurse educationalists and professional nurses. The findings of Case 1 are described in Chapter 4 and Case 2 and 3 in Chapter 5.

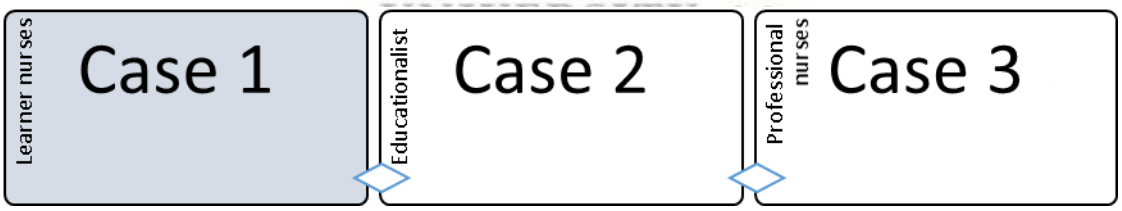


Figure 4.1: Multiple case

This chapter begins with an overview of the fieldwork activities, followed by an outline of the composition of the FGIs (Tables 4.1, 4.2 and 4.3) and a description of the demographic profile of the participating cases. In addition, comprehensive discussions of the findings per case are presented in a narrative format using italicised quotations from the FGIs and unstructured interviews, along with the field notes.

4.2 OVERVIEW OF THE PARTICIPANTS (PHASE 1)

The main data collection techniques were focus group interviews (FGIs), whereas both FGIs and unstructured individual interviews with professional nurses were conducted at one particular

healthcare facility. The combination of the data collection techniques provided complementary perspectives on the participants' experiences of professionalism at the higher education institution (HEI) and clinical nursing practice facilities in the Western Cape. English was the medium of communication for all the FGIs and some of the unstructured individual interviews. Afrikaans was spoken during an unstructured individual interview on the participant's request. The use of Afrikaans during an unstructured individual interview was acceptable as it did not infringe on the rights of any other participants, as would have been the case with FGIs.

Learner nurses

A total of eight FGIs with learner nurses were conducted across levels one to four of the undergraduate nursing programme at the HEI (Table 4.1).

The culture, language, ethnicity, and level of maturity. of the learner nurses varied, and a few were from abroad. Some were young and have recently completed their secondary schooling, while others were more mature and had previous work experience. Their ages ranged between 18 and 45. Learner nurses entering the programme directly after secondary school had an endorsed matric certificate for degree studies at a HEI as minimum qualification.

In **Objective 2 of Phase 1** (findings discussed in Chapter 5), FGIs and individual interview were conducted with: a) nurse educationalists; and b) professional nurses.

a) **Nurse educationalists**

Three FGIs and an individual interview with a clinical supervisor, (pilot) were conducted with nurse educationalists at the HEI in the Western Cape where the undergraduate learner nurses are registered for the formal four-year undergraduate nursing programme.

a) **Professional nurses**

Professional nurses who were working in the patient care wards where the learner nurses were placed for clinical practice learning took part in focus groups and individual interviews. One FGI was conducted at Hospital 1 (psychiatric hospital), two at Hospital 2 (secondary hospital) and two at Hospital 3 (tertiary hospital). All of these hospitals are regarded as training hospitals in the Western Cape Metropole (Table 4.3). Individual interviews were conducted in Hospital 4, a tertiary hospital (Table 4.4).

Table 4.1: Composition of FGIs per year level of Case 1: Learner nurses

FG	Year Level	Description of Participants	
1 Pilot	*Third year*	P 1 P 2 P 3	Female Female Female
2 Pilot	*Fourth Year*	P 1 P 2 P 3	Male Female Male
3	*Fourth Year*	P 1 P 2 P 3 P 4 P 5 P 6 P 7	Female Female Female Female Female Male Female
4	*Third Year*	P 1 P 2 P 3 P 4	Male Female Female Female
5	*Fourth Year*	P 1 P 2 P 3 P 4 P 5 P 6	Male Female Female Female Male Female
6	*First Year*	P 1-P 7	Females
7	*First Year*	P 1 P 2 P 3 P 4 P 5 P 6 P 7 P 8	Female Female Female Male Female Female Female Female
8	*Second Year*	P 1 P 2	Female Female

		P 3 P 4 P 5	Female Male Male

Table 4.2: Composition of FGIs and individual interviews of Case 2 (nurse educationalists)

FG	Position in nursing school	Description of participants	
1	Nurse educators – all four year levels	P 1- P7	Females
2	FG 2 Clinical supervisors	P 1- P 6	Females
3	FG 3 Nurse educators – all four year levels	P 1 P 2 P 3 P 4 P 5 P 6 P 7	Female Female Male Female Female Female Female
4	Unstructured individual interview (pilot)	P1	Female

Table 4.3: Composition of FGIs of Case 3: Professional nurses

FG	Healthcare Facility	Description of Participants	
1	Hospital 1 (psychiatric care)	P 1 P 2 P 3 P 4 P 5 P 6 P 7 P 8 P 9	Female Female Female Male Male Male Female Female Female
2	Hospital 2 (secondary/level 2 hospital)	P 1 – P 4	Females
3	Hospital 2 (secondary/level 2 hospital)	P 1 - P 5	Females
4	Hospital 3 (academic/tertiary hospital)	P 1 - P 5	Females
5	Hospital 3 (academic/tertiary hospital)	P 1 – P 6	Females

Table 4.4: Composition of unstructured individual interviews of Case 3: Professional nurses

Healthcare facility	**Individual interviews**	
Hospital 4 (academic hospital)	P 1	Male
	P 2	Female
	P 3	Female
	P 4	Female
	P 5	Male

Five individual interviews were conducted at the fourth hospital (tertiary/academic), of which one was in Afrikaans as it was the preferred language of the participant. Work experience ranged from some professional nurses just starting off their professional careers (i.e. two to five years' work experience), while others had twenty and more years' experience. Most professional nurses who were interviewed in the study were in charge of a patient care unit, a ward or an outpatient department. The professional nurses worked in medical-surgical, midwifery, psychiatric and general wards and outpatient departments. Among the participants who took part in the individual interviews at one of the academic hospitals were (i) a Nursing Service Manager in theatre; and (ii) an Assistant Director of the same academic hospital. One participant was a clinical facilitator for student nurses in the teaching division at one of the healthcare facilities, while another participant was involved as a manager in the staff development programme of the same healthcare facility.

In this study, the cross-case synthesis was used because it applies to the analysis of multiple cases (Yin, 2014:165). The three cases of undergraduate learner nurses, nurse educationalists and professional nurses described in Chapters 4 and 5, served as embedded units of analysis for the overall case study that was conceptualised with the literature in Chapter 6. This led to the development of a framework for facilitating professionalism among undergraduate learner nurses (Chapter 7). The identified themes and categories will now be discussed, accompanied by appropriate quotations from the raw data of the participants.

4.2.1 Case 1: Learner nurses (first to fourth year)

Despite being exposed and trained to develop professionalism and receiving support from educationalists and professional nurses (both in theory and practice), the learner nurses experienced mixed messages and emotional turbulence about what it really means to be a professional.

Table 4.5: Experiences of learner nurses regarding professionalism in the undergraduate nursing programme and possible ways of supporting the development of professionalism in learner nurses

Themes	Categories	Sub-categories
First- and second-year participants experienced role modelling of unprofessional behaviour of specific nurse practitioners in specific setting	Humiliating and demoralising style of communication and intolerant behaviour of professional nurse practitioners in specific settings	
	No respect for time	
	Incidences of misconduct and non-commitment to patient care	
	Inconsistent expectations of and/or ignoring of procedures and guidelines/performances	
First- and second-year participants' perceptions and experiences of the influence of language barriers on development of professional behaviour	Language barriers are experienced as detrimental to professional development	
Practitioners prejudiced towards HEI A students (all)	HEI B and college students advantaged in professional development because of more exposure to practice	
Participants' understanding/perception of professional behaviour	Respect in communication and behaviour towards all concerned	Politeness and communication skills
		Displaying empathy and caring relationships
		Approachability and tolerance in attitude within professional boundaries
		Displaying verbal and non-verbal communication skills
	Interaction of personal and basic human values, norms and professional values	Modification of personal values to fit into general values and norms and professional values
	Student role reversals: school learner to adult learner	Personal responsibility for learning and behaviour
	Dress code and professional image of a nurse	
Participants experience students' professional/unprofessional behaviour as contributing to the image of (name removed) HEI A (couple of first -and second-year voices, more views from	Some students do not act respectfully and do not take professional responsibility in practice seriously	

seniors)		
Reasons for students and practitioners' unprofessional behaviour and implications and suggestions for improvement	Specifics of professionalism not clear, practical guidelines needed	
	Professional values taught, but not internalised	
	Formal pledge in first year for commitment	
	Lack of motivation for nursing. Reconsider selection of motivated and committed students and practitioners	
	Unresolved grievances – students need platform for discussion	
	Traumatic experiences in life influence professional behaviour	
	Students need more academic help and mentoring, and supportive monitoring in practice	

4.2.1.1 Theme 1: First- and second-year participants experienced role modelling of unprofessional behaviour of specific nurse practitioners in specific settings

Role modelling is viewed as an overarching activity that encompasses everything a person does in their being and acting as professionals. It is understood and believed to be an important method of teaching in shaping the values, attitudes, behaviour and ethics of those who are learning (Boerebach, Lombarts, Keijzer, Heineman & Arah, 2012:1). Role modelling in the healthcare professions equate effective senior staff role models, whereas role modelling in nursing concerns learning in the practice environment (Felstead, 2013:224). Professional behaviour is described as "behavioural professionalism" or behaving in a manner to achieve optimal outcomes in professional tasks and interactions with others (Hammer, 2000:456).

The findings reflected strong feelings about the "unprofessional behaviour" of professional nurses at some settings and selective wards towards (name removed) HEI A's first and selected second-year students. These participants verbalised what they experience as unprofessional behaviour in the clinical learning environment where they were placed during their four-year professional training, leading to a qualification as a professional nurse. The experiences of unprofessional behaviour by nurse practitioners in specific settings included humiliating and demoralising communication, as well as in towards learner nurses. Learner nurses also experienced that professional nurses displayed a lack respect for time and were not orientated to the wards during their placement at some of the facilities. At the same time, incidences of

misconduct and non-commitment to patient care by professional nurses were also experienced by the participants.

The overwhelming theme of this experienced behaviour relates to professional nurses' verbal and non-verbal communication with students. These experiences should be interpreted as not upholding the values of respect and dignity of co-workers or peers (*"… she's shouting in front of the patients, your dignity is going to like decrease…" 1st yr. P11 FG1).* Similarly, second-year participants reflected on belittling communication by professional nurses. This seems to have made a very negative or degrading impression on inexperienced and sensitive students: "*We began by feeling very insecure about ourselves in the beginning...*" (*1st yr. P4 FG 2).* Adding to that, a few participants indicated that they struggled academically (*"I was in the foundation program …*"), were hurt by rudeness or reprimands (*"I'm hurt easily. I take things to heart." 1st yr. P8 FG 2)* that could lead to students either withdrawing or reacting with challenging behaviour. An example of an incident where a student withdrew was mentioned: "*…so it will be a bad reflection on the university like we're back-chatters and stuff. So I chose to be quiet and just walk away."* (*1st yr. P8 FG 2).* Another participant reacted with challenging behaviour: *"Now she's (the professional nurse) short of gauze. Now she's like: 'Nurse, can you please bring me gauze?' And I'm standing … I have this attitude with doctors that they undermine us too. They undermine us more than the sisters undermine us. So this doctor is like: 'Nurse, can you?' And I just stood there. I'm not a permanent staff."*(*1st yr. P8 FG 2).*

Examples of poor role modelling or misconduct was mentioned while an increasing internal locus of control for professional behaviour was demonstrated in the views of the more senior participants. On the other hand, some participants advocated for students to take control of negative role modelling and pay attention to their own unprofessional behaviour.

Category 1: Humiliating and demoralising style of communication and intolerant behaviour of professional nurse practitioners towards learner nurses in specific settings

Communication that humiliates learners is regarded as negative and creates effects such as anxiety in the learning environment (Richmond, Wrench & Gorham, 2009:66). Incidences of unprofessional behaviour were experienced by the learner nurses when professional nurses displayed demoralising, humiliating and intolerant behaviour towards the learner nurses throughout all the year levels. Participants, mainly in their first and second year of the programme, verbalised feeling a lack of confidence and described how being shouted at in front of patients. They felt that the professional nurses affected their dignity (personal reliability of their character) and the trusting professional relationships between patients and nurses. A

participant described feeling demoralised in the absence of leadership providing direction or guidance to correct mistakes. He did not feel unique, motivated and inspired by the rude way in which students were addressed when reprimanded for their mistakes:

"The supervisors and the registered nurses, they do not address you in an appropriate way, and the way you are disciplined within the ward, they are making you feel that you are dumb. When you do something … they will shout at you, they will tell you 'Oh, (name removed) HEI A students will also do this,' and go on about it. And then they don't guide when that student has done something really wrong now. They would not guide that student at all." (1st yr. P4 FG 2)

It seems that if corrective measures were applied when mistakes are made, it will be an empowering experience for learner nurses. Leaders are needed to guide followers appropriately so that they feel inspired and motivated to carry out the right tasks (Zhu, Sosik, Riggio & Yang, 2012:207). A first-year participant described being humiliated in front of peer learner nurses by the way the nurse educationalist communicated loudly with her:

"I also had a misunderstanding with a supervisor and the way she conducted herself with me. She was not; … I can say and stand for this, that she was not professional. She insulted me in front of my peers and she spoke loud enough so that her colleagues could also hear." (1st yr. P7 FG 2)

One participant responded by saying that human dignity was affected through shouting:

"Like now, because if she's (the sister in charge) shouting in front of the patients, your dignity is going to like decrease …." (1st yr. P11 FG1)

Individuals are unique in that they have a sense of self-worth and pride. When the dignity of individuals is disrespected, they become demoralised. It should be interpreted that when students feel demoralised, work performance and teamwork are hampered. Leadership is needed to help people grow and build high performance teams (Watt, 2013:31). A participant had the personal belief that privacy and respect are part of the characteristics of a professional nurse, and that appropriate verbal communication was essential, even in conflict:

"She normally shouts at us in front of the patient. And from my own perspective, I believe that if you are a professional, you are supposed to like talk to your colleague in a polite manner and go to a private room when you're going to talk like that." (1st yr. FG 1)

Participants described how they felt exposed by the professional nurses for their mistakes, instead of being corrected as part of the learning process:

"We were shouted at by the sisters there. If maybe you write your notes, every staff will look at you and when you turn around, they would go and read what you have said." (4th yr. P 7 FG 1)

Participants felt that confrontation should not take place in front of patients, but that a respectful conversation should take place in a private space where staff will not be humiliated and demoralised. Conflict could arise when there is a struggle between people with opposing needs, ideas, values and beliefs and goals (Foundation Coalition, n.d.). Effective conflict resolution of role players is therefore essential. Another participant explained how the unprofessional behaviour of a sister (professional nurse), broke the trusting relationship between the student (learner nurse) and the patient, leading to a situation in which the learner nurse felt insecure and without confidence:

"… she just starts shouting at you in front of the patient. That thing is not good, because it breaks them; the bond between you and the patient. The patient won't want you to help her and then you won't learn anything. Then when you come they would like when you come back … She doesn't know. She is in the university, but she can't even know how to … So you don't have that confidence to do it because they would like …." (2nd yr. P 6 FG 8)

Other participants also mentioned that their confidence was dampened down by the unprofessional behaviour of the professional nurses:

"So they undermine us … " (1st yr. P8 FG1) and *"… some of them, they speak it out in the open, pointing at you directly in front of the other staff of which they are like undermining you in the field of professionalism of which is not professional." (4th yr. P10 FG1)*

It seems as if learner nurses felt more confident to perform their patient care tasks when professional nurses addressed them respectfully in front of patients. Confidence in ones' own abilities and e.g. self-leadership is also important and could enhance trust between the nurse (recipient) and the patient (Rutherford, 2014:286). First-year learner nurses also had a need to feel safe and comfortable in the clinical learning environment, where it is expected that the professional nurse accompany them in the clinical setting in which they are placed. They, however, experienced that professional nurses did not understand that they were new in the profession and still needed guidance and support with newly learned skills. Poor communication and intolerance towards them were mentioned. Professional nurses showed intolerant behaviour towards first years starting as new learners in the wards:

"We don't know most things, especially first years. Because we're still even struggling doing full wash, but they still expect us to do urine analysis in a way that they understand it. Like they don't understand that we are still first-year students, we (are) still new at this, we're still learning. They can't communicate with us in the way that they should be. Usually when you do something, like for instance, it was the other day where I put dirty laundry in a place where I should've put it. And then the sister in charge was shouting and I just told her that I don't know. She could have just said to me: 'No, we don't do this; we do this this way and that way.'" (1st yr. FG1)

A second-year male participant felt that senior nurses were not role models of professionalism and failed to create a friendly clinical learning environment for new learner nurses coming to the clinical placements facilities. Learner nurses felt scared and were not comfortable when they went to the clinical sites:

"As I was doing my first year, when it comes to the clinical site, professionalism was not there. Instead, like every student, you don't feel that now… like your seniors, your superiors, you don't look up to them. You're always scared now. You're always scared to come out of from the shell." (2nd yr. 9 FG 8)

The clinical learning environment should be a place where learner nurses feel confident and safe to be themselves, and seniors such as professional nurses and clinical supervisors should be caring role models who encourage learner nurses to ask questions.

A participant felt demotivated and uninspired to go to the clinical facilities because of the negative attitudes of staff towards learner nurses:

" … when you wake up in the morning, you say: 'Oh, I'm going to that ward again, whereby now I'm going to feel terrible the whole day because the feeling or the attitude of I'm getting from the permanent staff.' (2nd yr. male participant 9 FG 1)

Motivation and inspiration could nurses lift 'morale and enable them to serve others in a work environment where there are good interpersonal relationships (Gaur & Ebrahimi, 2013:8). A second-year participant described being demeaned and prevented from optimally using learning opportunities in the healthcare facilities:

"They belittle us. They don't allow us to ask questions. They don't allow us to learn, especially at Hospital X." (2nd yr. P 5 FG8)

Appreciation and praise are important reward strategies that learner nurses could expect to receive when they demonstrate an eagerness to learn and to know more in the healthcare settings. It seemed that a learning environment conducive to learning was needed for a positive learning experience for learner nurses, where the exchange of knowledge and information could take place without fear of judgement. A fourth-year learner nurse mentioned an incidence where a learner was almost physically abused by a professional nurse who lacked self-control:

" … he (male professional nurse) tried to beat the other student that I was working with. Oh, it was bad. So there's a lack of professionalism. Shouting in front of the patient, so that patient will not even look at you like you know nothing and they don't even want to work with you." (4th yr. P 7 FG 1)

It seemed as if learner nurses were humiliated in front of patients when professional nurses lost self-control and became physically and emotionally abusive. Learner nurses felt that this behaviour by the professional nurse would cause patients to not trust them and be uncooperative. In other instances, gossiping occurred in the nurses' tearoom. Learner nurses experienced emotional and psychological abuse by being humiliated when professional nurses discussed mistakes learner nurses had made in front of other nursing staff members:

" … you're sitting in the tea room and everybody is talking about you – that's not professionalism…" (1st yr. FG 2 P 2) and *"They would just go on into the tea room and go gossip about it." (1st yr. P4 FG2)*

It seemed as if negative conversations like gossiping did not contribute to either the emotional and psychological wellbeing of the learner nurses, or the building of effective relationships. A fourth-year participant mentioned how they were being humiliated by the professional nurses in front of other staff in the tearoom:

"… we write the reports in the patient's books and then the sister would go and read it, and when they sit in the tea room, they will call your name and say: 'Who is this one?' And if your answer is: 'Me' … Then: 'What rubbish did you write in the patient file?' and they would discuss the patient in front of everyone … to me that is not professional practice, because they need to call us and like not to discuss in front of the patient. They have to tell us, because we are still learning to become a professional. So they need to teach us."(4th yr. P 2 FG 1)

Apparently the behaviour of professional nurses when giving feedback to learner nurses about their mistakes did not encourage professional development, but instead humiliated the learner nurses. They expected professional nurses to show humility (personal reliability) towards them when they made mistakes, as it was important for building trusting relationships with others. In an isolated incidence, a third-year learner nurse described how professional nurses abuse their power of authority through their leadership positions by bullying learner nurses into doing personal favours for them:

"If I can add more …This way of addressing us students, whether they are, just because they are older people, they expect us to do things sometimes that are not in our scope of practice. Maybe they want us to do their admin. Maybe they want to send us to the shop or do whatever … They'll think that you are being disrespectful to them; just because they are older than you. They put …they first personalise the matter before they put professionalism in place first. 'Since you're young, you're a child, attend to my needs first before you do what is expected of you. If I say go and make tea for me, you will do that tea before you do your immunisations if you do immunisations. Because I said so …I'm older than you. Whether I'm at a higher rank or whether I am at a lower rank with you, you're supposed to respect me because I'm older than you.' So we find it difficult sometimes to do what we are expected to do and our learning progress is very slow." (3rd yr. FG 1)

A fourth-year learner nurse described not being listened to by the staff in the clinical facilities, which resulted in the participant living with bullying and fear of intimidation throughout the four-year training programme.

" ... for the past few years that I've been studying, going to the clinical facilities, I decided for myself I'm never going to be assertive. I lived with bullying, because I think if you start to get ... if you stand up for yourself, what they do is, they give attitude. Then they have that thing of saying you think you're clever because you're doing a degree and then they like have this attitude towards you. So I thought no, I can't handle that. I'll let them do whatever they want to do, and just keep quiet. I am not assertive." (4th yr. P6 FG5)

It seemed as if learner nurses were not treated as equals and became less self-confident because they felt the staff in the ward intimidated them when they were assertive and stood up for themselves. Learner nurses felt that they were not trusted by the professional nurses to perform the higher level skills they already knew and that were appropriate for their year level at the clinical placement facilities. A participant was requested to repeat competencies that have already been assessed as a competency and completed at a lower year level:

"She's working there and she tells them about the objectives that she must meet and get done with. And then the sister says: 'No.' So she must first learn how to do blood pressure. Can you imagine, the time it is taking. She hasn't done any immunisations or any objectives that she has to be done with in her third year. So I think that it's not professional for that sister, because already she was at university. So she must know what is done in the third year, first year or second year." (3rd yr. FG 1)

The participants also verbalised being unhappy that they could not integrate the knowledge that they have learned at the university in the clinical practice facilities, but instead learning opportunities in the healthcare facilities were restricted, and they felt excluded from the team:

"It's like it is limiting our learning experiences, because we are ... we learn a lot at the university and we feel that we can do some things, but when we come to the facilities they don't allow us." (3rd yr. P 3 FG 4)

One participant said they were prevented to carry out their year level outcomes as taught at the university. There seems to be different learning needs and non-alignment of learning outcomes between the university and practice:

" ... they always prevent us from doing things that we are taught at school, because now we don't learn things much like in hospitals, because they do such different things. It's the way that they do it, we cannot come and implement what we've been taught at the university…." (3rd yr. FG 1)

Fourth-year participants needed professional nurses to demonstrate to them how to behave professionally in the clinical placements, creating an effective interpersonal relationship:

"I believe that the sisters in the wards have a huge role to play to portray how professionalism should be and … practically showing us how to behave professional. We do have lots of information – theoretically … you can teach me how to remove sutures, but it is a different story to remove them. You must show me how to remove them also if you're going to teach me. I need someone to show me how to behave professionally and that is not happening." (4th yr. FG 3)

A participant felt that they were treated unkindly in the hospital settings and expressed a sense of feeling disconnected from the setting. This could be due to not being regarded as part of the professional healthcare team. Instead, the professional nurses' opinion was that they have poor knowledge. They also showed no humility towards students and regarded them as inferior to the professional healthcare professionals. The participant believed that the ward sisters (professional nurses) should teach without passing judgement on them:

"In the hospital setting, I would say that students are not regarded as professional healthcare practitioners. So we are seen as inferior in knowledge. So they don't really want to leave us alone or let us do what we are supposed to do. And if we are not doing what we are supposed to be doing, they also criticise us – so from both ways we are getting like attacked, in my opinion. I believe as a sister of a ward or something you need to be able to teach students and not just criticise everything." (3rd yr. P4 FG 4)

Category 2: No respect for time

Respect for time is regarded as important in the clinical learning environment. It has been indicated to enhance productivity and when role models are on time for the clinical instruction of the learner nurse, valuable time is not wasted (Mubarak, 2011, in Britiller, Ramirez, Ramos, Reyes, Salazar & Sandoval, 2014:8). Britiller et al. (2014) are of the view that attendance, and being on time or punctual, show commitment, attentiveness and determination and indicate that a person is ready to get things done on time effectively and efficiently. Undergraduate learner nurses entered the clinical placement facilities for the first time during the second term in the first year of their training programme. They were theoretically prepared for going to the healthcare facilities, and were instructed on punctuality (personal responsibility) and being on time for the handover of staff during night to day shifts. The learners were also informed to honour appointments made with the clinical supervisors who were their mentors and support in the healthcare facilities where they were placed. However, participants experienced a lack of respect for time among permanent staff and clinical supervisors accompanying them in the clinical placement facilities:

"… you are confused whether you're acting in a professional way... you find that sisters, for instance people that we are supposed to look up to, they're not on time" (1st yr. FG 2) and *"… at times supervisors come for our procedures and they come wrong times."(1st yr. FG 2)*

Another first-year undergraduate participant described the irresponsible behaviour of permanent staff who abandon their nursing care duties, and shift their responsibilities on learner nurses:

"… the permanent staff disappears and then everything is left to be done by the students" (1st yr. FG 2 P2) and *"They (clinical supervisors) were sitting in the front desk just having a chat. It was just us and the simulated patient whereby it got to the point the simulated patient acted as though she was the supervisor …." (1st yr. FG 2 P6)*

Professional nurses should respect the learning needs of students with regard to being orientated in new units. Orientation of nurses is seen as the introduction of a nurse into the world of nursing. It is thus an essential part of the new nurses' need to assimilate into a units' culture and therefore has the potential to influence not only the novice nurses' practice, but also the patient outcomes (Riegel, 2013:1). Learner nurses experience that professional nurses did not equip them with the necessary information to adjust in a new working environment. They described feeling lost in a new work environment due to the poor organisational structure in the absence of an orientation programme to familiarise them with expectations (competencies) in a new ward. They experienced abandonment as the professional nurses didn't have time to support them to adapt to and socialise in the clinical learning environment. A fourth-year learner nurse highlighted that professional nurses have forgotten that they were also students themselves:

"… where there's a lack of professionalism in nursing …It's like the sisters of today, I don't see how they can have a bad attitude towards students. They don't take time to show you how to do something or to teach you or orientate you, but they expect you as a student to know stuff. And then it's like they were never students. They were just adults, born adults and born nurses and know how to do everything." (4th yr. FG 1 P4)

Another fourth-year participant described being intimidated, punished and treated unkindly by professional nurses. Furthermore, it seems that learner nurses were unaware of some aspects in the curriculum of the four-year undergraduate programme that were thought of as essential for assessment by the clinical supervisor:

"It's punitive, because you know what? The university, sorry to say this, they are being cruel in a way. Because we are like being treated with a threatening approach, but the moment you step into that ward and you get that sister, you going to be caught for things maybe stupid things … or even things that you were supposed to master … because there is a free approach you didn't master them … but they are there on the curriculum. So it has to be punitive. That is the reality." (4th yr. FG 3)

Category 3: Incidences of misconduct and non-commitment to patient care

Professional misconduct is regarded as a form of unprofessional conduct and considered below the standard expected of a registered healthcare practitioner, such as for example professional

nurses in this study, or others with an equivalent level of training or experience. Various forms of unprofessional conduct or conduct that is inconsistent with the healthcare practitioner being fit to hold registration in the profession, could occur (Cleary, 2014:27). Incidences of misconduct are sometimes due to unhealthy work environments where nurses suffer from burnout, but there have been incidences where nurses simply did not care (Oosthuizen, 2012:58). In this study, incidences of absence of professional capabilities (competence) of the professional nurses were experienced by participants in specifically two hospital settings. It was first-year participants who mentioned that misconduct, non-commitment to patient care and malpractice were demonstrated by nursing staff in specifically two hospital settings. These incidences occurred over weekends and during university vacation in clinical practice environments. A participant described irresponsible and unprofessional conduct by professional staff at certain times. They mentioned professional nurses being drunk on duty, especially over weekends, and that nurse leaders had a laissez-fair style of leading and lacked professional work ethic:

"In June vacation, sister comes drunk into the ward (interjection). She was busy giving handover. (Slurred speech) And everybody is like … and then after that, the other sisters were like … don't talk to me, I'm also babbelas. She's drunk and I'm babbelas. I have a headache. And how you are as a student are going to be like … okay, so I can come to work drunk because it is allowed. They know … and then when they see the matron coming, they would like here's matron … And then weekend, there's no matron. Saturday, Sunday when you're working during [vac] or working Saturday, it is do as you please as long as all the work is done." (1st yr. FG 2)

The participant also described how the sisters during these specific times neglected their patient care responsibilities by engaging in social media on their cell phones and condoning unprofessional behaviour by permitting learner nurses to their put personal interests first over the needs of patients:

"Sisters come and sit in the station, hosanna, the sister is on BBM, but when you're just looking at the time on your phone: 'Student, put the phone down. You're a student … And then after that go charge my phone by that patient,' and they cover for each other. A registered nurse you'll find because the medication trolley keeps you busy. The last time … on the 15th, the ENA disappeared after handover till before night handover. And when she came back, her hair was all done and her nails were all done." (1st yr. FG 2)

A fourth-year learner nurse described the same unprofessional behaviour where professional nurses were busy on their mobile devices when caring for the patients:

"My point is to mention is the use of cell phone. It's not really professional when sisters have to be on their cell phones when they're doing their care. It is heart-breaking to me when I see sisters doing this. How can we stop this?" (4th yr. P 4 FG 3)

A first-year participant mentioned that the professional staff sometimes abandoned their professional duties and did not take responsibility for their actions, also blaming one another for not being there for the patient:

" this one patient said: 'The patient passed away last night.' Nobody noticed because they were all talking about Tupperware. And only in the morning after handover they noticed that a patient had actually passed away. And then the sister was like, no, but the other sister, and then they want to shift blame to the one that's not here …." (1st yr. FG2)

An increasing workload accompanied by a sense of helplessness and rejection, where learner nurses became a burden in the execution of daily tasks. A participant described how they struggled to do the right things in the hospitals in the way they were taught in the classroom:

"They do shortcuts and we, what we are taught in university, we are struggling in the hospital setting, because we tend to want to do what we are taught at school about professionalism, but then … in the hospital setting they'd be complaining that we're taking a lot of time and they need to reach some certain targets, they've got patients per day and at the rate that we are going we are really slowing them or preventing them from reaching that target. So they'd rather reach that target rather than practising the professional way of doing things." (3rd yr. P1 FG 1)

Learner nurses described how hospital staff took shortcuts to get through the workload of the day. These experiences created tension and feelings of frustration within the learner nurses as they were unable to apply their theoretical knowledge (learned in the academic environment) to the clinical practice environment. Malpractice and negligence sometimes occurred due to a lack of proper clinical teaching, learning material and equipment. A fourth-year learner nurse explained why simulation in the clinical laboratory should be closer to the real practice:

" …can't we improve it so that when the student gets out there, they see the real thing... Because one day I spent the whole day at Hospital 6 (name removed). I was stitching this guy who was hit by a hammer. The whole head … it took me the whole day to stitch the guy. If I was like a little not (inaudible) there … I would not even manage to stitch that head because the sister in charge would say: 'No, you can't because you're missing all these spots here' … because I will be thinking of the sponge, the sponge, the sponge, the sponge. And the sponge is not going to help me. So I would understand when some of the students get shouted at because they're practising not on a real thing. Get new plastic models, we have nice models which are more human like. I'm happy when I get to that heartbeat one that is there … And the one that we've got at Hospital Y (name removed), the one that gives birth. Give the student something more practical. The professionalism is going to come out because when I see it, this thing … (sound), coming out, this is fascinating. When you see the baby comes out you're not going to run … as I saw it in the hospital; it was in our practical situations. For which that will help a bit to improve also the collaboration between the students, the facilitator and the staff in the hospital." (4th yr. P 6 FG 2)

Learner nurses described attempts to resist adapting to unwanted professional behaviour, but instead find themselves obliged to conform to malpractice which exist in some of the clinical placement facilities in the professional practice environment:

"With all the misconducts that professional people in our course have conducted towards us, whether it be in the ward or at the skills lab, I think that plays a very big part. Because we also kind of take that influence and we put it with ourselves; forgetting that at the end of the day we're going to be dealing with real lives in the hospitals and we're going to be the ones who are going to be responsible for it now… Also the example of stuff happening in the ward of the sister being late. You're also going to adapt to that kind of habits and behaviour; forgetting that you are going to be the sister one day. You are the one who is going to have all those responsibilities that's going to be on your shoulders. We also lose what we're here for and end up taking on … conforming to the norms of other people that have been going on and on and on." (1st yr. P3 FG 2)

Category 4: Inconsistent expectations of and/or ignoring of procedural guidelines/ performances

Adherence to guidelines (e.g. procedural performances) promotes patient safety and is associated with positive clinical outcomes (Nilsson, Grankvist, Juthberg, Brulin & Söderberg, 2014:1). According to Nilsson et al. (2014), possible reasons for non-adherence during clinical practice are that students adapt to observed behaviour and norms within the learning environment. They state that learner nurses tend to report similar levels of adherence to guidelines as those of professional nurses in clinical practice. Nilsson et al. (2014:6) further state that deviation from guideline practices increases close to graduation and therefore it becomes crucial that the issue of students deviating from best practice guidelines while attending a university programme is taken seriously. Difficulty adhering to guidelines could possibly be explained by the professionalisation process during clinical practice in which students often unknowingly imitate their supervisors' procedures rather than maintaining a correct approach to following established guidelines (Cornish & Jones, 2010; Curtis, Horton & Smith, 2013). Participants described that the clinical staff had inconsistent expectations and did not adhere to procedure guidelines. First-year participants described their need for clear direction and guidance about what is expected from them during their academic and clinical training programme to ensure professional preparation for nursing practice. A participant explained that there were inconsistencies in the way clinical skills were demonstrated to them:

" … if they're (clinical supervisors) going to teach me to give a bedpan this way and teach her to give a bedpan that way … everybody is telling us to do it in different ways. How are we supposed to do it right when they're not showing us the right way and then we can't be a professional nurse doing things the right way?" (1st yr. FG 2)

There were even inconsistencies in how skills were being assessed by the clinical supervisors:

" ... they mark you down if you don't do it their way ...." (1st yr. FG 2)

Some participants experienced that no one was available to guide them in the skills laboratory. A participant said:

"...then you are supposed to do whatever is in your scope of practice ...you end up doing things that are not in your scope of practice. I was at the skills lab, and the supervisors weren't there at the stations." (1st yr. FG 2)

Another first-year participant commented by saying that there should be consistency and uniformity among the different nursing schools in terms of what is taught to learner nurses about professional conduct in the placement facilities (hospitals):

"They didn't tell us you must do this and you must do that. Just let there be communication and team work among us. But there was like nothing. It wasn't professional for me ...we should all learn the same thing. We should all do it the same way ... within the different schools there are different things we are taught and it puts a strain as to yourself and how you conduct yourself in the hospital." (1st yr. FG 2)

4.2.1.2 Theme 2: First- and second-year participants' perceptions and experiences of language barriers in the development of professional behaviour

In this theme, learner nurses throughout all year levels in the undergraduate nursing programme, but especially among first- and second-year learner nurses, experienced that in some clinical practice placement facilities, language barriers negatively affected their professional development.

Category 1: Language barriers are experienced as detrimental to professional development

Language, including body language, is forms of verbal and non-verbal communication that are important in people's understanding of one another (Omolola & Gray, 2014:10). Language barriers inhibit effective communication, especially in a diverse multicultural population (Tay, Ang & Hegney, 2012:2648, 2654). The ability of the learner nurse to communicate and relate with nursing staff and patients is a crucial part of clinical nursing practice as it ensures that safe nursing care is provided. Language barriers, however, can cause limitations and challenges to healthcare professionals (Omolola & Gray, 2014:18). Cohen, Lawrence and Keith (2005) in Omolola et al. (2014) claim that language barriers are caused by a limited language proficiency, with the inability to comprehend, speak, write and relate a particular language to an effective capability, which will establish effective interaction between the professional nurse and the

patient. In this study, language barriers were mentioned by learner nurses coming from different cultural backgrounds and entering the clinical placement environment where they are expected to interact with colleagues, other professionals and patients in a multicultural environment. The experiences of participants were that language barriers created misunderstandings and distorted meanings in terms of the expectations of professionalism. This indicated a barrier in communication (connection domain). A learner nurse explained that they experience difficulty in understanding the language in the placement facilities because of the way people converse with each other:

"I think there is a language barrier … It must come with the way you talk to people … There is a language barrier there. We don't understand." (4th yr. P6 FG 3)

Language as a form of communication could enable people to understand meaning and prevent misunderstandings between people. It seemed that it was important to address interpersonal compatibility in nursing practice. Interpersonal compatibility is affected by language differences and therefore a common language is needed (Sandal, Bye & Van de Vijver, 2011:147) for understanding others (Grice, Monson, Pitlick, Chereson & Duncan, 2013:9). Participants mentioned that they are unable to express themselves or even understand what has been communicated about patient care in patient documents:

"Everybody was like Xhosa and then she was handing over in Xhosa and I was the only coloured there. And so I was like, okay, I'm going to listen. But now I'm asking my other colleague next to me: 'What is she saying?' But now the thing is, she can't speak English fluently." (1st yr. FG 2)

For some learner nurses, the use of vernacular (slang) language and language spoken in other cultural groups makes it difficult for them to comprehend what was communicated:

"Afrikaans in Cape Town... You guys are not speaking Afrikaans … I do not understand it … It is not Afrikaans. It is not the Afrikaans that I learned, like it's 'Ek het nie' … it's not 'Ek hettie' … It's 'het nie'". (1st yr. FG 2)

Participants also described that not being able to express themselves in a specific language lowers their self-image:

"And English. Because when you're not able to communicate, you become shy when you need to address anyone – whether it's a superior or someone else, a co-student, you become inferior to address them because you feel that, okay, I'm not fluent in this kind of speech." (1st yr. FG 2)

A first-year participant experienced that the body language of some professional nurses was offensive. She also said that she lost interest and did not pay attention because a professional nurse's verbal and non-verbal communication gestures were incongruent:

"And their body language...! They should improve their body language, because for example, if I'm going to say… coming to Thabisa and ask Thabisa something, I have to like... when I get Thabisa, my facial expression must tell me everything that she is going to talk to me. If now I come to her and I look bored …." (1st yr. FG 1)

4.2.1.3 Theme 3: Practitioners' prejudice towards degree students

Undergraduate learner nurses from the university share the clinical placement facilities with learner nurses from other HEIs and nursing colleges offering a four-year diploma qualification instead of a degree. Although the learning outcomes for the education and training at these institutions are in line as required by the SANC, the way in which curricula are structured and offered could differ between institutions. Participants who undergo the undergraduate training at the university are occasionally labelled and compared to their counterparts who studied at the nursing college. There is a perception among the hospital staff that university degree learner nurses believe that they are better at performing skills:

"So they always have that mind-set that the university students think that they're smarter than them because we do things in a certain way." (3rd yr. FG 1)

A first-year participant also mentioned having issues with the professional nurse in charge who passed judgement and compared the practical skills of the university students to those of the college students in the clinical practice setting:

"The sister in charge … they have like that attitude, (name removed) HEI A (offering degree) students are full of theory and not practical. So they're like … they are separating us. No, the (name removed) HEI B (offering diploma) students are like good in practical and you are the ones that are good in theory. So we don't want theory here at work." (1st yr. FG 1)

The participants felt judged and discriminated (social justice) against because of they come from a HEI. They expressed feelings of inferiority and humiliation in clinical settings:

"You're from (name removed) HEI A. You don't know what you do … " (1st yr. P 1 FG 2) and *"They would be like why are you so stupid? They are very condescending and judgmental towards you." (3rd yr. P 1 FG 2)*

Category 1: HEI B/college diploma students advantaged in professional development because of more exposure to practice

In this category, participants were of the opinion that the diploma students are advantaged by their greater exposure to the clinical learning environment:

"It's between (name removed) HEI B (diploma) and (name removed) HEI A (degree). But (name removed) HEI B (diploma) students have more exposure to clinical environment." (3rd yr. P3 FG 4) and *"They (diploma students) of (name removed) HEI B know more and they practice more and they learn it more when it comes to actual nursing." (3rd yr. P1 FG 2)*

It can be interpreted that participants are of the opinion that learner nurses who are more frequently exposed to the clinical practice environment are more proficient in terms of the knowledge and skills they acquire in the clinical learning environment. Knowledge and skills are professional capabilities in the competence domain. Knowledge requires that the learner nurse develops and builds upon a strong foundation of knowledge, whereas skills refer to the learner nurse's accurate application of a variety of cognitive and psychomotor processes in clinical practice (Grice et al., 2013). Fourth-year participants described their fears of having inadequate clinical (practical) skills. Negative experiences lower their self-esteem and make them feel less confident in performing patient care tasks:

"The curriculum is the same, it's the same learning, but our focus is more on theory. It is not really much of practical. So now the professionalism we are talking about, if I don't have the skills, or enough exposure, so when I get out there next year, I'm going to be fearful. And that will impact on my professionalism. That will affect my self-esteem. It will affect my confidence and professionalism." (4th yr. FG 3)

4.2.1.4 Theme 4: Participants' understanding of professional behaviour

Learner nurses described their understanding of professionalism during their four-year undergraduate professional nurse training programme at a HEI and the nursing practice environment (NPE) where they were placed for clinical practice learning. Participants explained that professional nurses should possess important professional attributes (such as communication skills) and values (such as respect and dignity) to interact with others in a caring way.

Category 1: Respectful communication with and behaviour towards all concerned

Respect and politeness are forms of formal interactions that help to create a professional superior-subordinate relationship in the workplace environment (Gaur & Ebrahimi, 2013). Participants across the undergraduate B.NUR programme verbalised the need for respectful communication towards authorities, fellow colleagues, students and patients. Their expectations about professionalism is that professional staff, including nurse educators, clinical supervisors and professional nurses, should be people with (i) personal reliability, e.g. people who they can trust; (ii) professional capability, e.g. having knowledge; and (iii) interpersonal compatibility through being warm, friendly, polite and tolerant towards their shortcomings and imperfections and having good communication skills.

- *Sub-category 1: Politeness and communication skills*

Participants referred to politeness as general values of courtesy, good manners and respect; behaviour everybody should exhibit. Participants expected to be treated with kind-heartedness and compassion (interpersonal compatibility) by the professional staff when they enter the clinical learning environment. The participants perceived the interaction and behaviour by professional staff as humiliating and unprofessional, especially when colleagues are confronted in front of others. They felt that their dignity (character) was harmed. A first-year participant perceived the behaviour and manner in which professional staff communicated as impolite and inconsiderate. The learner could be mindful of being humiliated in front of others as the participant was of the opinion that such behaviour and way of communication should happen in a private space:

"... from my own perspective, I believe that if you are a professional, you are supposed to like talk to your colleague in a polite manner and go to a private room when you're going to talk like that. You aren't supposed to do this; not in front of everyone." (1st yr. FG 1)

Third-year participants thought professional behaviour should be centred around the admiration for educators and mutual respect between educators and students:

"Mutual respect" ... "One needs to make sure mutual respect. I think that's the first ...I think that's the most important thing. Just as long as there's respect for the teacher and respect for the students as well." (3rd yr. P 1 FG 2)

Other participants also placed value on respect and communication skills, as well as being a role model and having managerial skills (such as organising) as components of professionalism, all of which form part of the training programme:

"Respect for patient and communication skills, and being organised and being a role model. So it starts from there. It starts from the course." (4th yr. FG 3)

A fourth-year learner nurse perceived professional behaviour in terms of respectful communication, which includes being assertive without being rude:

"... your assertiveness must be professional. You're not going to say, I'm not going to do this …." (4th yr. FG 3)

Another fourth-year participant explained that professionalism is when the learner nurse takes personal responsibility (part of reliability) to courteously (politely) and respectfully communicate their rights in terms of their learning needs to the professional nurse. It was also recommended that learner nurses should be self-directed and know what is expected of them to be able to communicate their needs with confidence:

"I said: 'Sorry sister, I'm here to do this and that.' And the next week, politely: 'Please, I'm here to do this.' And immediately they rectify and I'm over target – respectful, but I know my rights and what I'm supposed to do. So maybe professionalism we should take it beyond … do you know what you're supposed to be doing? You know what you're supposed to do – go for it with confidence and know." (4th yr. FG 3)

- *Sub-category 2: Displaying empathy and caring relationships*

Participants indicated that seniors who display empathy and demonstrate a caring relationship should be viewed as compassionate towards learner nurses in the clinical placement facilities.

One participant described occurrences where they were treated with kindness and where professional staff was considerate by showing that they cared about the cultural differences of learner nurses. A participant described how staff was compassionate by explaining tasks to them in a language that they understood:

"… the environment that I'm working in, the nurses there are very professional, even though they are Afrikaans speaking. But they've got a way of making you feel comfortable, even though their files/folders are written in Afrikaans. But they are willing to explain and try to make you understand what does this mean." (1st yr. FG 1)

Another participant appreciated being treated with respect and fairness (social justice) by the professional staff:

"I haven't experienced so much of the bad side of nursing, with the staff. I think the staff is very nice to students. They don't treat us so badly. I think those guys are fair to us." (2nd yr. FG 1)

Another participant felt that all learner nurses should be treated equally and with fairness (social justice). There was a perception that some learner nurses were favoured over others, which results in feelings of worthlessness and despair. Learner nurses valued appreciation by professional staff and clinical supervisors:

"… we are all humans and we are all like can't control our tempers at some point. Because if you know how to handle, I can handle you, but if Ms B here is going to favour your side, I will feel like I'm useless. There's no need for me here. So I will be having that attitude, even if I don't do this I am still not going to be appreciated." (1st yr. FG 1)

One participant in her fourth year described her thoughts of becoming professional by being considerate and mindful towards the cultural diversity of others when you are working with patients and colleagues in a hospital setting, and that this attitude could contribute towards effective teamwork and collegiality. The need for a culture-rich clinical environment was expressed:

"And about the culture issue, there are so many cultures in South Africa and different languages. And I think it just comes down to consideration you know. You can have your culture – that's fine, but when you're in a hospital setting, you should be considerate of your patients, considerate of your fellow colleagues. And I think if everyone can just keep that in mind, then we can all work together much better." (4th yr. P 3 FG 3)

A participant described that if staff in the placement facilities are from a different background than those of learner nurses, they (learner nurses) were not treated with empathy, and when not understood, could bring forth unprofessional behaviour within these learners in future.

"Professionalism, yes, I also want to add that most nurses they give us attitude in the facilities, because firstly, they have a different background. If the nurse doesn't know they're not going to be good to you … because they don't want to be asked a question. And I heard some of them talking about it that you just have to ignore the students. So that then also contributes to our lack of professionalism." (4th yr. FG 3)

A learner nurse described how coming from a different background influences the way she saw things in life (philosophy) and that a person's upbringing affected his/her attitude towards professionalism:

"The difficult aspect of it, it's not possible to change your person. So then the problem comes I come from my house. I come to campus to study for four years. And the other person comes from different background. We see things differently. We are brought up differently … so especially the attitude that I would have would affect my professionalism. And I'm not in any way going to be able to change my colleague over night that has a different attitude." (4th yr. FG 3)

Fourth-year learner nurses expressed the need that others should be culturally sensitive and have knowledge (professional capability) about the different backgrounds nurses come from, because some behaviour are acceptable in certain cultures and in others not:

"... in my culture, I would cut him halfway without even finishing. Saying: 'Hi, suga', we don't say it is like something bad. In another culture we regard that as unprofessional. Where I don't see it that way … So I think it place a … for instance, I don't agree with you and I would make this noise: 'Hey, no, no, no.' We see nothing wrong with that. The Xhosas, our culture is very loud. I'm sitting next to him but I will be talking so loud. So … (laughter), so you know, as … you will think that this is not professional." (4th yr. FG 3)

A fourth-year participant mentioned the responsibility (personal reliability) of trained professional nurses "to care" regardless of their cultural background or nationality:

"And she is Xhosa and she is coloured and she is black and she is a foreigner… I mean, if you are a nurse you are a nurse. Your job is to do what you were trained to do – to care and not all other … I fear to bring about unprofessional behaviour to work." (4th yr. FG 3)

Learner nurses from different cultural backgrounds should be confident in what they do rather than having anxiety or being fearful of behaving unprofessionally because of cultural

differences. A second-year learner experienced disrespectful behaviour of professional staff towards patients who wanted to practice their religious rights:

"She is a practising Christian. So there are certain things she does and certain things she doesn't do. But as a practising Christian, the nurses didn't take those things into account. Some of the things that she mentioned to me was when she would recite the Bible for example … they would walk past in such a loud tone or they would be so rude or they would switch the TV on very loud; not taking into consideration that this is her prayer time." (2nd yr. FG1)

One would have expected staff to be considerate and caring towards the religious (spiritual) needs of patients. The participant further verbalised that she was personally treated unfairly and that her religious rights were violated. Staff offended her by speaking in an impolite and unfriendly way when they requested her to remove the scarf she wore for religious reasons:

"I did however feel that it was unfair because firstly, for me I felt that they were violating my Muslim right as a Muslim woman... because a lot of them are older and a lot of them have been perhaps for Hajj and really want to wear the scarf for their own religious purposes and I feel that I've been told in a rude way; not even in a nice way. And I feel somebody needs to speak to the department because at the end of the day if our scarves were … if there was any infection control, cross-control that was happening, then I could understand there was cross-infection. But the scarf is neatly tucked in. Nothing is being exposed to patients. Doctors will walk in there with their hair loose. Physio's walk in with pony tails. Then why are they not so strict on those nurses dressing in proper protocol, dressing professionally, why is it sort of just focused on the nurses that they do not wear their scarf?" (2nd yr. female FG 1)

Other first-year learner nurses described that they retaliate in reaction to the unprofessional and disrespectful behaviour shown to them by the professional nurses:

"… how can she shout at you like that? She doesn't respect you … so you don't have to respect her either." (1st yr. FG 1)

Another participant described being tempted to lose control and get upset when professional staff displayed disrespectful behaviour towards them:

"And it is so intimidating to answer her back because they will look at me and so this child is so disrespectful. But knowing myself, I stood up for myself. I will not be badgered by her." (1st yr. FG2)

- *Sub-category 3: Approachability and tolerance within professional boundaries*

Approachability refers to being accessible, willing to engage in open communication and being patient as a professional. The participants expressed the need to feel comfortable and at ease around the professional nurses in the clinical placement environment, without being intimidated by an unfriendly, intolerant attitude. Learner nurses described their understanding of

professionalism and professional behaviour in terms of being open to interact with a patient, having a friendly attitude, and that a persons' behaviour should match their dress code:

"I think that professionalism should be like someone who is approachable, you know, like for instance, if a patient wants this, they can't just say, no. Everyone in the hospital has to be approachable, even the sisters – all of them. They should work on their behaviour as such, because in terms of when you're looking at them physically, they have the uniform and all that, but they are tidy, looking neat and everything. But when it comes to their behaviour is where everything goes wrong. That is where they should change and try to be more approachable to people." (1st yr. FG 1)

The learner nurses perceived the lecturers (nurse educators) as more professional and friendly than the professional nurses in the hospital environment where there is poor relationships (interpersonal compatibility) with learner nurses.

"Here at school, the professionalism is quite, it is really quite good, because the lecturers are professional, but they are friendly in a way. When you get to hospital, it's another environment where they actually don't know how to communicate with us as students." (1st yr. FG 1)

One participant stated that the academic staff should be courteous towards the learners because they possess the ability to act within their professional limitations:

"They (lecturers) have boundaries. They have to be friendly." (1st yr. FG 1)

In other cases, participants felt that the clinical supervisors visiting the clinical placement should be proficient and kinder to the learner nurses in a professional environment of role modelling:

"What I can say ... we are not supported by our supervisors like some of them in hospital. I would like them to be more professional with us and more friendly, and also have some boundaries with us so that we can learn from them how to be professional. So we need to learn from them what we can do and what we cannot do." (1st yr. FG 1)

Participants also believed that the clinical supervisors could demonstrate respectful professional interaction:

"They can show us some things and make us learn everything like the ones to ... have that boundary that you cannot disrespect them and talk to them like anyhow." (1st yr. FG 1)

Second-year participants expressed appreciation for the nurse leadership who provided educational opportunities in some of the clinical facilities to facilitate learning:

"F (name removed) ... is a nice ward. It's educational. In the morning they collect all the students and ask: 'What are you doing? Okay, tell us about something.' It depends on the sister in charge …." (2nd yr. FG 1)

One of the professional attributes participants valued in professional nurses was self-confident to delegate nursing duties to the learner nurses:

"Sister F. was really good. In professionalism, she was assertive. She gave us responsibility." (2nd yr. FG 1)

- *Sub-category 4: Displaying verbal and non-verbal communication skills*

Verbal and non-verbal communication skills were found to be needed to build effective professional relationships and to convey congruent messages in the learning environment. First-year learner nurses regarded communication as an important attribute of professionalism that is absent in both the hospital (clinical) and the academic learning environment where part of the clinical learning took place in the skills laboratory at the HEI:

"… within professionalism, there should be communication and that is one main thing that lacks in the hospital setting and within the skills lab." (1st yr. FG 2)

Learner nurses further continue to verbalise the lack of communication between university and hospital settings. They mentioned that the healthcare authorities should have the same authority (influence/control) as the academic learning institution to impose disciplinary measures on learner nurses who misbehaved in the clinical placement environment:

"I think there's a lack of communication between the university and the facility … they don't know what they're supposed to do, I mean the registered nurses in the facilities. From my first year, most of them they say: 'You are not your own mind. You have to do what the university wants….' They must be given powers to, like, say for example a student misbehaves, they must have the power to send that student home or phone the university or something … but they don't do that. They just have an approach of just you belong to your university … but one day I'm going to belong here and what kind of nurse are you producing?" (4th yr. FG 3)

One participant strongly expressed feeling confused by the conflicting messages and inconsistent way of communication of the clinical supervisors (nurse leaders) in the clinical skills laboratory:

"… communication in the skills lab, you'll find that one supervisor tells you that and the other one tells you that. The other one tells you that. And then you are actually confused as to who do you actually listen to because you believe that if an adult tells me this, I should follow this way. And then if someone else is going to say: 'No, you can't do it this way, you should do it that way.' You end up being lost. You lose the main focus." (1st yr. FG2)

It seems that participants needed to be motivated and inspired by clinical supervisors during clinical practice sessions in the skills laboratories where learner nurses applied their skills of listening and wished to understand what clinical supervisors were saying.

Category 2: Interaction between norms, personal, basic human and professional values

Values are the prime drivers of personal, social and professional choices (Suar & Khuntia, 2010:443). They could influence how individuals live their lives both professionally and personally. This category will be discussed under the sub-category of the modification of personal values to fit with professional value.

- *Sub-category 1: Modification of personal values to fit with professional values*

Participants became aware (mindful) of who they were and where they come from. Being aware of who you are could be meaningful when realising the importance of linking your personal values with the professional values of the nursing profession. The findings indicated an interplay between personal and professional values. Participants agreed that nurses enter the nursing profession with basic values of respect, kindness, politeness or good manners (interpersonal compatibility), and punctuality (personal reliability) and that they should maintain these values throughout the undergraduate nursing programme. It was stated:

"... in your schooling and in your life experience you just learn the basic values, punctuality – when you have to be somewhere, you must be there, you must be on duty. You know if you have an appointment, you must be there. Basic respect, basic politeness, all of these things are just basic human conduct that most people have. And it just seems that for some reason when you become a student you just lose all of these values." (4th yr. P3 FG 3)

Conflict occurs when the nurses' personal and professional values are not aligned in e.g. the way people behave in a certain culture (see Sub-category 2: Displaying empathy and caring relationships):

" ... we are loud people. We are very loud. The Xhosas – our culture is very loud... you will think that this is not professional ...." (4th yr. P 6 FG 3)

The participants agreed that their cultural background cant' be changed, but realised that they should do what is right (moral courage) and modify unwanted behaviour.

"... we can't change it. It's the culture we come from. But maybe we can modify it ...." (4th yr. FG 3)

Category 3: Student role reversals – from school learner to adult learner

Role reversal is a complex exercise that is never completely possible, as the feelings, attitudes and motives of another person can never be fully conceptualised (Yaniv, 2012:75). A person might move through different phases of role reversal, of which one is empathetic role taking, in

which mental abilities such as awareness of ones' own feelings and thoughts in the role of the other are used (Yaniv, 2012:72). Some participants felt that novices who enter the profession were too young to immediately carry out big responsibilities. Assuming responsibilities such as handing over patient progress reports to the rest of the staff in your first year could be viewed as an unfair request for the neophyte learner nurses:

"… most of the students have just left school, so they're still kids and now you like want to impose adult stuff upon them. I don't think it's fair. They're still children, although they're still... they are at university." (3rd yr. FG 2)

- *Sub-category 1: Personal responsibility for learning and behaviour*

Personal responsibility is one of the qualities of the human spirit (Hackett & Wang, 2012:879). Mergler and Patton (2007:58) state that "personal responsibility is most commonly understood as accepting accountability for ones' action, or lack of action and the resulting consequences". Participants expressed the importance of being aware of the specific learning environment they find themselves in, being able to identify which professional role to play and then to take responsibility for their own learning:

"… making sure that we understand the environment, then in hospital, so it's important to make the students understand that at school age you are taught by people, actually the lecturer will run after you to make sure you're doing your project or whatever, but at university level people must be made to understand that you are now responsible for yourself." (3rd yr. P 4 FG 2)

Participants, especially those in fourth year, mentioned being able to apply the value of judgement and assuming self-leadership roles at times when they occupied a specific learning environment. The participants described their ability to influence themselves to behave appropriately while assuming different roles of leadership when necessary in the undergraduate programme:

"… although at times I get to behave as a student, there are also some settings that I could … here on campus such as (inaudible) student leadership. When that happens, then I do put myself into being professional. It's just … I don't know why, but it just happens automatically, but when I have to play a certain role, I know that here I have to be professional … but now when I'm a student, I want to be a student, that is what I want. I want to be a student. I want to feel like a student and I want to behave like a student. So I don't want anyone to tell me to wear a suit." (Laughing) (4th yr. FG 3)

Other participants reflected on their own experiences of becoming adult learners, assuming self-directedness and self-leadership roles by taking responsibility for their own learning. A participant described how easy it is to follow or conform to others and not use their own initiative (proactivity) for doing what needs to be done in leading oneself:

"You can be a follower or you can be an advocate or a leader and not follow. But sometimes it is so easy to follow everyone else. And you do fall into that trap. And once you've fallen into that trap, I think it is very difficult to get yourself out of it." (4th yr. P3 FG 3)

Participants described taking ownership of their learning and taking responsibility for what they need to learn and mentioned the importance of reflecting on integrated theory and practice:

"I need to act in a certain way. I know what I've been taught on campus or at school, I need to meet those objectives. I know what I need to do today. I need to attend to those things today. And then every day you should reflect on what you did that specific day. So that you know what to change the following day or you know what you should improve on or whatever you need to adjust on, but you should know what I was struggling with a specific time today. So that tomorrow you can fix that. Concentrate more on what you were struggling with rather on what your strengths were. So if you can reflect each and every day and link it with what you were taught at school, then I don't see us struggling. Even if you are faced with such obstacles in the clinic, but you know what you need to know. You know what you need to learn. You will try by all means to cope with the situation around that, but not leaving out what you are expected to know or what you expected yourself to learn that specific day. So reflection is necessary each and every day." (3rd yr. FG1)

Category 4: Dress code and professional image of a nurse

A professional image strongly influences other peoples' perception, and role models can influence students' perceptions of nursing (Hecht, 2014:1), and promotes public relations with the community. Professional appearance is referred to by Hecht (2014) as clothing that enhances authority and promotes respect. Participants from the first to the fourth year associated professionalism with the nurses' uniform and appearance. A participant in the first year said that professionalism should start with the professional nurses as leaders and that they should be role models for the profession:

"… it starts with the people who are acting, who are actually practising the profession, to bring out professionalism so that people can also see that it is a profession."1st yr. P 6 FG 2)

A student associated professionalism with the nurses' uniform, which on first impressing could portray the impression of professional identity:

"… professionalism for me, it starts with the outer image first before you can even say anything. So when we came here the first time to come into your uniform to see. Find everyone professional and neat and everything. But as the time went on, the years went on, in the placement you can see that this is really unnecessary." (1st yr. P 6 FG 2)

Clinical supervisors were viewed as role models who should be professionally dressed and prepared, thereby inspiring and motivating learners:

"And as to our supervisors, they also need to be moulded and groomed so that we can look up to them … Because everybody likes seeing nice things. So when you see something nice you want to do something nice. But when you see something is not so nice, you're not even motivated to even try and do that thing." (1st yr. P 6 FG 2)

It was mentioned that peer modelling could improve professional nursing:

"Even the second years, we should be able to look up to our second years as well. We should also be structured and moulded so that people coming in next year, if they succeed to the following year, they can also look up to us. We don't need to jump straight to looking up to a matron in a ward. We should also be able to look up at the second and third year as well. And in that way, we can work together and develop a more professional kind of nursing." (1st yr. P 6 FG 2)

Another participant pointed out the inconsistencies in the dress code (a uniform dress code should unite people) and lack of role modelling:

"… what you know you're supposed to do like your dress code, what you're supposed to do in the work environment, I remember when we came our first year as nurses, they told us we must wear a navy blue pants or a skirt and then with a white jacket and then with the black closed shoes. But when you get into the facility, the way the in-charges dress their (inaudible) [some of them they put on sandals]… that that is according to what they told us is not a dress code. So I'm like: What kind of example are they showing us? If we also put on [sandals…]… or put on half trousers to work, they won't allow us to work because of the dress code that we have. So I feel like they should try to be more responsible and put up as a role model to those that are coming after them." (4th yr. FG 1)

It was viewed as unprofessional when members of the nursing profession did not exercise judgement about their behavioural choices or when they did not make wise decisions about their professional appearance and conduct in public:

"… is not a professional practice … its' not a good one when you are seen with your uniform and you are smoking or drinking or you come to work in the morning and you smell of alcohol." (4th yr. FG 3)

The participants also mentioned that wearing a uniform in the academic learning environment will contribute positively to the professional behaviour of nurses:

"… if it can go back to other colleges when you go to class you wear your uniform. So if we can go back to that. If you come to class then you wear your uniform. So you behave like a nurse from the moment you go out of your home …." (4th yr. P6 FG 3)

Another participant said that wearing a uniform in the academic learning environment positively affected their attitude from just being an ordinary student:

"Even if you know it, I'm a student as I am, but if I put on my uniform that is going to change my attitude: I'm just a student. So what? I'm going to change my attitude somehow." (4th yr. FG 3)

A participant mentioned being mindful of her choices in behaviour when in the nurses' uniform:

"I remember, you know, I'm that kind of a person who likes to eat when I walk, I eat. I walk, I eat. But I don't do that in my uniform. In my nurse's uniform, I don't walk and eat. But if I don't have a uniform, I will walk down there eating my piece of chicken. So I think that uniform plays a big role in terms of make you aware of …." (4th yr. P 6 FG 3)

Wearing a uniform could build character and could create a sense of self-respect and pride.

4.2.1.5 Theme 5: Participants experience students' professional behaviour as contributing to the image of the university degree students

It seems that undergraduate learner nurses were proud to be associated with the nursing profession. When some of their peers, however, displayed unprofessional behaviour, these learner nurses became embarrassed because such conduct could be contributing to the stigma attached to the profession.

Category 1: Some students do not act with respect and do not take professional responsibility in practice seriously

Disrespectful behaviour is also referred to as disruptive behaviour, humiliating treatment of nurses, patients and students in training, passive aggressive behaviour and passive disrespect (Leape, Shore, Dienstag, Mayer, Edgman-Levitan, Meyer & Healy, 2012:845). The authors state that disrespectful behaviour is partly rooted in insecurity or aggressiveness, but it is also learned, tolerated and reinforced in the hospital culture. According to participants, some learner nurses did not know how to conduct themselves professionally and were disrespectful towards senior professional staff in the clinical placement settings:

"They (some students) don't know how to speak to the other person, how to speak to a senior when they're working as well. So they don't know how to be professional or what to do to act professional towards any other person." (4th yr. P1 FG 3)

A participant mentioned that learner nurses were not serious and did not have the appropriate attitude or mind-set when they went to the nursing workplace environment:

"... we are taking this student mentality to a hospital or to a work place and we're still thinking we're students in that sense – have fun and enjoy ourselves throughout the whole day, which is not true. Immediately there is a professional standard in the hospital self." (3rd yr. P1 FG 2)

One participant explained that learner nurses should have commitment and be self-motivated to become a nurse:

" ... that's where the stigma is because people don't want to be here. I want to be here. I want to become a nurse. I always wanted to become a nurse. I'm always one to ask questions. I see what the sisters are doing ... poke my head in with the patients. I want to be here." (3rd yr. P1 FG 2)

4.2.1.6 Theme 6: Reasons for and implications of students and practitioners' unprofessional behaviour and suggestions for improvement

In this theme, it became clear why undergraduate learner nurses and nurse practitioners displayed unprofessional behaviour. These reasons will be discussed, together with the implications of such behaviour, and suggestions will be made for improving the unprofessional behaviour among learner nurses in the undergraduate nursing programme at the HEI. Seven categories were identified for this theme.

Category 1: Specifics of professionalism not clear, practical guidelines needed

Nursing is guided by guidelines of which some comes from the RNOAs' (2007:42) best practice guidelines on professionalism (De Swardt, 2012:86). As a multi-dimensional concept, professionalism is not easy to define in one simple definition. According to Fantahun, Demessie, Gebrekirstos, Zemene and Yetayeh (2014:2), it can be assessed in terms of individual attributes, capacities and behaviours, interpersonal interactions with other individuals and contexts, as well as social dimensions that include social responsibility, morality and socio-political and economic dimensions. Nurses who therefore value professionalism are required to adhere to professional practice standards (Fantahun et al., 2014:2). Participants in their fourth year expressed the need for clear guidance and direction on how to act professionally in the nursing practice.

"And I would really appreciate it if there should be someone who can explain to me what must I do. If you want professionalism, you must put everything down. What must I do if you want me to be a professional – 100 percent professional." (4th yr. P6 FG 3)

De Swardt (2012:9) refers to guidelines as directions that support students in the process of professional socialisation. Participants also expressed that they were ignorant about what professionalism meant and how they should apply it in the clinical settings:

"Not everyone knows what the word 'professionalism' means. They don't know. So they act, like in their eyes, they're professional. But actually they're not. Because there's not enough emphasis placed on professionalism. Also, in the clinical settings, you get to work 20 percent of the time the staff is professional, but the other 80 percent of the time they're not. They do what they want to do and that is the time that you also fall into that trap when you do things that isn't right. And that is unprofessional." (4th yr. FG 3)

They verbalised the need for having standards of professionalism:

" if there should be standards of professionalism for us to be taught. What are the standards? What are the things if I'm doing this I'm being unprofessional? Or if I'm doing this I'm not being professional. I think that will help us a lot to understand what professionalism is all about. Honestly, we are told to be professional, but we don't know how to be professional." (4th yr. P 2 FG 3)

Participants mentioned that there is a need for a focus on training a new generation of learner nurses at universities:

"I think it's … let's focus on the students. Let's start from first-year students. So, how can we train them from first year? How do we do it? The old sisters, they don't, you know, most of them don't even have these things (cell phones). But the new generation, we are the problem. And the professionalism we are talking about is because of all the new sisters. So how can we address that from the university? Can we do anything about it?" (4th yr. FG 5)

Category 2: Professional values taught but not internalised

Professional value acquisition is inherent to nursing practice and begins in nursing education (Schmith, 2014:3). Schmith (2014) suggests that a better understanding of core professional values may enable nurse educators to assist learner nurses to internalise professional values. An interesting revelation was made by third- and fourth-year participants who mentioned not being able to comprehend what has been taught. They came to the realisation that they are not internalising the professional values taught to them throughout their training. A learner nurse confesses that she memorised the professional values in order to pass an assessment:

"*I didn't even understand it. I just memorised it and then I wrote it in a test and then I let it go." (4th yr. P6 FG3)*

A third-year participant described not being motivated and lacking commitment for taking responsibility for knowledge in nursing practice:

"Everything is there. It's just ignorance. They know that they should be professionals. And I think with us as students, if you can remove this mentality of we're also doing things for the sake of passing, we would go a long way. Because we just do things because you know that I'm just going to get over and done with this procedure and then I'm done with it and the next way we just forget what you're supposed to do." (3rd yr. FG 1)

A fourth-year participant did not know how to implement her knowledge and skills in terms of being a professional:

"We were taught how to be a professional, but for me at that time when I was doing first year, I thought I'm just going to memorise it and write it and pass and that's it. I thought it doesn't apply to me. I honestly thought it doesn't apply to me. So what is happening to us as students?

We tend to think that here we're going to be nurses in four years' time. So this is what we're going to do that year. We don't have to do it now (laughter)." (4th yr. P6 FG3)

Another fourth-year learner nurse confirmed having the knowledge, but not applying it:

"But the thing is our aim is just to write the thing and pass. We are not internalising it. Even third year, last year, we did all these things about professionalism." (4th yr. FG3)

Category 3: Formal commitment pledge in the first year

To pledge is to commit by a solemn promise or agreement to do or refrain from doing something (Pledge, n.d). In this category, a participant referred to the commitment that nurses should make when entering the profession:

" ... you start your first year, you pledge as a student." (3rd yr. P2 FG 2)

The participant suggested that learner nurses should have the professional capability to commit to human service by pledging to it at the beginning of their four-year professional training:

"... so why don't they have a pledge for learner nurses. Because if you read that pledge, you're pledging the four years that you're going to be a student and you're going to help people and you have people's lives in their hands, they should do something and I think that it will change. Students will change if they have a pledge." (3rd yr. P2 FG 2)

Category 4: Lack of motivation

Motivation plays an important role in student learning and thus should impact their selection of a course or programme (Bahl & Black, 2011:14). The findings indicated that the institution should reconsider selections and only recruit motivated and committed students. A participant described how learner nurses go through the professional nurses' training programme feeling demotivated and not inspired to do nursing:

"They (nurses' training school) need to find the people who want to do it and the people who don't want to do it ... sometimes they even get to third year and they're like, I don't want to be here." (3rd yr. P1 FG 2)

Category 5: Students need a platform for grievances

A grievance can be defined as "any discontent or dissatisfaction arising from a feeling or a belief of injustice by an employee or a group of employees in connection with the work place environment (Arif, 2015:192). Participants felt that there should be a platform for them on which to make complaints about the manner in which learner nurses are treated in the clinical

healthcare settings. Discontent and the need for mentors and influential nurse leaders in the clinical placement setting were mentioned:

"...there should be a platform whereby she can consult and like being able to complain about the attitude and the response that she getting from the registered nurses. I believe that people are above setting an example for us. And I don't think that I have any complaints with our lecturers because they make themselves so available to us that we can even abuse the access that we have to them. Because they try, they go the extra mile and not with us when we are at the hospital. We also need that extra support when we are inside the hospital as well … because we come in for the course, you're motivated that you're going to be a nurse. You want to change and you want to make a difference. And then when you enter a setting whereby you're just surrounded by negativity your motivation and all your positive levels will come down and it will only come up when you meet with or go for consultations with your lecturer and they motivate you: 'No, keep strong.'" (1st yr. P6 FG 2)

Participants also verbalised that an opportunity should be created for learner nurses to give feedback to hospital authorities on improving professional development of seniors and mentors in the clinical environment:

"... we should be writing reports as well, (interjections). Not the sisters marking reports on us, but we should also be writing reports as feedback from this clinical … You don't have that opportunity. So if we would also get reports as the students, so that we can assist whoever will be implementing the change of remoulding the senior people in that position. We write a report about this is okay, in this ward we experienced such and such, and we give it to our seniors. The seniors can do their own follow up... So I feel that the students should be doing some sort of feedback platform as well whereby we give feedback so that you can help us restructure and reframe the whole profession." (1st yr. FG 2)

Category 6: Influence of traumatic experiences in personal life and practice on professional behaviour

Trauma results from a physically or emotionally harmful or life threatening event or set of circumstances that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing (SAMHSA, 2012, in NREPP, 2016:1). The findings indicated the need for emotional support of learner nurses. A second-year participant described the life of a learner nurse in the undergraduate programme and said that personal, social and academic challenges influence their professionalism and prevent them from performing academically:

"I think it is struggling for us, because like I said when you incorporate … it's like we're working Monday to Friday and then we're studying … Because if we look at our days for example, on a Monday and a Wednesday, so we full days of campus... But then Tuesday and Thursday we work seven till seven and then sometimes we write tests on a Friday afternoon and then we have mental health on a Friday morning and on a Saturday we might have another test again. And you know, being a student, you have a life, whether it be inside the campus or outside

the campus. And things that do affect students, they do become sick. I had an incident this year when I was on ARVs which was difficult for me. Then I was in a motor vehicle accident while I was busy with my exam. I had bilateral conjunctivitis and then, you know, my uncle passed away not too long ago. And there are different aspects. It's not just ... it's sort of your personal aspects and academics. So you literally need a structure, but I think it's difficult for us because we're constantly on a Monday to Friday, we're busy. On a Tuesday and on a Thursday we are demoralised by our sort of so-called role models or our colleagues at hospitals. A lot of us don't pitch Mondays or Wednesdays for the first two periods, not because we don't want to, but because we're so tired... . And it's not because we're stupid. It's just because we don't have time. But if we had for example the block system like (name removed) HEI B has, we'd be getting so much more experience in hospitals within a particular ward that we're placed in... . not only do we have priorities towards our studies, but some of us are married. Some of us have elderly parents. There are so many different challenges that are not taken into consideration." (2nd yr. FG1)

A participant described her exposure to death and dying in the hospitals, feeling overworked and the need for a support structure in the form of a nurse councillor who will understand the unique emotional and academic challenges of the academic undergraduate nursing programme:

"I think that if we can have like ... the support structures in hospital ... where you could go to when they have a problem, but in the university it's very hard to utilise the support structure because it is not always available. They say we have a campus counsellor. But you know, there's never time to get to it ... And I think that in my opinion from what I've seen the reason why people stopped studying or fail is because they are pushed so hard beyond their breaking point and at no time is there really a time to rest and gather yourself again to move forward. And it's the same in the hospital environment. We care for so many people. People do die and its said that you must be fine with it and move on. It gets too much and people start having problems. People started getting depressed ... need help. And how can a nurse who has problems themselves be able to look after people who have problems." (3rd yr. P4 FG 2)

A participant expressed the need for nursing support structures for dealing with fear of being at risk of contracting diseases:

"With regard to the structures to help the nurses, especially from second year up until fourth year, the things you do in hospital, it exposes you to a lot of diseases, for example, if you have a needle-prick injury or blood splatter in your eyes, blood splatter everywhere, something like that. And when you're exposed it's okay, go and see a counsellor. It's is easy for them to say go to that person. We don't know that person from any which way. It must be a nurse, because he doesn't understand anything we do. He doesn't know how we feel. A nurse would know how you feel at that point to give you counselling. Because you are going to continue working with that mind-set and you're going to go crazy." (3rd yr. P2 FG 2)

Participants sometimes need a mentor to be available so that they can ventilate their personal issues:

"I think if we can just have someone like a mentor to go to just to in regard to any questions that you would have, just to make sure that you are still fine and on track, not just your studies, but

your personal life as well. It would be much easier … at least once a month ….” (3rd yr. P4 FG 2)

One participant described how humour in the placement facilities can help learner nurses to cope with the pressure and relief stress:

“And sometimes the sisters in the ward and not only the sisters, sometimes the staff nurses, the things that they do, you can’t help but laugh (laughter). It’s:‘ Oh my word. I’m not supposed to say this in front of a patient.’ Yes, you can’t help … I think you have to see the humour as well, otherwise you’ll never survive (laughter).” (3rd yr. FG 1)

Category 7: Learner nurses need more academic help and supportive monitoring in the clinical practice settings

In this category, undergraduate learner nurses across the nursing programme verbalised the need for more academic support. Learner nurses in the third year verbalised their need to have monitoring structures and more academic support on year level outcomes in order to perform well:

“... monitor the students when it comes to nursing, I think we need more of a help, not a facilitator but a lecturer … last year was horrible for me, I can’t believe I passed … I passed cause I work very hard. The marks that I got wasn’t what I wanted. It wasn’t what I was expecting from the work that I put in. I think we’d be better nursing if we just had a better outline. Third year… we don’t have objectives … Outcomes …?” (3rd yr. P1 FG 2)

One participant said that they relied on clinical supervisors to advocate on their behalf in the clinical learning environment:

“… with regards to the supervisors who work in hospital, we’re relying on supervisors to be there to be like our second voice of charge and to be in control of us.” (1st yr. P2 FG 2)

Supervisors should be required to be courageous (personal reliability) and do what is right. They should be available to intervene on behalf of the students when mistakes are made or when students do tasks at a higher year level than expected. This was strongly expressed by one participant:

“...even if she was wrong, there must be somebody there every time to at least take care of this in-house squabbling. It’s always going to be there with the students, because we are students and the student is meant to make a mistake here and there.” (4th yr. P6 FG 1) and *“They’ll tell you: ‘Oh no, yesterday you made some mistake. Please stop doing it. Stop, stop, stop... Stop, stop, stop, leave it, just go and do temperatures.’ I’m like... what are temperatures? She’s a second year and she wants to do the medication … but if there’s somebody to quickly supervise it, the nurse will be given another chance. And the student will grow to be a proper and professional nurse.” (4th yr. P 6 FG 1)*

Clinical supervisors should also support the participants with their actual clinical learning:

"… I would prefer a supervisor that comes and we do not experiment. She comes and sign that we are present." (2nd yr. P9 FG 1)

Another participant expressed the need for clinical supervisors to be stationed at each hospital so that they are within reach of learner nurses:

"Just to add to what my colleague is saying, if there should be mentors specifically for students in each and every hospital, it would be fine." (4th yr. P6 FG 3)

Human and financial resources were needed to oversee the professional academic and clinical development aspect for learner nurses:

"… if we have more clinical supervisors. But I know that is not always viable – financially. At hospital Z there's a sister who is in charge of the students exclusively … I know it's a smaller hospital … if there's any problems in the ward … can be sent down to her. She does training for the students and we're all a little bit scared of her because she has this authority and she's also very nice. She calls for meetings every week. Like 2:00 we all have to go down there and have meetings and she just really emphasises our knowledge, our skills, how to behave, she looks at how to dress. She already caught us out for the name tags. Some people have little platelets. We have to have a student card and already she caught us on all things. She looks at how we dress. She's excellent. And I think having such a focused … institution, I think if every hospital had that it would make a difference. Because on campus we have the lecturers there to teach us... And the other thing, the facilitators, and the tutors as well, they're so busy and they have so many students." (4th yr. P3 FG 3)

4.3 CONCLUSION

In this chapter, findings from learner nurses from Case 1 were described. The participants shared their experiences of the academic and clinical practice environment and outlined how their professionalism in nursing practice could be supported in the academic and clinical learning environments. In Chapter 5, the findings of Case 2 (nurse educationalist i.e. lecturers and clinical supervisors) and Case 3 (professional nurses) will be discussed.

CHAPTER 5

RESULTS OF THE NURSE EDUCATIONALISTS (NURSE EDUCATORS AND CLINICAL SUPERVISORS) AND PROFESSIONAL NURSES IN PHASE 1

5.1 INTRODUCTION

The findings were described as a multiple case (see Point 1.8.2), consisting of learner nurses, nurse educationalists and PN`s. The findings of Case 2 and Case 3 will be discussed in Chapter 5. Case 2 addressed nurse educationalists (nurse educators and clinical supervisors) and Case 3 the PN`s in practice (Figure 5.1).

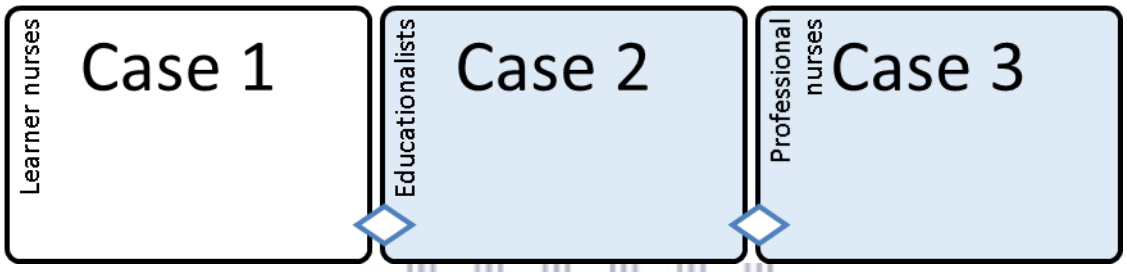


Figure 5.1: Multiple case

5.2 FINDINGS OF CASE 2: NURSE EDUCATIONALISTS

Nurse educationalists were employed by a HEI, a university in the Western Cape, which offers the four-year undergraduate B.NUR degree programme. In this programme, nurse educators teach and facilitate theoretical classes in the general, midwifery, community health and psychiatric nursing disciplines in the respective year levels. They, however, have a dual academic role, linking the theoretical component of the programme to the clinical component and following up and accompanying learner nurses in the clinical placement facilities. To further assist in the clinical training of the learner nurses, clinical supervisors are appointed to accompany the learner nurses from their first to fourth year in the clinical placement facilities. All the participants had more than a year's experience in the teaching environment of the learner nurses. In addition to this qualification, most had a post basic qualification in Nursing Education. The experiences of the nurse educationalists focused on the learning issues and their expectations of professionalism in terms behaviour, demeanour and adherence to the professional rules and guidelines.

Table 5.1: Nurse educators' (NEs) and clinical supervisors' (CS) experiences of learner nurses' professional behaviour

Themes	Categories	Sub-categories
NE's and CS's expectations of professional behaviour	Adhering to prescribed dress code	
	Behaviour that reflects internalising of professional values and norms	Internalising means internal locus of control of professional behaviour
		Internalising and practising professional behaviour also needs consistent reinforcement strategies in practical and theoretical teaching
	Practice examples of expected professional behaviour	Entire image and respectful social behaviour reflected in practice and class
		Professional boundaries in relationships between students, supervisors and patients
		Appropriate clinical competence
		Respectful and confident interaction with patients and professionals
		Motivation and taking responsibility to learn
Suggestions to improve professionalism in nursing	Educators and clinical supervisors to work towards bridging gap between theory and practice	Specific, differentiated and scaffolding in skills training at different levels
		Empowering students to resist poor practice examples/role modelling and adapt to different policies and practices of facilities (empowering for no-excuse-of-own behaviour)
	Finding the fine balance between considering exceptions to the rules of professional behaviour and reinforcing them	
	Reward system with accolades for professional behaviour	
	Platform for students to voice grievances relating to professional behaviour	
	Role modelling respectful behaviour, appropriate dress code and punctuality	
	Assessing relevance of certain professional conduct rules in changing era	Modern times for students/nursing dress codes and the use of technology

The identified themes and associated categories will be discussed in the following passage, accompanied by the appropriate quotations from the raw data, followed by the interpretations of the researcher and evidence from the literature. Two themes emerged from the raw data as described by the nurse educators. An overview of the themes and categories are outlined in Table 5.1. In the findings, reference will be made to e.g. Ind. 1, referring to individual interview 1, or FG 1 as Focus group 1, and CS CHN as clinical supervisor Community Health Nursing.

5.2.1 Theme 1: Nurse educators' and clinical supervisors' expectations of professional behaviour

Three categories emerged from this theme: i) adhering to the prescribed dress code; ii) behaviour that reflects the internalisation of professional values and iii) practice examples of expected professional behaviour. These categories, together with their corresponding sub-categories, are discussed below.

Category 1: Adhering to the prescribed dress code

The profession of nursing subscribes to a certain dress code that includes for example wearing distinguishing devices with the appropriate dress code, and ensuring that nails are short and that hair does not reach the collar or is tied up (De Swardt, 2012:68). Over the years, the white uniform has been replaced by a dark navy uniform. However, according to Nurse Educators Association (NEA) Newsflash (2011, in De Swardt, 2012), stakeholders are requested to advocate the wearing of a white uniform, which indicates that the current practices regarding the dress code do not portray the desired image. The CS and NEs were focused on a prescribed dress code that would indicate a unified nurse identity and improve of the image of the profession.

"... they're supposed to dress like this... because you know they get to wear navy, this rule of white is for everybody – you can't run away from it." (CS CHN)

A nurse educator expected that learner nurses should adhere to the professional dress code, and be identifiable:

"I do clinical and I do theory as well and also when I walk into a ward and I see my student, I want to see the dress code should be there. They should be identified. The way that they talk to me... the way that they're dressed." (NE P4 FG2)

It was mentioned that learner nurses do not regard wearing the proper dress code as important; therefore, they needed to be directed (guided) to conform to wearing the nurses' uniform:

"... they need guidance regarding uniform. They do try to convince you that they do not have money for the uniform, but once the emphasis is put on when you come to the clinic and you

ask... and you ask: 'Where's your name tag, why is your hair loose, why do you have this shirt on or these shoes on?'... they are a bit careful on the days when you come." (CS midwifery Ind. 1)

One participant showed her intolerance to the non-adherence to the dress code of some fourth years. She expected learner nurses to conform to the professional dress code because nurse educationalists of the university were the role models who demonstrate how learner nurses should dress:

"There comes a stage, especially if you're fourth year, if you have told the student from the beginning of the term: 'Why are you working without your name tag? Do you know why we wear a name tag? Because it is the right of the patient to know who is training. I don't want to wear this stuff. I don't like it, but I wear it because I'm a professional person and I'm working for HEI A. So I represent them. You represent a nurse.' That's why I like epaulettes. But the students aren't wearing epaulettes. If the students wear epaulettes they can be easily identified." (CS CHN)

One participant had a strong view on the personal responsibility to uphold the total professional image that rests on each member in the nursing profession. The following quote justifies the view of the participant:

"... then everybody ... because it takes one bad apple I suppose to make everybody bad." (NE P1 FG1)

Category 2: Behaviour that reflects internalisation of professional behaviour

In the study by De Swardt (2012), PN`s believed that it was important for learner nurses to be coached to internalise the correct professional behaviour. The way in which they are taught thus might contribute to the internalisation of the expected professional behaviour (De Swardt, 2012; Lai & Lim, 2012:33). The findings of this study indicated that nurse educationalists expected learner nurses to reflect on the professional behaviour taught to them.

- *Sub-category 1: Internalising means of internal locus of control*

Participants made reference to learner nurses having inherent personal values, as important elements of professionalism:

"One of the most important things for me in terms of professionalism is your values and your attitudes that you have." (NE P4 FG2)

The participants verbalised that they expected learner nurses to turn the values inward to show personal integrity so that they can be counted on to do the right thing when no one is looking (commitment to excellence):

"They've got to internalise the values and believe in them enough to act according to those values, regardless if anybody is going to see me or reward me or if anybody is going to catch me and punish me, because otherwise you're going to end up with a student who complies when your eyes are on them and doesn't when your eyes are off them." (NE P11 FG2)

Participants also expected learner nurses to do their best in the interest of building their character (personal reliability), as this was important for personal and professional development:

"... whether you like it or not, for your own self and your own development, you always do the best you can and that's building your character and also your professional behaviour." (NE P7 FG2)

Some educationalists felt that learner nurses should be considered as unique individuals, and be rewarded and understood within a specific context:

"They are university students and they want to be rowdy. They want to act like everybody else is acting. But I think sometimes we give too little credit to the students like when we see them in a clinical area, in the clinical facilities, they are completely different people, because they have to be, because there's a patient or there's a senior peer in attendance or this person is dependent on them. So they almost have two personalities." (NE P8 FG1)

The participant felt that educators should be aware of and understand that the expected professional behaviour will develop over time:

"I really feel that once we've set the benchmarks, it will come. It will come later where the benchmark of professionalism is carried through from home into the class onto the street, at the taxi, all over. But while they are undergraduates, I really don't believe that they have internalised professionalism. I don't think our undergraduates are in any position to apply these rules to every component of their lives." (NE P8 FG1)

- *Sub-category 2: Internalisation and practice of professional behaviour need consistent reinforcement strategies in practical and theoretical teaching*

Participants (NEs) explained that when learner nurses were taught aspects or elements of professionalism in theory, they expect that behavioural changes towards positive professional outcomes or excellence should have taken place in the learner nurse:

"I also taught professional practice module to the fourth-year students ... experienced the students to be very interactive, we had cases with the discussions and all of that. But somehow it didn't rub off on them. They were fully participating and talking about ... because most of the module is about professionalism. It's professional practice or different aspects like legislation and leadership and advocacy and all the aspects that will be part of professionalism. And then when they've completed the module and even while they're busy, the next week I will see a student doing this or talking this way or that way or some or other behaviour or being absent or whatever." (NE P7 FG2)

The participants also explained how important it is for nurse educationalists to be proactive by exercising sound judgement when applying strategies of reward or punishment to encourage positive behavioural outcomes in learner nurses:

"If you want to get students to do any particular behaviour is what you reward and what do you punish. Because those things will have a big impact on what students end up doing." (NE P11 FG2)

The participant also emphasised that the correct application of disciplinary measures and policies is important to avoid unfair judgements and to be accountable for actions:

"Rewarding the unprofessional behaviour and almost punishing the professional behaviour because the students who actually did the hours and all the rest is not being rewarded for that fail, that module, and they've got a suspended sentence for a year. Very light sentence ... university system that we have to abide by... ." (NE P11 FG2)

It was also echoed that learner nurses should be motivated to conduct themselves professionally by praising desirable behaviour:

"... about reward and punishment that encourages or discourages certain behaviour and P7 was mentioning the thing of praising the students, and I really think that it's something that is quite a lot neglected." (NE P11 FG2)

One participant described experiencing personal satisfaction after encouraging and praising learner nurses and then observing the change in them:

"I focused on positive things and to compliment the students about it. I cannot tell you sometimes how rewarding it is to see how a person's face lights up." (NE P 7 FG2)

Category 3: Practice examples of expected professional behaviour

In this category, examples of the expected professional behaviour in nursing practice are described by nurse educationalists. Professional behaviour in practice should be reflected, according to the participants, in the entire image and social behaviour of learner nurses in the classroom and in nursing practice; professional boundaries in the relationships between the clinical supervisor, learner nurse and patient; appropriate clinical competence; respectfulness and confidence in interaction with patients and professionals; as well as motivation and taking responsibility.

- *Sub- category 1: Entire image and respectful social behaviour reflected in practice and class*

Nurse educationalists (NEs and CS) expected undergraduate learner nurses to display professionalism in the classroom as well as at the clinical practice facility. The participants expected that elements of professionalism should be evident in how the learner nurses dress:

"Professionalism is the uniform, it is how you speak, it is how you react, it is how you nurse." (CS Midwifery Ind. 1)

A participant mentioned the linkage of professional behaviour in class to the behaviour observed in the clinical placement such as being on time:

"I see students in the classroom and I do clinical supervision as well. So I see them in the clinical facility ... one is professional and another one is not behaving professionally. And I think the first thing that I always notice is if students are on time in class. And then how they behave, they're not busy with their breakfast or something like that. (When lecturer gets into class), the way that they talk, and whether they're screaming or they're loud... ." (NE P7 FG 2)

Nurse learners come with their own set of rules and late-coming to class is typical of some learner nurses:

"Some of them are habitual latecomers." (NE P10 FG2)

- *Sub-category 2: Professional boundaries in relationship between student and supervisor and patient*

Professional boundaries are parameters that describe a relationship where one person entrusts their welfare and safety to a professional, often in circumstances where a power imbalance may exist (College of Registered Nurses of Nova Scotia, 2012:3). Educators are in the unique position of having relationship of trust, care, authority and influence with their students, which means that there is always an inherent power imbalance between teachers and students. Thus when interacting with students, educators should use good judgement and think very carefully about the implications and potential consequences of engaging in certain behaviours with students (Teacher Registration Board, 2015:2). In the nursing profession, there is also constant interaction between nurses, patients, learner nurses and their supervisors who at times make use of social media as a means of communication to relay important messages to undergraduate learner nurses in the clinical practice environment (Teacher Registration Board, 2015:9). Some participants observed learner nurses using social media as a tool to get in touch with their lecturers or CS. In other instances social media was used irresponsibly, when learner nurses and

educationalists (NEs and CS) crossed the social and private space of one another. A supervisor said:

"... if you hear a supervisor speaking to a student … and I've heard that they are on Facebook and things like that … how do you keep professional if you are conducting yourself in an inappropriate manner? I know this is the way of the world now, but there's e-learning. You can still do it within the boundaries of the professional environment without the student losing that respect for you. And you will maybe … it seems harmless, but I can see that students react differently to supervisors where they have that familiarity... So when this familiarity is created among student and supervisor, then you take away that professionalism. You can no longer have that boundary of professionalism." (CS Midwifery Ind I)

One participant shared her personal view of engaging with learner nurses on social media platforms:

"I also think the network, the social media network, I mean, I believe, it is my personal view, not with my students on BBM or Facebook or wherever … but a lot of people are on Facebook with the students." (CS FNS/GNS)

- *Sub-category 3: Appropriate clinical competence*

CS are mostly involved in the clinical or practical training of undergraduate learner nurses in the clinical skills laboratory, as well as in clinical practice, when they accompany the learner nurses in the healthcare facilities. A participant observed that learner nurses should be skilled in the performance of basic year level outcomes:

"I see the midwifery students, skills lab, they don't know the basics of injection... their clinical competency is very, very poor." (CS Midwifery Ind I)

Other experiences mentioned by the participants were that the learner nurses did well academically, but lacked the necessary confidence to perform well in the practice environment:

"We had students who do very well academically – a lot of them, but they don't … we had students who were afraid of speaking to patients." (CS Midwifery Ind I)

- *Sub-category 4: Respectfulness and confidence in interaction with patients and professionals*

In order to establish a relationship marked with confidence, the PN`s is required to constantly interact with the patient (Berg, Kaspersen, Unby & Hollman Frisman, 2013:2). Participants expected learner nurses to be respectful and considerate towards professional leaders:

"Ms. X was going to come and address the students about community placements and all that and she (Ms X) happened to be late on that morning. So when she arrived, the students were disregarding her. They were on their laptops, they were talking and she said that the message she wanted him (student) to take is (to) maybe go and tell the students about professionalism." (NE FG1)

A participant said that learner nurses should act in the best interest of the patient by making the patient feel safe, which will promote wellbeing in the patient:

"... behaviour or that attitude that is going to instil fear in a patient. It is going to compromise that client's wellbeing." (NE P 8 FG 1)

Another participant verbalised that learner nurses copy the unprofessional communication of seniors and treated vulnerable patients who are in pain with disrespect:

"... some of them they speak to the patients the way they hear the facility staff speaking and that's not always professional... It's no excuse really to be rude... if a student should make a remark that a permanent staff member makes... even it's just wrong. And I found that they tend to pick up those bad habits at the facility, especially with midwifery, because patients come in pain, most of them disorientated at times." (CS Midwifery Ind I)

Learner nurses seemed not to be in control of their emotions and lacked compassion and human dignity when treating vulnerable patients who were in pain and disorientated. One participant valued interpersonal skills and being able to connect with others as important elements of professionalism:

"Communication and building relationships are also important aspects of professionalism." (NE P 7 FG 2)

A participant said that the interaction between the learner nurse and the patient should create a relationship of trust, through self-confident communication, which makes a patient feel comfortable:

"... the interaction between the student and the patient, and sometimes there is an awkwardness and you see maybe the student lack... I don't know, self-confidence... even if the student doesn't know anything about whatever you should be doing now, if the communication and building the relationship with the client or the patient is good, then the patient is already relaxed." (NE P 7 FG 2)

- *Sub-category 5: Motivation and taking responsibility*

Motivation to learn is an important variable in professional learning, leading to academic success (Hassankani, Aghdam, Raghmani & Mohammadpoorfard, 2015:97). A participant viewed it as unprofessional when learner nurses did not show interest in taking responsibility for their own learning.

"I also see it as unprofessional, if you are just there and you don't even ask questions to learn what is happening there." (NE P 7 FG2)

Learner nurses were expected to focus on their own learning by approaching the sisters (PN`s) in the wards with their learning needs:

"You don't expect that the sister must approach you and ask you what should you be learning here. You should go there and present yourself." (NE P 7 FG 2)

A participant mentioned that learner nurses should be motivated and show eagerness to be professional and to do what needs to be done when they are in the clinical placement facilities:

"... there is definitely a link between motivation and enthusiasm with professionalism, because that is also what was raised, two weeks ago. I had to do a mid-placement evaluation... those sisters sat in to give their input. It came up over and over again." (NE P 7 FG2)

5.2.2 Theme 2: Suggestions to improve professionalism in nursing

Under this theme, the participants described how professionalism should be improved among undergraduate learner nurses in the academic and clinical placement environment. These suggestions are discussed below in the following categories: i) educators and CS work towards bridging the gap between theory and practice; ii) finding the fine balance between considering exceptions to the rules of professional behaviour and reinforcing them; iii) reward system with accolades for professional behaviour; iv) platform for students to voice grievances relating to professional behaviour; v) role modelling respectful behaviour, appropriate dress code, and being punctual; and vi) assessing relevance of some rules of professional conduct in a changing era.

Category 1: Educators and CS work towards bridging the gap between theory and practice

The theory-practice gap has been described as inconsistencies between the theoretical content student nurses have learned and what is expected from them in the clinical nursing practice (De Swardt, 2012:1). Strategies to bridge the gap in value orientation between theory or nursing education and nursing practice are needed to strengthen professional commitment and maintain the viability of the profession (LeDuc & Kotzer, 2009:279). Participants mentioned the need for NEs and CS to bridge the gap between theory and practice:

"So from a clinical supervisor and a lecturer's point of view there is a big gap. There's a huge gap. I'm not sure where it's coming from or if it has always been like this, but it seems to me as if there is this clash between theory and clinical … we can maybe bridge that gap, we can go a long way with regard to professionalism in this profession." (CS Midwifery Ind I)

Ways in which this should be achieved are described under the following sub-categories: i) specific, differentiated and scaffolding in skills training at different levels; and ii) empowering students for resisting poor practice examples/role modelling and adapting to different policies and practices of facilities (empowering for no-excuse-of-own behaviour).

- *Sub-category 1: Specific, differentiated and scaffolding in skills training at different levels*

It is stated that scaffolding may increase motivation and accommodate the ability of the learner nurse to self-regulate, self-assess and engage with peers and educators (Salyer, Carter, Cairns & Durrer, 2014:3). Participants suggested that one of the ways to bridge the gap between theory and practice is to be specific about the expectations around professionalism in the respective year levels when they attend the skills laboratory. First-year learner nurses should know what is expected from them in terms of professionalism right from the beginning of their training:

"… supervisors, CS we can really do a lot more with regard to professionalism – students are really struggling with professionalism right at the beginning at first-year level. I can see in the skills lab, when I see them, they really don't know what's expected. And I think if we can focus on that our fourth-year and our third-year levels will know what's expected." (CS Midwifery Ind I)

A participant felt that learner nurses who were more experienced had a responsibility to share their knowledge with their fellow younger learner nurses:

"The responsibility I think that you take on for your slightly older student or with work experience and so on, you can see they are more responsible, they will take the lead maybe in doing things, showing others maybe what they know, sharing ideas and so on... ." (CS Psychiatric nursing)

NEs had strong opinions on how learner nurses could be modelling (shaping) the expected professional behaviour throughout all the year levels and that the values of the profession should be instilled in the first years:

"And I think, like you said, you start with the first year, inculcate the value system, explaining the code of conduct, explaining things like that and expect them to start shaping and show I think a degree of professional conduct as they progress through the year levels." (NE P3 FG1)

CS described the need for moulding professional behaviour throughout the four years of professional training:

" … I feel that they can both … from year level 1 up till year level 4, because we do see the student is growing in … mature and so on, but that could also help them if it is taken from 1st to 4th year… Just by adding on every year just as part of moulding them as well." (CS Psychiatric nursing))

- *Sub-Category 2: Empowering students to resist poor practice examples/role modelling and adapt to different policies and practices of facilities (empowering for no-excuse-of-own behaviour)*

Participants (NEs and CS) should empower learner nurses to adhere to the policies and guidelines of the profession, which will allow them to resist following poor examples of role models of professional behaviour in practice. A nurse educator stated:

"They need to adhere to their policies and guidelines. That is part of professional behaviour and I need to know because things are different... discussion with the students that are not resistant because this is part of developing your professionalism is to adhere to what the policies and guidelines are expected of you. Because they need a little bit more support in knowing that that is what professional behaviour is all about." (NE P7 FG2)

Category 2: Finding the fine balance between considering exceptions to the rules of professional behaviour and reinforcing them

NEs mentioned that they understood the reasons why learner nurses display certain behaviour in the academic and clinical learning environment and had empathy with them:

"... some come late because of reasons. Whether it is to class or whether it is to the clinical placement. It does not mean that they don't display professionalism." (NE P10 FG2)

It was felt that NEs should apply their knowledge in finding a balance between considering exceptions to the rule and reinforcing the rules of behaviour:

"... use your own discretion in that particular case of student, because I had this one student, she stayed in Wellington, I'm not sure if it was Wellington or Worcester. But I know it took her four hours per train to get to campus." (NE P5 FG2)

There should be adherence to the rules and regulations of the profession by holding learner nurses responsible and accountable for their conduct regardless of economic circumstances:

"... where do they draw the line. If we should start allowing things to happen, because for example the student does not have money to buy shoes or the student keeps on being late because she does not have money to be on time due to the taxis. I mean we have the same circumstances, but we have to be early. I mean think about the other person that they need to relieve." (NE P9 FG2)

A participant described an incident where a professional nurse was empathetic towards a learner nurse with similar poor economic circumstances but who were motivated to walk to work:

"... there was one incident when the student was late at work for clinical placement, and she was late, because that morning she had no money to go to work. So she walked. And that is a sign of professionalism. That is a sign of motivation and that is a sign of dedication. Her coming to

work, she was not managed well initially, but with the explanation, everybody's views changed about this particular student." (NE P10 FG 2)

In one incidence, a participant described that educationalists should have the courage to do what is right by being honest in their assessment of learner nurses with physical disabilities/impairments or challenges:

"I mean, you're not helping this professional, you're not informing her (learner nurse), you're not taking her from one step to the other. I would rather fail you … what kind of students are we grooming to be a professional? Now I've got a blind student also, but I failed that student." (CS CHN)

Category 3: Reward system with accolades for professional behaviour

In this category, educationalists gave attention to the idea of giving learner nurses incentives by praising them for their professional behaviour. One participant suggested honouring learner nurses in their fourth year of the undergraduate nurses training programme when they can show proof of their professional development throughout the undergraduate nurses training programme. The participant emphasised the importance of informing first and second-year learner nurses about the expectations of professionalism and having them sign a contract for professional development over the four years of the nursing training programme. This contract should then be submitted as part of learner nurses' portfolio of evidence on which they build every year. During the students' fourth year, educationalists evaluate their own leadership in assisting the learner nurses to develop professionalism:

"... there should be a new award system for professional development of students... in the fourth year when they do take professional development, they can even submit it there... and get an accolade there. And in the portfolio we can include a contract and say as a first year student, this is the professional development that we expect from you as a first year. In second year, this is what you need to build on now from the first year to the second year. And we allow them to build onto that for the entire four years and then we evaluate at the end and see, did we assist and did we guide the student enough to become professional." (NE P9 FG2)

Category 4: Platform for students to voice grievances relating to professional behaviour

Nurse educationalists should take initiative and be proactive in creating a professional platform for learner nurses to be listened to and to ventilate their grievances:

"Because the students do have genuine grievances at times... How do you do it in the professional way? And when they do it in a professional way, then they should be listened to. It shouldn't only happen something gets done about it when they riot, because then we're rewarding bad behaviour." (NE P11 FG2)

Category 5: Role modelling respectful behaviour, appropriate dress code, and punctuality

Participants mentioned conducting themselves in a professional manner by demonstrating the characteristics relating to behaviour that is in accordance with the professional code of conduct for nurses:

"So if we can also maybe in our own everyday life come with our professionalism and give it over to the students where they see it. We don't only preach it, but they actually see how we conduct ourselves among each other, with the students. That we keep it professional and not just dictate the words, but actually live by the professionalism code." (CS Midwifery Ind I)

A nurse educator described the need to take responsibility and be professional role models by changing or modifying their own personal behaviour (personality or nature) in the interest of the profession:

"... what I'm taking from here is for me to uphold professionalism, somebody on the receiving end must not be made to feel insignificant, feel belittled, feel insulted, feel like an idiot even if they were. So I think we've got to stop. I think that is then the role modelling that we talked about. Nothing stifling my personality because I'm always going to be loud, but then we've got to modify it and look at the whole picture." (NE P8 FG 1)

Another participant mentioned that PN`s should role model professional behaviour so that learner nurses can follow their example:

"If I as a professional nurse is late at work or if I dress in a way that is not assumed or seemed as professional, surely the student will follow that lead. And that is what we see time and time again in clinical facilities." (NE P10 FG 2)

Category 6: Assessing relevance of some professional conduct rules in a changing era

The assessment of professional conduct rules requires combinations of different approaches, assessing professionalism at individual, interpersonal and institutional levels, especially because the relationship of health professions, including nursing, with society has come under strain due to a combination of factors that include reaction to unprofessional conduct (Goldie, 2013:35). Professionalism develops over time and the profession has the potential to be restored to an acceptable status in the public's view while being dynamic and changing with the generation:

"It is difficult concept 'professionalism'. It is not easy and this is what I want to say to wrap up. It is not an easy concept to instil in a human being, because a human being changes. Human being – it is not easy to predict. It is not in a science lab and it's not … it's like you're instilling humanity or you're instilling those values, the important values in a human being and I think that if it started it will take time but it will at the end get some fruit at the end. Because we will put this profession back to where we were – not really in that militaristic or traditional way, but in a way that will be acceptable and acceptable in the community and it will be dynamic and

changing with the generation, but it will be the same profession that we all love and embrace." (NE P5 FG 1)

Professional nurses should be more empathetic and be mindful of the socio-political influences when they teach professionalism to the learner nurses:

"And I think that is what a participant earlier also implied in what you are saying that unfortunately we also need to take into consideration what is happening in our societies. We are part of a community. And I think it's a really difficult task in this time to help students to become professionals, I sometimes really have empathy with the students, because they just do what they see what's happening around them." (NE P 7 FG 2)

According to another nurse educator, a revision of the current environment in which learner nurses are prepared for nursing practice is needed:

"And we need to look into our profession. How rigid … are we still traditional on this? Nowadays technology, we are changing things. Records are kept in a computer and there's a virus that can come in there and challenge is the viruses. But we still keep those documents and everything. We are no longer writing and all that … so we need to look into what challenges are there with this professionalism? And what things are there at home, in the institution, in the placement." (NE P3 FG 1)

- *Sub-Category 1: Modern times, nursing dress codes and the use of technology*

Professionalism should be revisited because the students and patients are diverse and some practices might not be relevant or applicable to the training of learner nurses in this era:

" …revisit what do we see as professionalism … we are moving in different times as well … what do we expect from our diverse student bodies and we have diverse patients. And sometimes I myself don't know what exactly is professionalism anymore. Because some things that I've learned as a student and as a professional, now sometimes seems that it is not supposed to be like this anymore …" (NE P 4 FG 2)

The participant also felt that the use of technology in the 21st century (as the method of communication for the learner nurse) should be included in the criteria for professional capability:

"We are moving very much into the technology field. If we look at the criteria, at this point in time there is no talk of any technology. And I think technology plays a big role in our students' lives at the moment in the way they communicate … maybe we need to look at other ways or how we are going to redefine professional, where we actually meet both worlds; where we come from as a profession, but also where are we going to in the 21st century." (NE P4 FG2)

Participants also thought that the social and economic challenges the learner nurses face should be considered a part of the changing times.

"But also with the time factor, we should also look at the socio-economic factor. Because there are some of our students who do not qualify for bursaries or some of them do get bursaries, but the money, if they get bursaries, the money goes to sustaining families." (NE P10 FG2)

5.3 FINDINGS CASE 3: PROFESSIONAL NURSES

The professional nurses' experiences of professional behaviour will be discussed in the following section. Five themes emerged from the data analysis: (i) professional nurses' perceptions or experiences of unprofessional behaviour of university students; (ii) expectations and experiences of realising expectations of professional behaviour in practice; (iii) professional nurses' roles in enhancing and strengthening professional behaviour; (iv) obstacles in mentoring and monitoring students' professional behaviour; and (v) suggestions to support/enhance students professional behaviour (Table 5.2).

Table 5.2: Professional nurses' experiences of learner nurses' professional behaviour

Themes	Categories	Sub-categories
Professional nurses (PNs) perceptions/experiences of unprofessional behaviour of university students	Variation in perceptions of the incidence of unprofessional behaviour/lack of motivation according to wards	
Expectations and experiences of professional behaviour in practice	Respectful behaviour towards and acknowledgment of professionals and their commands	
	Adherence to professional dress code, demeanour (entire image) and neatness/non-adherence in some cases	
	Skill levels entering practice – (not complying with expectations)	
	Personal motivation for nursing (positive in selective cases)	Motivation affects general attitude and commitment to duties
		Motivation or lack thereof and attitude affect behaviour and non-adherence to rules, punctuality, cell phone etiquette
		Ethical behaviour
PNs' roles in enhancing/strengthening students' professional behaviour	Role modelling of professional behaviour in hospitals	Issues of attitude, behaviour and commitment
		Issue of dress code and punctuality
	Mentoring and monitoring students' professional behaviour	
Obstacles in mentoring and monitoring students' professional behaviour	Approachability and attitude of PNs	
	Work pressure and shortage of staff (one group) (no time to orientate learner nurses)	

Suggestions to support/enhance students' professional behaviour	Students should monitor their own progress by means of reports	
	Students should take responsibility for own behaviour and learning	
	PNs should orientate, welcome student in the team and clarify expectations	
	Mentorship and monitoring should be put into practice	Platform for students to voice their concerns and needs and opportunity for emotional support
	More exposure to learning in practice to improve professional competence and behaviour	

5.3.1 Theme 1: Professional nurses' perceptions/experiences of unprofessional behaviour of university students

The participants were responsible and accountable to carry out the daily tasks and responsibilities of safe patient care. The undergraduate learner nurses were placed in the wards under the supervision of the PNs for clinical learning. The participants described their experiences of unprofessional behaviour of undergraduate learner nurses from a HEI in the Western Cape under the category below:

Category 1: Variation in perceptions of the incidence of unprofessional behaviour/lack of motivation by learner nurses, according to wards

The experiences of unprofessional behaviour of undergraduate learner nurses as described by the participants in the different clinical learning facilities varied. Participants from two different healthcare institutions had positive experiences of undergraduate learner nurses who were polite towards patients:

"16 jaar wat ek in chirurgiese saal werk, het dit weinig voorgekom of kom dit glad nie voor waar studente skree op pasiënte nie – ek het nog glad nie studente gekry met "attitude problems" nie". ("For the past 16 years that I`m working in a surgical ward, none or rarely any of the students shouted at patients. I've never had students with attitude problems.") (Hosp. 4 P4)

It seems that learner nurses were well-disciplined and had a professional attitude, although they were vulnerable and anxious:

"Neëntig persent van hulle is baie goed gedissiplineerd; professioneel in hul houding wanneer hulle in die afdeling kom, maar jy kan ook agterkom, veral by die eerstejaars, hulle is 'n bietjie skrikkering, angstig." ("90% of them are well-disciplined; have a professional attitude when they come to the facility, but you can see, especially with first years, they are somewhat scared and anxious.") (Hosp. 4 P4)

One participant did not recently encounter any challenges with the learner nurses:

"So I haven't had any problems since 2010, except that one student." (Hosp.1 FG 1)

Another participant responded by saying that learner nurses who enter the profession were not passionate about doing nursing:

"I will say 50% you can see is very positive about nursing, and 50%, I don't know if it is just about that there is no other work outside maybe. Do they really want to be a nurse?" (Hosp. 4 P3)

A participant explained that learner nurses who are placed in the placement facilities were admirable. The participant mentioned that learner nurses wanted to know more and were eager to learn. However, some learner nurses lacked interest and were not motivated to learn:

"It's 50-50 I would say in my experience with learner nurses, you get those excellent ones that cannot get enough and cannot sponge enough information and roll their sleeves up. And then you get the others sitting under a thick coat waiting for the day to go over." (Hosp. 3 FG 2 P1)

One participant had negative experiences with learner nurses, especially in speciality areas in which they were placed for clinical learning. Learner nurses could not be relied upon to perform allocated responsibilities, and by leaving the area without permission, they behaved disrespectfully towards the PNs in those speciality clinical learning areas:

"I experience a lot of very bad things that happen in the theatres according the students that we train in the theatre and I've got, don't know what professionalism is. You send them for tea and then they abscond. The other thing that I experience is that some of the mentors come and retrieve the students for other areas maybe to go and take out stitches or sutures and stuff like that and then we struggle in the theatre because we allocated that student nurse maybe for swab count or something like that. And they don't come and tell us that they want to go to the mentor or something like that; they abscond out of the theatres." (Hosp. 4 P5)

One participant observed that learner nurses behaved unprofessionally by disrespecting patients and talking to them in an impolite manner:

"The way how she was talking to the patient wasn't very professional. It's like you're talking to someone or people talking on the street with each other. But towards the staff I think they're quite professional... They have respect. They treat you with respect and not talking to you like its friends. But with the patients, I noticed that they do that." (Hosp. 4 P2)

5.3.2 Theme 2: Expectations and experiences of professional behaviour in practice

Participants involved with the learner nurses in the healthcare facilities where they are placed for clinical learning had expectations of professional behaviour. The expectations and the experiences of the participants will be discussed in the following categories: i) respectful behaviour towards and acknowledgement of professionals and their commands; ii) adherence to dress code, demeanour (entire image) and neatness/non-adherence in some cases; iii) skill levels

entering practice (not complying with expectations); iv) personal motivation for nursing (positive in selective cases).

Category 1: Respectful behaviour towards and acknowledgement of professionals and their commands

One participant described professionalism by saying that nurses should conduct themselves respectfully towards the patients and their peers:

"Professional behaviour is the way you behave in certain ways and how you conduct yourself. Professionalism is like something is like you must be professional in every way. How you act with your patients, your colleagues... ." (Hosp. 1 FG1)

Patients should be treated with respect and dignity by the learner nurses:

"The way in which you conduct yourself and speaking to them (referring to patients), the respect and dignity that you have and even your loyalty. They can tell you who come early and who come late." (Hosp. 2 FG 2)

Participants expected respect from the undergraduate learner nurses in the clinical practice environment:

"... the respect, you know. If the sister or ... the matron or even if the sister says it's the matron coming, in the olden days we get up and greet. But nowadays they sit. Even if you have a meeting they sit right in front, and sit and sleep without feeling guilty when a senior person wakes them up. They're just laugh, it's nothing." (Hosp.3 FG2 P7)

One participant described how a learner nurse disobeyed a command and did not show a caring attitude or humility towards the patients when refusing to carry out basic nursing care responsibilities (personal reliability):

"... students don't want to listen to us ... I ask her: 'Go and fetch for the patient a blanket and a pillow. The patient is getting cold here on the trolley.' She said to me: 'No, I don't go for a blanket or a pillow now.'" (Hosp. 4 P5)

One participant observed that patients valued learner nurses who were compassionate and who deserved to be rewarded for rendering satisfactory patient care services. They described the patient's point of view as follows:

"They (patients) will also point out certain students as, that will go out of their way for them and they will say: 'Sister, give a good report about that one.'" (Hosp. 2 FG 2)

Category 2: Adherence to professional dress code, demeanour (entire image) and neatness (non-adherence in some cases)

PNs expect undergraduate learner nurses to adhere to the code of conduct for nurses. Participants described their expectations about professionalism and mentioned that identification and appearance in public were important aspects to consider:

"Dress code is an important factor … I want to see the student nurse must wear student epaulettes and the student nurse must know about the uniform code, know about how to appear in the public or in the wards." (Hosp. 1 FG 1)

Another participant mentioned the importance of being identifiable in the workplace environment because identification creates a sense of security when PNs know who are on duty:

"They sometimes don't wear their ID bands, the ID tags and that is so important. So you don't know who is working." (Hosp. 2 FG1)

A participant described disliking male nurses wearing earrings, also mentioned by Alino, Aprosta, Lugod, Montilla, Tabuan and Uba (2012:25). The participant stated:

"And also how they dress themselves to get to work, you know, the hair styles and that's not much, but earrings, especially the males." (Hosp. 3 FG 2 P5)

Another participant commented on the appearance of learner nurses at the public HEI, compared to the disciplined dress code of private colleges:

"In their behaviour and their appearance the university students are very sloppy in the sense that they will come with colourful sweaters, Tommy tekkies where the private colleges are very disciplined in that manner." (Hosp. 2 FG 2)

One participant emphasised that the dress code contributes to a positive professional image:

"... dat jy 'n positiewe beeld uitdra om elke dag professioneel in uniform geklee te wees. Dit is baie belangrik." ("It is important that you portray a positive image by dressing professionally every day.") (Hosp. 4 P4)

Category 3: Skills level entering practice (not complying with expectations)

Participants in three of the clinical placement facilities described that learner nurses should have the appropriate skills per year level when entering the healthcare facilities. A participant said that learner nurses enter the clinical placement facilities ill-prepared for the patient care needs in the hospitals, adding to the frustration of PNs who do not have time to teach basic nursing skills:

"The first time that we went to the hospitals, you know, they couldn't even do vital signs, because they weren't taught that. They were only taught the baby wash and the adult wash. And when I asked the tutor, you know, why don't they first see that they can do vital signs and I was

told that no, they must learn at the hospital. And those people they don't have time to teach vital signs. And my poor colleagues were very frustrated with them. And the permanent staff get agitated with them because now they're standing around because they don't know how to do blood pressure and things like that... ." (Hosp. 1 FG 1)

Learner nurses should have basic clinical skills and be able to apply critical judgement with regards to patient care in the wards.

"When it comes to your basics and you're not yet competent. We as the sisters can see. Because when you hand over you see the pulse rate was high and you see the temperature was high. And you know the students were there. They don't come and report it." (Hosp. 2 FG1)

A learner nurse in the last (fourth) year of the academic programme was unable to apply knowledge to the practice environment:

"I had one a while back and one of the students, he was fourth year and he was finishing and he did not know the difference... between a nebuliser and giving oxygen." (Hosp. 2 FG1)

An observation made by another participant was an indication that learner nurses were unable to integrate theory and practice and that academic staff at the HEI should use strategies for learning such as reinforcement (procedure) of essential skills:

"The manner in which they write and the way that they document according to the processes and those principles need to be reinforced at college so that they need to learn how to evaluate a patient, to set a patient, nursing diagnose a patient, draw up a care plan to implement. I think those are the skills that they are lacking." (Hosp.3 FG1)

One participant referred to graduate university professionals who lacked the knowledge and who were inadequately prepared to practice as PNs in the patient care facilities:

"The B. Cur sisters don't know anything if they start in the wards... ." (Hosp. 2 FG 1)

An interesting observation was made by another participant who reflected that university learner nurses who are uninterested in patient care showed an interest in managerial and organisational work. PNs also expected learner nurses to be more service-orientated and spend time with patients instead of doing administrative work:

"(Name removed) HEI A students in the ward, they will always be in the office. And when we have (name removed) HEI B students in the ward, they will always be among the patients. That is what I've picked up." "They will be more interested in the administrative work, the (name removed) HEI A students. The administrative work in the office... And the (name removed) HEI B students wouldn't have a problem sitting among the patient." (Hosp. 1 FG 1)

One participant made the observation that university learner nurses are more theory-orientated than non-degree learner nurses:

"… what I've noticed is that (name removed) HEI B is more practical than (name removed) HEI A students. It's because (name removed) HEI B are more in the settings than (name removed) HEI A. But (name removed) HEI A, they are more advanced than them when it comes to theory." (Hosp. 1 FG 1 P2)

Category 4: Personal motivation for nursing (positive in selective cases)

Personal motivation in this category refers to the learner nurses' ability to be their own driving force in the training programme and the expectation that they should be intrinsically motivated.

- *Sub-Category 1: Motivation affects general attitude and commitment to duties*

Participants at the various clinical placement facilities verbalised the need for motivated nurses who are committed to nursing and carrying out nursing care duties in the placement facilities.

A participant mentioned that professionalism is a lifelong commitment and said that learner nurses should have the attitude to be service-orientated (altruism) when they are in the placement facilities, instead of being concerned about their personal needs:

"Professionalism is really a continuous thing and I think they are now with the mind-set, I'm a student and I don't need to help them and I don't need to be here. I'm just here for my book." (Hosp. 1 FG1 P3)

Another participant agreed that learner nurses should be motivated and inspired to study nursing:

"Students come for different reasons … Some come for the bursary because there's nothing else that they can do. Some come because they want to do nursing. Some see the parents' calling and those are all the things basically that contribute to how professional students are at the end of the day." (Hosp. 1 FG 1 P6)

Another participant expected enthusiastic learner nurses to have a passion for nursing and to display reliability by putting the interests of the patient ahead of their own interests:

"And I think the student nurses aren't called for this duty... And they are only there to get a job. A few of them are called for this duty; it's all about attitude …. " (Hosp. 4 P5)

Learner nurses should show commitment by having intrinsic motivation to learn what needs to be learned:

"Most of the students from (name removed) HEI A especially are here and they are not self-directed or motivated. So they just come here... they are students... because psych (psychiatry) is more relaxed, they tend to relax … ('I'm late because trains were late or the bus'). So the punctuality … around that, especially for those who stay outside the hostel and who travel on their own. They have a tendency of coming late." (Hosp. 1 FG1 P4)

Another participant described an experience where a basic nursing task was beneath the learner nurse and an instance where another learner nurse acted in self-interest by refusing to obey orders because of own physical needs:

"… when the patient asked for the bedpan,... She told this patient: 'I'm a fourth-year student, I don't carry bedpans anymore...' the other sister asked a student: 'Come, let's go to the doctor's ward round.' 'Oh no, I'm too tired.' You know, it's all about your attitude and how serious you are about your course." (Hosp. 1 FG1)

Some learner nurses did not show their commitment to serve the needs of the patient, but instead acted in their own self-interest by demonstrating that the patient is not worthy of their nursing care service:

"And even if you leave them in a room with a sick patient and you say, talk with the patient, help the patient. And when you just pass in the passage, then maybe someone is standing with a cell phone." (Hosp. 4 P3)

One participant described the lack of commitment by the learner nurses when they did not show responsibility to do what needed to be done:

"It was tea time and she left the patient alone. Who is responsible for that patient …." (Hosp. 2 FG 1)

Learner nurses should use common sense, exercise critical judgment and have the capacity to make wise decisions so that they do not have to be told what to do:

"If their mind-set can come to that point, I think they will better themselves. Then if the temperature is high, it should be reported because you must know the consequences. If the pulse rate is high, what are the consequences for the patient going to be. Their mind-set must become: I'm here for the patient. I must take responsibility." (Hosp. 2 FG1)

- *Sub-category 2: Motivation (or lack thereof) and attitude affect behaviour and non-adherence to rules, punctuality, cell phone etiquette (misconduct)*

PNs working in the patient care wards where the learner nurses were placed explained that learner nurses who are enthusiastic about nursing had a positive attitude and adhered to the rules and policies of the ward (healthcare institution) by displaying good manners of greeting, calling the ward for off duties and asking where they can be of assistance in the wards. The participants also expected senior learner nurses to assume their responsibility and do what needed to be done without being told and to continue working according to their commitment to patient care duties. Participants mentioned that cell phones should be used more responsibly. One of the participants stated:

"I think first of all they don't call to find out what their off duties are and they will pitch up on the wrong day. So they already start off on the wrong foot. When they do arrive in the wards, they often struggling to dress, they don't greet, they don't introduce themselves. They seem to be lost, standing around expecting you to do all the work … Now I don't expect that from a fourth year, they all have their cell phones on them and they're constantly checking their emails or WhatsApp." (Hosp. 3 FG1 P5)

Learner nurses should take responsibility and be held accountable for their actions rather than blaming others for their wrongdoing:

"They need to be responsible for their own actions. We try as much as possible to enforce rules … They go on their phone, it's hectic, but ultimately, they're adults and they're going to be responsible for a ward of about 20 patients one of these days. So they can't turn around and tell me that the permanent staffs are doing this. What are you going to do when you're a sister one day?" (Hosp. 3 FG 1)

Participants working in institutions where the learner nurses were placed for clinical learning verbalised that learner nurses did not have the patients' best interest at heart (compassion) because they were on their cell phones:

" … even when they walk in the passage, they walk with their cell phones. You can speak to them, you can educate them, but it is continuously happening with university students and also then some of the private students as well." (Hosp. 2 FG 2)

"I will talk to them about cell phone etiquette. You know, because you get students, they are on their cell phones all the time … So I would go through protocols …." (Hosp. 4 P1)

Another participant mentioned that learner nurses were not altruistic. They described cases where learner nurses were not serving the needs of the patients, but instead shifted nursing responsibilities to others:

"... we still are receiving numerous complaints of patients where they say that I asked for a bedpan but the student was on the phone. The student said: 'I will call somebody.'" (Hosp. 4 P1)

In other cases, participants said that learner nurses did wrong when they were not serious about teachable moments in the clinical learning environment and attended to personal matters first:

"... if you're busy like a demonstration, some of them will go out and they will go and answer their phone. And just say that was important." (Hosp.1 FG1 P3)

Other responses from participants were about expectations from learner nurses to adhere to and obey the rules and protocols of punctuality, courtesy and respect:

"I will just tell them: 'You write the time that you come here.' But now some of them are taking chances, they don't write in the time, they just sign. But I go back to the book and I call them. You must sign in the time that you come." (Hosp. 1 FG1)

Learner nurses were expected to be respectful and adhere to the rules of the healthcare facility:

"It's polite for them to come and say, I'm going to tea and I'm coming back. But the thing is, they don't know we have to know where they are." (Hosp. 2 FG1)

- *Sub-category 3: Ethical behaviour*

Another expectation of the participants was that undergraduate learner nurses should display ethical behaviour by possessing personal integrity. A participant described an experience of dishonest behaviour where learner nurses engaged in a practice of misconduct:

"It was the last group that was allocated where I'm working, they forged my signature." (Hosp.3 FG 2)

5.3.3 Theme 3: Professional nurses' roles in enhancing/strengthening students' professional behaviour

The participants recognised and became aware of their role and function as leaders improving the professional behaviour of the learner nurses in the workplace or clinical practice environment. The following categories will be discussed: i) role modelling of professional behaviour in hospitals; and ii) mentoring and monitoring students' professional behaviour.

Category 1: Role modelling of professional behaviour in hospitals

In this category, the PNs described their role in demonstrating professional behaviour in the healthcare facilities.

- *Sub-category 1: Issues of attitude, behaviour and commitment*

A participant described the commitment and responsibility of PNs to inspire learner nurses to follow good examples:

"If the leader is good, the students will also become good. That is where it starts. As I said, we must start with us as sisters." (Hosp. 2 FG 2)

One participant shared the same view by stating that PNs should lead as examples of professionalism and be held accountable for their professional conduct because learners copy the behaviour of PNs:

"The PNs in the unit should be a role model to the student nurse so that we can be at least being all accountable for professionalism at the end of the day... The student, they also just mimic what the PNs are doing in the ward." (Hosp.1 FG 1)

Nurse role models should effect positive change in the behaviour of learner nurses because learner nurses are influenced by the examples of PNs.

Another participant described how PNs should demonstrate self-control by maintaining a stable affect under work pressure. The participant described that stressors in the workplace environment sometimes require leaders to deal with conflict:

"We should be an example for them the way we lead. Because sometimes in a workplace, from a general setup, and I've seen how stressors … if you don't know how to manage stressors... and conflict management as well." (Hosp. 1 FG 1)

Negative behaviour, influences and attitudes of disgruntled permanent staff were adopted by the learner nurses:

"My general feeling is that because the staff who is permanently employed have a negative attitude, job dissatisfaction and all of those issues, and it obviously boils over to the students." (Hosp.1 FG 1)

A participant echoed that PNs should be role models so that learner nurses can follow the good examples:

"And how productive are we at ward level... Because the students pick up from us. Because when they get: 'Oh, the sister is cool, she won't mind.' They tend to have that same behaviour and that is where respect goes out of the window." (Hosp.1 FG 1)

There is awareness among senior PNs that their behaviour towards patients and the professional treatment which they give to learner nurses are disrespectful and demeaning. A senior professional nurse became conscious of the fact that there should be a change in the way learner nurses are treated:

"It must also come from us as the seniors. The way we speak to our patients … The way we address our patients. We must respect. I think we should also come in there the way we're handling the students." (Hosp. 2 FG 1)

- *Sub-category 2: Issues of dress code and punctuality*

While most of the responses regarding the experiences and expectations of a more professional appearance were directed at the undergraduate learner nurses, interesting responses also surfaced where participants in this case realised the essence of dressing professionally. A participant responded by stating that PNs should be examples to learner nurses by dressing professionally as it influences them to behave professionally during interaction:

"We ourselves would act more professionally if we are dressed professionally. So for me, I just feel that if I'm talking to a student, I must also be the example for you... So you must dress professionally to act professionally." (Hosp. 4 P 1)

PNs should be an example (role model) by honouring the rules of the workplace and be punctual. A participant mentioned that PNs should demonstrate a commitment (professional capability) to service (personal reliability) by adhering to the work ethic of the healthcare facility:

"You can't check the student if you're coming half past seven on duty." (Hosp. 1 FG 1)

Category 2: Mentoring and monitoring students' professional behaviour

PNs acknowledged their role and function as NEs in a culturally diverse nation. A participant explained that they should have the courage to apply their knowledge and skill in order to achieve the desired professional outcome (behaviour) in learner nurses. They should also emphasise what is acceptable and unacceptable by reinforcing the rules of the profession to novice nurses entering nursing practice from diverse backgrounds:

"The first year when the ground rules should be strictly enforced or reinforced because we will get students from all over, other provinces as well, and it also lies in our culture and customs, and our values and our norms how we were trained at home as well. Our role and function as PNs are about education and training as well. So we also have a role to play in that, not just a mentor. So when you find any student or any professional nurse and you know that it was taught that no professional can sit on a bed of a patient you should address it." (Hosp. 2 FG2)

Another participant at one of the clinical placement facilities responded in a similar way by stating that PNs should have the courage to do what is right and be assertive in addressing issues pertaining to the code of conduct, thus directing learner nurses to the right path of professional development:

"We PNs shouldn't just only think that students should know everything because they are in their fourth year. And I think we should also help them to become better professional persons throughout their career … I think like coming late on duty and phones and so, we should feel free to address that kind of issues. So that they will know that when they go to the next ward I did it and I tried it and nobody said something, but now somebody is actually saying something they know it's wrong. It's not that they don't know that it's wrong. But then they will realise, okay, this is not on. So I won't try that anymore." (Hosp. 1 FG 1)

One of the participants mentioned the importance of continuously reinforcing what professionalism entails:

"So we must just reinforce every year, we should reinforce what is professionalism all about." (Hosp. 1 FG 1)

Teaching strategies should be employed to communicate the expectations of professionalism at the clinical placement facilities and to support learner nurses to develop professionally:

"Hospital X should like have a lecture of what we regard as professionalism. So then those students will know what we expect from them. And maybe try to better themselves." (Hosp. 1 FG 1)

Other strategies such as to put emphasis on and practice professionalism were also suggested by one of the other PNs at one of the major academic healthcare facilities:

"The seniors must drill professionalism into our students. Like our seniors did before." (Hosp. 4 P5).

One of the PNs described her behaviour towards the learner nurses as warm and welcoming. The participant demonstrated patience and tolerance in behaviour, but suggested that the learner nurses should be committed and self-directed to learn what is necessary in terms of their learning outcomes:

"I'm the kind of sister that would welcome the student into the unit and I will tell them: 'If you have procedures, let me know. But I'm not going to stand behind you. It is your duty to come to me and tell me, sister, I need to know this.' Because that is how we would do it when we were students. Students don't often come to me for signatures because I don't just sign any book unless they can do that practical on their own and that they're competent enough to." (Hosp. 1 FG 1)

5.3.4 Theme 4: Obstacles in mentoring and monitoring students' professional behaviour

Obstacles in mentoring and monitoring students' professional behaviour have been identified by participants. PNs expected learner nurses to approach them for guidance regarding their clinical learning in the placement facilities. The obstacles are discussed with regards to i) approachability and attitude of PNs; and ii) work pressure and shortage of staff (no time to orientate learner nurses).

Category 1: Approachability and attitude of PNs

A participant experienced that undergraduate learner nurses were reluctant to ask for assistance. The participant emphasised that PNs should demonstrate their availability to serve the needs of the learner nurse in the clinical placement facilities:

"We as sisters must also emphasise to them that we are approachable. We are there for them. And ask questions if they don't know." (Hosp. 2 FG 1)

At the same time, while the expectation is for undergraduate learner nurses to approach the PNs, it has also become evident that the way in which these learner nurses are addressed and treated by the PNs should not deter the learner nurses from approaching the PNs. Two participants responded as follows:

"Sisters must also be very cautious how we address, especially the students... because they feel quickly offended ...." (Hosp. 2 FG 1) and *"... the way she (the sister) approaches them (learner nurses) sometimes put them off. And already there we will get resistance from that student... if you talk they will ignore you. ... But we must look at a broader picture of the student of how we approach them as a person." (Hosp. 2 FG 2)*

Participants verbalised that PNs should be caring and friendly towards learner nurses. A participant mentioned being mindful of the learner nurses by acknowledging them as part of the team and making them feel welcome in the wards:

"There were cases of abuse that I've witnessed from the nurses towards the students. That is why it is so important for the sister in the meeting to say: 'Welcome students,' and introduce the students to all of the nurses. So that there is someone kind of acknowledging of the students to ask them to make the students feel comfortable." (Hosp. 2 FG 2)

Another participant agreed that the learner nurses should be orientated and be welcomed as part of the team. They should also be made aware (mindfulness) of what is expected of them, and that they (as part of a team) have a responsibility to be self-directed learners in the ward:

"... they must welcome the students to be part of the team, because when I orientate them, I will tell them: 'You do have responsibility to a certain degree because you're working in a team. So we're going to expect that in your second year, you can do certain things. But if you don't know, then tell the sister.' ... We are also like the culprits, you know. Yes, because we have now this full ward, and stress, and you get pressure from this side and that side and then the poor student... ." (Hosp. 2 FG 2)

One participant was mindful of PNs who were at fault and not willing to serve the needs of the learner nurse:

"... we do have the problem that some PNs do send out: 'No, I don't like to work with students. You go to that one'. So we ourselves are at fault as PNs." (Hosp. 1 FG1)

Category 2: Work pressure and shortage of staff (no time to orientate learner nurses)

PNs verbalised that they suffer emotional and physical challenges because of work pressure and shortage of staff, which prevent them from maintaining professional conduct. They mentioned becoming mindful of taking responsibility and accountability for not being able to guide and direct (orientate) learner nurses in the clinical practice facilities when there is chaos in the wards.

One participant described the importance of having a stable affect (self-control) and making time to orientate new students, even though they experience pressure in the wards:

"We have been at fault, one or two times where the unit is just so unpredictable. You come on duty. Students start the first day. Things are hectic. Ward rounds – there are fights, aggression. And we just tell the students, sorry, just find your feet just for today. As soon as I get a chance we will orientate you to the unit, but not now. And I mean we've been at fault and it is a terrible feeling to come into a unit and the staff can't take note of you at that particular time." (Hosp.1 FG1)

One participant described said that PNs should apologise for their shortcomings to serve the needs of learner nurses. PNs should be more caring and show that they are compassionate and empathetic towards the learner nurses, despite work pressure and shortage of staff:

"... the two units, they are very, very busy. And the majority of the time, you don't actually have time. So you have to go back at a later stage and explain to them and you have to apologise to them … And also the shortage of staff …." (Hosp. 1 FG1)

Another participant described not being able to give immediate attention to the learner nurses due to the shortage of staff, but acknowledged the teaching function of PNs in the professional development of learner nurses:

"Everywhere there's a shortage of staff … Sometimes you can do it and sometimes you just don't get through your day. You don't know how you got through from seven till seven. But we must try. We must really. Because teaching is one of your functions." (Hosp. 2 FG1)

A participant mentioned that PNs should demonstrate kindness and interest in the learner nurses on their first day in the clinical placement wards. PNs should be tolerant towards the shortcomings of the learner nurses and be motivated to assist the learner nurses by telling them what is expected of them, thereby avoiding misunderstandings:

"There are nurses who, when the students come in, they must just be shown where to put the bag and nothing else and then when they're short of staff then they expect the students to know each and everything. While on the first day, when they came on duty, they were shown absolutely no interest in helping the student … And only when it was short and then you expect them to know this and that. And when they don't know, you start swearing at them, the student, they don't know anything and all those things. So it depends also how motivated are you as a professional nurse to assist the student." (Hosp.1 FG 1)

5.3.5 Theme 5: Suggestions to support/enhance students' professional behaviour

The participants from the different clinical practice facilities where the study had been done shared their suggestions on how undergraduate learner nurses should be supported to improve professionalism for nursing care practice. Five categories emerged from this theme: i) students

should monitor their own progress by means of reports; ii) students should take responsibility for own behaviour and learning; iii) PNs should orientate and welcome students in the team and clarify expectations; iv) mentorship and monitoring should be put into practice; and v) more exposure to learning in practice to improve professional competence and behaviour.

Category 1: Students should monitor their own progress by means of reports

A participant mentioned the importance of giving feedback to HEIs about their experiences of the learner nurses during their placements in the wards. Feedback (in the form of reports) should monitor the progress of learner nurses in the clinical placement wards as part of being proactive in the professional development of the learner nurse:

"The progress report that we should complete. For the past two years I noticed we don't get that anymore from students. You just give feedback to the college of how the student has been in the ward. So I think from our side there's actually no, like feedback, from how do we as PNs see or experienced while they're placed in the wards." (Hosp. 1 FG 1)

Category 2: Students should take responsibility for own behaviour and learning

A participant suggested that the learner nurses should voice their learning needs by being self-directed and taking responsibility to recognise what needs to be learned:

"The students, they must come to us and say: 'Okay, sister, can you tell us how to do this and this.'" (Hosp. 2 FG 1)

Category 3: PNs should orientate and welcome students in the team and clarify expectations

Participants at three of the clinical placement facilities in this study mentioned that learner nurses should be treated with warmth. PNs should also welcome them into the professional team by orientating them to the hospital environment so that there are no misunderstandings:

"Maybe give them orientation in the first week before they are placed in the units to give them an oversight of the hospital." (Hosp. 1 FG1)

Learner nurses should be orientated so that they know what is expected of them in the wards:

"You must orientate them well into your unit or into your ward. You must spell it out to them what do you expect from them." (Hosp. 4 P3)

PNs should guide learner nurses (followers) according to their scope of practice for their appropriate year level. They should be role models who should inspire (interpersonal compatibility) and motivate the learner nurses to be part of the team:

"When I am working with my students, I look at what year they are so that they can work in that scope. If the student is a fourth year, I would say: 'Come walk with and let me show you how we do this,' … that is how you get the students to be interested. Someone to look up to. So I think it's teamwork." (Hosp. 2 FG 2)

Category 4: Mentorship and monitoring in practice

Two of the healthcare facilities where the learner nurses were placed for clinical learning mentioned having mentors who could guide the learner nurses. One participant felt that mentors should be available in the clinical placement area to monitor and supervise learner nurses in collaboration with the PNs who can give feedback regarding issues of conflict of interest:

"Students should be closely monitored by their mentorships or whatever the leaders, and that they should often visit them and see and that we should be clear as PNs about the reports that we write so that they can see where there are problems." (Hosp. 1 FG1)

A participant from one of the academic hospitals chosen for this study felt that PNs are influential in showing learner nurses the right thing to do. They should take the lead and direct the learner nurses to become professional:

"We must be the example and we must take them by the hand. If we see that they are not doing things right, we must show them, we must guide them, and show them right." (Hosp. 4 P1)

Another participant from the same healthcare facility emphasised that PNs should have the courage and not be afraid to impose disciplinary actions against the wrongdoing of learner nurses:

"We must not be shy for disciplinary actions when the student did wrong. We have to discipline them. I think that will be our main concern now." (Hosp. 4 P5)

It was emphasised that participants should rigorously enforce rules as they assist learner nurses with their professional development and achieving the desired level of professionalism:

"Rules must be strictly enforced so that they can grow with that to a reach a level of maturity and responsibility." (Hosp. 2 FG 2)

- *Sub-Category 1: Platform for students to voice their concerns and needs and opportunity for emotional support*

Participants were in support of learner nurses having a voice and being able to communicate their challenges in a safe context. A participant suggested having a platform in which learner nurses can freely express themselves:

"The students sometimes do also have problems with the staff, but they don't verbalise that. I think the students should feel free to say if they also do have a problem." (Hosp. 1 FG1)

Category 5: More exposure to learning in practice to improve professional competence and behaviour

An overwhelming response came from a certain healthcare placement facility where it was suggested that learner nurses' professional competence could be improved by increased exposure to practice. This was the response of one of the participants:

"I think to get the exposure that they need is the biggest part of it." (Hosp. 2 FG 1)

A participant suggested that the learner nurse could benefit by receiving bedside (on the spot) or in-service training in the healthcare facility:

"In-service training. Or spot-on training." (Hosp. 2 FG 1)

Another participant felt that more practical exposure will improve the integration of theory and practice:

"The book knowledge and the practical, they don't bring it together." (Hosp. 2 FG 1)

One participant compared the different nursing education institutions and stated that the learner nurses from the HEI where the study was conducted will positively contribute to the image and would develop professionally, provided that they get more practical exposure:

"... if I can just say, the (name removed) Institution B students are very more matured in their appearance, because they are more here at the facility working shifts. I would like Institution A also to implement if they can do that, because it will be a positive thing for the student as well." (Hosp. 2 FG 2)

One participant suggested increasing the students' practical exposure through a block system in which classroom time and ward time are separated:

"They should be more in the wards where they can catch up maybe three days a week in the wards and the other days they are in class. So they can sharpen their practical knowledge." (Hosp. 2 FG 1)

5.4 SUMMARY OF THE OVERALL CASE

The aim of this study was to develop a framework for nurse educationalists and PNs to facilitate professionalism among undergraduate learner nurses. Cross-case synthesis is part of the

development (Yin, 2014) of this framework. The final data analysis included data about the separate three cases that shared their experiences of nursing professionalism during their involvement in a nursing undergraduate programme (Table 6.1). The researcher aimed to match patterns in the data within and between the three cases (Yin, 2003, in Baxter & Jack, 2008:555). The final product is a case study of professionalism in an undergraduate nursing programme, based on a cross-case synthesis from the three units or cases of analysis (Yin, 2014:167). A summary of the across-case analysis of the common themes and categories of the three cases follows.

Different generations of nurses have different perceptions of the realisation of the concept of professionalism (professional behaviour). Various challenges were experienced by participants. Aspects to be addressed are the humiliating and demoralising style of communication by PNs in specific settings, the lack of orientation of learners to clinical placement environments, misconduct and non-commitment to patient care by PNs, challenges around organisational structure, and learner nurses who conform and adapt to the unethical and unprofessional behaviour of PNs. When addressing professional development, the educational needs of a new generation of learners should be emphasised, while the traditional, historical heritage of the nursing profession should also be acknowledged. NEs and PNs should recognise the teaching and learning (educational needs) processes in theory and practice for the professional development of the new generation. Recognising and meeting the challenges of and influences on professional learning within the socio-cultural context in the 21st century should take cognisance of the diversity in culture, background and social economic environments of learners. Educational needs should be addressed by means of scaffolding, consistent learning reinforcement teaching strategies (e.g. mobile learning) in practical settings and theory, and more experiential learning to identify with and internalise professional values. Agents, the educationalists (lecturers and CS) and PNs, need to work towards bridging the gap between theory and practice.

Nurses should demonstrate their professional values during interactions with authorities, fellow colleagues and learners, and patients. This could first be achieved by interpersonal compatibility (politeness, approachability and tolerance within professional boundaries, being caring, and having self-control, empathy and influence). Second, professional (capabilities) competencies are needed through demeanour reflected in practice and class (knowledge, skills and wisdom). Third, characteristics of personal reliability in professionalism (e.g. adherence to professional ethics and guidelines, trust, honesty, reliability, humanity, responsibility and a commitment to excellence, service and courage) are needed.

Role modelling is related to individuals and different cultural and socio-economical backgrounds of individuals in a changing environment, although agents' and recipients' experiences of professional behaviour vary. On the other hand, CS' and NEs ' experiences of unprofessional behaviour need to be attended to by further professional development.

Nurses' communication with all stakeholders in the external environment is important and they should display effective verbal and non-verbal communication skills of listening, language use, assertiveness and the total professional image of nurses.

Support mechanisms to promote professionalism in learner nurses are needed. The first means is by improving organisational structures e.g. counselling. Suggestions are to increase human resources, learning resources and space; to organise time and workload; to effectively monitor and evaluate programs; and to effectively select motivated and committed students and practitioners. Second, mentorship in practice should provide for the academic and emotional support of learners (mentees). Third, learner students should have the opportunity to gain appropriate clinical competence in practice.

Underlying professionalism is mindfulness of self-leadership. Learner nurses should be self-aware and be able to internalise and develop professional behaviour in the clinical practice. Realisation of the concepts of professionalism is through appropriate clinical competence in practice and appropriate theory integration with practice.

5.5 CONCLUSION

In Chapter 4 and 5, findings from learner nurses, nurse educationalists and PNs were described in separate cases. The participants described what they valued in terms of professional behaviour in the academic and clinical practice environment. Participants also made suggestions on how learner nurses' professional development in the nursing practice can be supported in the academic and clinical learning environments. This led to the description of a final case that will be conceptualised in Chapter 6, with supporting literature.

CHAPTER 6

FINDINGS ON AND CONCEPTUALISATION OF THE CROSS-CASE ANALYSIS

6.1 INTRODUCTION

Chapter 5 concluded with a cross-validation summary of the three cases. The cross-case synthesis technique was used because it made the findings from the separate analysis of the (i) learner nurses, (ii) nurse educationalists and the (iii) PNs more robust (Yin, 2014:164). The cross-validation is usually an attempt to assess the accuracy of the findings as best described by the researcher and the participants (Creswell, 2013:247).

6.2 DISCUSSION OF THE FINDINGS OF THE CROSS-CASE ANALYSIS

From the cross-validation analysis of the three cases, six main themes emerged. These themes, with the associated categories and sub-categories, are presented in Table 6.1.

Table 6.1: Common themes of the three cases (learner nurses, nurse educationalists and PNs)

Themes	Categories	Sub-Categories
Nurses should demonstrate professional values during interaction with authorities, fellow colleagues, and patients	Interpersonal compatibility	Politeness (kindness, compassion, respect, human dignity, warm and friendly attitude); approachability and tolerance within professional boundaries; caring attitude (underlying dynamic); self-control; empathy; influence (motivate, inspire)
	Professional (capabilities) competencies reflected in practice/class	Knowledge and applied skills; proactive/commitment to excellence; wisdom
	Characteristics of personal reliability in professionalism	Adherence to professional guidelines and ethics; building trust; honesty; reliable; humility; responsibility and a commitment to excellence; service/altruism; courage
Interpersonal communication of nurses with all stakeholders	Displaying good verbal and non-verbal communication skills	
	Assertiveness	
	Total image, professional dress code and demeanour reflected in practice and class	
Realisation of	Orientation to clinical placement	

essential role modelling in different settings	Conduct and commitment to patient care	
	Conforming and adapting to ethical and professional behaviour	Non-professional behaviour by CS, educators and PNs
Support mechanisms to promote professionalism in learner nurses	Gaining appropriate clinical competence	
	Improving organisational structures	Increasing human resources, learning resources, space, time and fair workload; monitoring and evaluating program; selection of motivated and committed students and practitioners
	Mentorship in practice for academic and emotional support	
Nurses to be mindful in practice	Self-awareness and self-realisation to internalise and develop professional behaviour in the learner nurse	
Recognition of teaching and learning needs in theory and practice, for professional development of new generation and historical heritage of the profession	Diversity in culture, background, social economic environment	
	Scaffolding learning	
	More experiential learning to internalise professional values	
	Consistent reinforcements to promote professionalism	
	Educators and CS to work towards bridging the gap between theory and practice	

Literature was used to conceptualise these findings. The three cases did not necessary share their experiences under each theme, as found in the cross-validation analysis. The underlying story line was that different generations of nurses had different understandings of professionalism (professional behaviour). The themes across the cases were: i) nurses should demonstrate their professional values during interactions with authorities, fellow colleagues and patients; ii) interpersonal communication of nurses with all stakeholders in the external environment; iii) the realisation of essential role modelling in different settings; iv) support mechanisms to promote professionalism in learner nurses; v) all nurses should be mindful in nursing practice; and vi) NEs and PNs should recognise the teaching and learning (educational needs) processes in theory and practice for the sake of the professional development of the new generation (and acknowledge the traditional historical heritage of the profession).

6.2.1 Nurses should demonstrate their professional values during interactions with authorities, fellow colleagues and patients

Values impact individuals' attitudes, their approach to life situations, their relationships and interaction with people, and the meaning they assign to situations and the behaviour of others (Thomas, 2013:19). Thomas (2013) states that the organisational or professional values play a role in the development of an organisational culture, as shared values shape the norms and behaviours of its members. It is, however, difficult to convert knowledge and awareness of values into behaviour, yet it occurs within the context of both organisational and clinical relationships (Thomas, 2013:19). The manner in which a person interacts and communicates with others are important aspects of professionalism. Respectful communication, where colleagues listen to, respect and appreciate each other and the patients, could foster positive relationships (Norgaard, Ammentorp, Kyvik & Kofoed, 2012:2). Communication is a skill requiring respect for others (also see 6.2.2). The findings indicated that *nurse educationalists and PNs* expected learner nurses to communicate respectfully with the nurses in leadership positions. The professional values of nurses in this study refer to i) interpersonal compatibility; ii) personal reliability; and iii) professional capability.

6.2.1.1 *Interpersonal compatibility*

Healthcare professionals, including nurses, should have the capacity to build relationships with others and connect with them through meaningful communication, also referred to by Brown and Ferrill (2009) as the connection domain and interpersonal compatibility. Interpersonal compatibility fosters the values of understanding others, caring about them, being polite (kind and compassionate) by being courteous and showing warmth, approachable and tolerant, having empathy and showing respect through human dignity, self-control and influence. These values, including communication skills, are collectively framed as "people skills" by Brown and Ferrill (2009).

- *Politeness*

Politeness, according to the Health and Care Professions Council (HCPC, 2014:16), is associated with good manners, courtesy, respect and consideration for others, and is viewed as compulsory professional behaviour for encounters with others (Ali & Sazalie, 2010:18). Participants from a specific academic hospital verbalised that undergraduate learner nurses were polite towards patients and were well-disciplined. *PNs* expected learner nurses to obey instructions and commands of senior PNs while they are in the clinical placement facilities. Nurses should have a professional attitude in they respect the seniority of others (Marcum, 2013:5). However,

situational factors, such as social status, familiarity or gender could influence people's politeness strategies (Reid, 2012:360). Some *learner nurses* experienced the communication and behaviour of professional staff as humiliating and unprofessional, especially when colleagues were confronted in front of others. *Learner nurses* felt that their dignity was harmed in such instances. It seemed that they stayed polite. Politeness could be understood in terms of conflict avoidance (Brown & Levinson, 1978, in Zhao, 2008:630).

❖ *Compassion*

Compassion is a value of a nurse`s character and it is stated in the NMC`s (2015) code of conduct, that nurses should treat people with kindness, respect and compassion (Brass, 2016:22). Across all the year levels, *learner nurses* experienced the need to be treated with *compassion and kindness.* Although *compassion* is about kindness, consideration, empathy, feeling and identification with 'the other' at times of vulnerability, pain and distress, it is context dependent (Tweddle, 2007, in Reid, 2012:18). From the *nurse educationalists*' perspective, the expectation was that learner nurses should always act in the best interest of the patient by building a trust relationship which promotes wellbeing in the patient. Compassion is about conveying a caring attitude (Brown & Ferrill, 2009:5). Nurse educationalists emphasised that learner nurses should care for patients by fulfilling their basic needs through being warm, compassionate and creating an atmosphere which puts patients at ease. Staff who appear friendly, warm, sociable, approachable and who engage with patients in a way that builds rapport are perceived, as 'good' practitioners (Van der Elst et al., 2011, in Reid 2012:18). A kind demeanour creates a welcoming atmosphere, which puts people at ease. *Kindness* could foster tolerance. According to the *learner nurses,* the professional staff should be tolerant to them by understanding their shortcomings and imperfections in the professional academic and clinical environments where they were placed. Compassion is relevant to all staff as it concerns human connection, respect for humanity, and treating another in a manner in which one could expect to be treated (Tweddle, 2007, in Reid, 2012:218).

❖ *Human dignity and respect*

Dignity is promoted when individuals are enabled to do the best within their capabilities, exercise (self-control, display self-confidence, demonstrate respect, make choices and feel involved in the decision-making that underpins their care (Parandeh, Khaghanizade, Mohammadi & Mokhtari-Nouri, 2016:1). Creating a respectful educational environment based on the facilitation of dignity and mutual respect could be an important factor in effective learning. The learning process should involve respectful interaction between academics and

students. The behaviour of an individual whose dignity has been preserved is polite (Parandeh et. al., 2016).

First-year learner nurses expected professional behaviour of staff in clinical placements and expected lecturers in the university to treat them with courtesy and respect. Respect for the inherent worth and uniqueness of a person is a virtue of human dignity (Francis & Dugger, 2014:131). Human dignity and respect shown in this way strengthens interactions with others (Shaw & Degazon, 2008:45; Brown & Ferrill, 2009:5; Parandeh et al., 2016:1).

In the NPE, *learner nurses* experienced that some professionals did not show human dignity but rather demonstrated intolerance (see point on tolerance later) towards their shortcomings and imperfections. In specific situations, especially when staff work under stressful conditions or are upset, human dignity was compromised. In cases where the learner nurses have been treated with disrespect, they displayed retaliation and reported that such disrespect and unprofessional behaviour shown to them were reasons for them wanting to leave the profession. On the other hand, *nurse educationalists* and *PNs* both noted instances during clinical supervision with learner nurses in the clinical practice environment when learner nurses did not show respect for the dignity of the patient. *Nurse educationalists* discovered that some learner nurses quickly copy unprofessional habits displayed by professional staff in specific patient care units or wards. It is of moral and human importance to protect people when they are weak and vulnerable; to strive towards recovery and healing; and to ensure the humanity of care (Goodrich & Cornwell, 2008:3). *Professional nurses* also expected learner nurses to be respectful and dignified in their communication and behaviour towards the patients by being *dependable and reliable* (personal reliability). Human dignity and respect should underlie all the interactions a nurse has with individuals such as students, patients and colleagues. In an academic setting, human dignity is bound by the recognition (on the part of the nursing educator) of the learning needs, strengths, deficits and goals of each individual student (Shaw & Degazon, 2008:45). Parandeh et al. (2016:1) assert that human dignity, as one of the most important professional values, has become part of ethical issues in the field of education and nursing practice. Professionalism could be threatened by behaviour that signals a lack of respect for others, called incivility. Incivility includes rudeness, intimidation, aggression, humiliation and uncooperative or passive aggressive behaviour (Brennan & Monson, 2014:647).

- ❖ *Approachability and tolerance within professional boundaries*

Being *approachable* is essential, as nursing professionals thereby foster an inviting culture in which learner nurses feel comfortable asking questions and/or seeking help when they are in the

clinical practice environment (Rouse & Al-Maqbali, 2014:7). The person who is approachable should be caring, warm, enthusiastic and accessible (Shibaev & Shibaeva, 2014:462). Approachability, in this study, refers to being accessible, open in communication and having patience or tolerance. *Tolerance,* according to the Declaration of UNESCO (1995), is respect, acceptance and appreciation of the rich diversity of our world's cultures, our forms of expression and ways of being human. It is fostered by knowledge, openness, communication, freedom of thought, conscience and belief.

Learner nurses described *approachability* as having a friendly attitude, and being accessible and open to interact with a patient. L*earner nurses* expressed the need to feel comfortable and at ease around the PNs in the clinical placement environment. They did not want to feel intimidated by an unfriendly, intolerant attitude. Intimidation is conveyed both verbally (with condescending language) and non-verbally (by showing intolerance through tone of voice or body language) (Brennan & Monson, 2014:647). The learner nurses experienced the academic staff (nurse educationalists) as skilled, as opposed to their experience of PNs as being unskilled. Some verbalised experiences of being treated unjustly, and that no understanding was shown for them being vulnerable learner nurses. On the other hand, *PNs* from the secondary hospital experienced that undergraduate learner nurses were reluctant to approach and ask for assistance in the clinical placement facilities. The PNs mentioned that the way in which they address the learner nurses could be deterring learner nurses to approach the PNs and be the reason why the learner nurses resist and ignore them in the facilities.

Professional boundaries make a distinction between what is acceptable and unacceptable in the nursing professional (including the nurse educationalist) in both the professional practice and academic environment (Doel, Allmark, Conway, Cowburn, Flynn, Nelson & Tod, 2009:2). *Learner nurses* acknowledged that PNs possessed the capability to interact within professional boundaries, because, in order to establish and sustain interpersonal relationships, PNs have to establish boundaries that limit the interaction between them and the learner nurse. The professional nurse should take responsibility for setting professional boundaries and having a professional relationship with learner nurses. The boundaries are created from ethical, legal and professional codes of practice (Bach & Grant, 2009:78, 80).

The use of technology in the learning environment led to mixed reactions by some *nurse educationalists*. Social media was often used for contact with lecturers or CS, but sometimes it was used irresponsibly when learner nurses and educationalists engaged on a personal level with each other on social network e.g. Facebook, creating familiarity. Nurses should become aware of

their professional vulnerability online and know that they should be mindful of the principles of professionalism (Osman, Wardle & Caesar, 2012).

Professional nurses mentioned that when learner nurses were made to feel welcome and part of the professional team, teamwork, collegiality and better work relationships in the ward were facilitated. One way to make learner nurses feel part of a team, is when they are acknowledged by PNs in the patient care wards and provided educational opportunities in some of the clinical facilities as a means of facilitating learning *(*Garman, Evans, Krause & Anfossi, 2006:220).

❖ *Self-control*

Behaviour frequently included on measures of professionalism are being on time (punctuality), honesty, good relationships with patients and colleagues, following ethical and legal standards and taking initiative or do what needs to be done (Hershberger, Zryd, Rodes & Stolfi, 2010:36). All of these actions require self-control. *Nurse educationalists* expected learner nurses to have control over their emotions and not allow their behaviour to deteriorate under certain conditions in which they find themselves in nursing practice. By demonstrating tolerance, the PNs could be in control of their emotions and could deal with the imperfections of others. When nurses have self-control, they convey a caring attitude. A caring attitude could be destabilised if the nurse does not show a stable affect (Brown & Ferrill, 2009:5). PNs are able to positively influence learner nurses in the clinical placement facilities when they display a stable affect or calmness and show that they are in control of their emotions, even when carrying out nursing care duties under a heavy workload. PNs need to convey a more caring attitude towards the learner nurses, even though the staff experiences heavy workloads and pressure in the wards (Watson, 2009:144-5).

❖ *Empathy*

Communication is shaped by inter alia listening, empathy and assertiveness (Bach & Grant, 2009:10). *Learner nurses* described their discontent in their ability to understand and follow reports on the continuation of patient care during handover of shifts. There is a need for NEs and CS to intervene and advocate for a platform for learner nurses (recipients) to voice their concerns and where they (learner nurses) could be listened to. High-quality healthcare is dependent upon empathic, effective communication (Moll, Frolic & Key, 2015:36).

Empathy is an effective communication tool which enhances the therapeutic effectiveness of the nurse-patient relationship. It is considered an ability and/or a mental capacity to feel and/or comprehend another person's emotional situation or state (Marcum, 2013:2). NEs were expected

to show empathy and demonstrate that they understand the socio-economic circumstances of learner nurses. These circumstances form part of the holistic needs of learner nurses, which impact on the health (professionalism) or academic performance of the learner nurse. It was also suggested that, at the same time, nurse educationalists should understand, care and have empathy for the "student" status of the learner nurse and be aware that professional behaviour (professionalism) will be internalised and developed over time within the learner nurse.

Professional nurses seemed to have a of lack empathy for the varied cultural backgrounds of learner nurses entering the clinical placement environment. Caring is the root of an empathetic response and underlies professionalism. Empathy therefore means caring about another person's suffering in an affective and mental way, with the ability to assess what is required to relieve it (Marcum, 2013:3). When PNs demonstrate empathy towards cultural differences, learner nurses could feel that they are understood in the clinical placement facilities for their differences. All nurses should therefore show empathy and be considerate towards the cultural and religious backgrounds of not only patients, but also their fellow colleagues, as it facilitates collegiality, effective interaction and better work relations in the hospital environment (Butts, 2013:85, 88).

❖ *Influence*

The ability of all nurses, including learner nurses, to provide best practice is influenced by the environment in which they work (Australian College of Nursing (ACN), 2015:8). The learning environment should be a positive environment in which learner nurses are inspired and motivated by the PNs to serve others. Nurse educationalists and PNs in practice have a responsibility to inspire positive work ethics in followers by conducting themselves appropriately in a professional manner and by being punctual. PNs should act as leaders who are able to guide learner nurses (recipients) to feel inspired and motivated and to carry out the right nursing tasks (Zhu, Sosik, Riggio & Yang, 2012: 207). The ACN (2015:8) states that nursing leadership influences the quality of nursing care by providing a commitment to safety and quality and through its impact on the work environment and workplace behaviours. *PNs* in this study realised that they have a commitment to positively influence behaviour in learner nurses. They experienced that learner nurses mimic what the PNs do in the clinical practice environment and described the importance of being nurse leaders who are role models and who have a caring attitude towards learner nurses. PNs who act self-confident in the delegation of nursing responsibilities could be able to influence learner nurses positively. PNs encouraged learner nurses to actively participate in the patient care wards. Peer or follower behaviour, however, is found to have more influence on team effectiveness than leader behaviour (Ter Halle, 2016:1).

6.2.1.2 *Professional (capabilities) competencies reflected in practice and class*

Professional capabilities are concerned with standards and sets of attributes: knowledge and skills, and values and attitudes in professional practice. Professional capabilities allow educationalists to ask critical questions about learning outcomes being encoded into competency frameworks, joining technical considerations of knowledge, competencies attitudes and learning experiences (Lee, Steketee, Rogers & Moran, 2013:70).

❖ *Knowledge and applied skill*

The knowledge and skills obtained during professional training is intended to assist the learner nurse to develop higher-order reasoning so that they are able to adjust their own behaviour as required for rendering ethically sound nursing care to the public. Learner nurses are expected to demonstrate critical judgement when bridging the gap between theory and practice, and applying their knowledge and practical skills in the clinical placement facilities. This is essential for developing wisdom as a value of their professional capabilities (D'Antonio, 2014). They should have the knowledge to conduct themselves professionally in the clinical learning environment. It was mentioned, for example, that learner nurses should be respectful in their communication with senior professional staff in the clinical placement settings. Furthermore, learner nurses should be competent in the basic clinical skills and be able to apply critical judgement and analytical thought with regards to patient care in the wards. *PNs* were aware that they should share their knowledge and skills in acting responsibly in the different learning environments with learner nurses. This should also be done to combat the negative view that the clinical learning environment is the most anxiety-provoking component of nursing education (Papastavrou, Dimitriadou, Tsangari & Andreou, 2016:2).

❖ *Proactivity (commitment to excellence)*

Excellence has been identified as a value that incorporates using current knowledge and theory in practice, integrating judgment and critical thinking, and understanding personal limitations (Aguilar et al., 2012:28). It was mentioned that learner nurses should take responsibility for their learning needs in the programme. A commitment to excellence is contained in the ability of nurses to be proactive, take initiative to do what needs to be done and strive towards quality patient care services (Grice, 2013). The findings indicated that *nurse educationalists and PNs* could be *proactive* and take initiative by applying their knowledge and skill to monitor and assess learner nurses, thereby facilitating professionalism. Together, nursing education and nursing practice are responsible for providing learner nurses the tools necessary to meet the complexities of healthcare and to demand the knowledge, skills and attitudes consistent with

professional practice (Mannino & Cotter, 2016:3). In the classroom, NEs teach the professional values as essential components of professional practice and expect learner nurses to turn the values inward and have personal integrity so that they can be trusted and counted on to do the right thing (personal reliability). This demonstrates a commitment to excellence on the part of the learner nurse who has a sense of responsibility to perform the necessary nursing care tasks and responsibilities. Excellence is therefore a professional value that demands all nurses to have the responsibility to integrate knowledge and skills apply judgement in performing nursing duties and have an understanding for the professional boundaries within which these duties take place (Aguilar et al., 2012:28).

❖ *Wisdom*

Wisdom is the capacity to apply knowledge and skill (professional skill) effectively through analytical thought, from the highest level of abstract reasoning to the most basic applications of common sense (Brown & Ferrill, 2009). Wisdom is a way to excellence, as shown in the integration of knowledge and character, mind and virtue (D'Antonio, 2014:105). It was found that nurse educationalists should be wise in their decision-making about interacting with learner nurses on social media networks. *NEs* should also use their discretion/wisdom (as part of their professional capabilities) when making decisions about granting exceptions to the rules or imposing discipline, but only after a careful analysis of the situation. D'Antonio (2014:105) states that values, such as truthfulness, respect for others, sincerity, fairness and the desire and ability to help others, are important components that provide balance to a wise person.

Nurse educationalists indicated that they constantly directed and guided learner nurses to provide nursing care to the public to the best of their ability (in both the professional academic or healthcare environment) by adhering to the ethical guidelines for nurses. Educating undergraduate nurses with the construct of wisdom is believed to be an answer to meeting the difficulties inherent in creating a nursing curriculum that meets the demands of the 21st century nursing practice, as stated by D'Antonio (2014:105). Learner nurses were expected to apply *critical judgement (wisdom)* and consciously think about the consequences of their actions and behaviour. There were isolated instances in which *CS* experienced that the learner nurse acted without thinking about consequences. Wisdom, a goal of intellectual development, is attained when an individual operates from a solid and sound knowledge-base, uses effective critical thinking skills and displays a sense of duty and altruism to mankind. The professional nurse knows how to apply these values in the professional domain (Halldorsdottir & Karlsdottir, 2011:810). Professional ethical behaviour requires wisdom, acquired by means of the nurses'

formal training based on human existence and the meaning of life, written and prescribed in the code of ethics for nurses (SANC, 2013).

6.2.1.3 *Characteristics of personal reliability in professionalism*

Personal reliability embraces integrity (honesty and truth), humility, responsibility, altruism (service) and moral courage (Grice et al., 2013:9; Brown & Ferrill, 2009:6). The findings of this study emphasised the importance *nurse educationalists* attached to the value of personal reliability. All nurses have to achieve goals that build their character in being honest, fair to all, and making relevant ethical decisions, while distinguishing between right and wrong both the academic and NPE. According to Grice et al. (2013) and Brown and Ferril (2009), personal reliability includes being responsible and holding oneself accountable when things do not go as planned. Personal reliability is present in a person's character. A person of character is able to function and carry out duties and responsibilities from a base of morality and ethics, which requires a sense of right and wrong, and is based on professional standards and moral truth (Brown & Ferrill, 2009).

- *Adherence to professional ethics and guidelines*

Professional ethics is described by Muller (2009:60) as the "agreed upon standards and behaviours expected from members of the nursing profession and as described in a code of professional conduct". The findings of this study revealed a commitment to the ethical-legal framework in terms of the professional standards and the code of ethics for nurses. *Learner nurses* summed up their expectations of professional behaviour by verbalising that nurses who have undergone professional education and training, adhered to the nursing standards and behaviour, honoured the code of conduct for nurses and applied what they have learned. They described their expectations of working in a professional environment within the limitations of the regulatory framework for nurses that takes into account commitment to the scope of practice for nurses, and the ethical principle of confidentiality as well as patient rights. What also became evident from this study was that first-year learner nurses were exposed and sensitized to their professional role and behaviour as nurses right from the start by learning about the ethical-legal framework, which includes the professional standards and code of ethics for nurses. During contact with the learner nurse, whether in the professional academic or healthcare environment, *nurse educationalists* constantly directed and guided learner nurses to provide nursing care to the public to the best of their ability by adhering to the ethical guidelines for nurses. Professional ethical behaviour is acquired through the nurses' formal training, based on human existence and the meaning of life and the code of ethics for nurses (SANC, 2013).

Professional nurses described the lack of responsibility of undergraduate learner nurses towards the patient, employer and other members of the nursing staff. Professional nurses experienced that the learner nurses' motivation and attitude affected behaviour and non-adherence to rules (e.g. concerning punctuality). In another isolated incidence, a professional nurse described a negative experience in which learner nurses were dishonest by forging her signature. Professional ethics is one of the most important features of the nursing profession as it is based on personal morality, the foundation of the trust the patient and community have in nursing (Searle et al., 2009:265).

- *Trust*

Trust is an important element in establishing an effective nurse-patient relationship (Wloszczak-Szubzda & Jarosz, 2013:186). *Learner nurses* mentioned that PNs did not allow them to practice skills appropriate to their year level objectives. They therefore did not feel trusted by the PNs to perform higher level skills that matched their learning outcomes. *Learner nurses and PNs* at the different healthcare facilities in this study made the observation that learner nurses did not have work ethic. *Nurse educationalists* also raised their concerns about learner nurses who were habitual latecomers in the classroom. Adherence to rules concerning punctuality and cell phone etiquette in practice was seen to be important for instilling *trust* in the patient and showing reliability and demonstrating that one could depend upon them. *PNs* in the clinical practice environment also mentioned that learner nurses should obey the rules of the profession by being committed to render a reliable and trustworthy patient care service. *PNs* described the challenges they experienced in speciality areas, such as theatre, where they felt that they could not depend on the learner nurses because they were irresponsible and left the area without reporting to the person in charge. They explained that learner nurses, who were assigned tasks and responsibilities in theatre during their clinical placement, were withdrawn from that specific unit for clinical skills training in another ward or patient care unit. The nurses' loyalty to the patient and others is important (Butts, 2013:84).

- *Integrity and honesty*

Integrity and honesty are characteristics of personal reliability which the learner nurse should possess in order to be trustworthy and build trusting relationships with patients and colleagues in the NPE. *Integrity* refers to nurses acting consistently in accordance with an appropriate code of ethics and accepted standards of practice (AACN, 2008; Shaw & Degazon, 2008). *Honesty* relates to the nurse's duty to act in a truthful manner in their interaction with others (how they communicate and conduct themselves in the professional practice environment) (Project

Management Institute, 2016). *Learner nurses* expected PNs to show humility (personal reliability) towards them when they made mistakes by giving them honest feedback, as it was important for building trust relationships with patients and other colleagues. *PNs* expected learner nurses to be honest in their ethical and professional conduct and not engage in unlawful practices such as forging signatures. The learner nurse's academic performance is dependent on ethical and professional conduct and where there is evidence of such unprofessional behaviour, disciplinary action should be imposed. In such instances, educators should implement policy and procedures to address the violation of the professional code of conduct (Killam, Mossey, Montgomery & Timmermans, 2013, in Anselmi, Smith Glasgow & Gambecia, 2014:482). Furthermore, all PNs, NEs and CS are responsible for guiding learner nurses in the correct application of their *professional capability* (according to their scope of practice). They should also be honest when assessing learner nurses, as a lack of adherence to the professional standards in nursing might directly compromise patient safety (Anselmi et al., 2013:482).

❖ *Humility*

Humility is an important value of selflessness, which is achieved when the interest of others are put ahead of self-interest, while remaining humble despite own success (Aguilar, Stupans, Scutter & King, 2012:211). *Professional nurses* described incidences where learner nurses acted in their own interest when they disobeyed instructions to attend to basic nursing responsibilities. PNs described that learner nurses attended clinical practice only to complete their practical skills so that their clinical books could be signed by the professional nurse. They expected learner nurses to have a passion or desire to do nursing and not only to do it for financial gain. Humility is secondly shown in making the patient feel worthy of the nursing care service rendered. Senior learner nurses should also not think that basic nursing care needs (such as offering a bedpan) is beneath them. Humility is reflected in having a humble attitude (Brown & Ferril, 2009:6). PNs demonstrate humbleness to learner nurses when they show them that they are worthy of their time, especially when the wards are busy and there is no time for creating learning opportunities for learner nurses in the patient care wards. PNs could show humbleness in apologising to the learner nurse for not being able to immediately fulfil the educational needs of the learner nurse. In so doing, the professional nurse in practice demonstrates a characteristic of personal reliability in assisting learner nurses with their educational learning needs and applying their *theoretical knowledge and clinical skills* (professional capability). One of the criteria forming the framework of professionalism for nursing in southern Africa is the existence of a body of specialised knowledge and skill that could be used to be competent RNs (Searle et al., 2009:8).

❖ *Responsibility and a commitment to excellence*

Having a sense of responsibility provides the motivation to perform tasks while being committed to excellence (Shaw & Degazon, 2008:45; Jooste, 2017). Learner nurses expressed the importance of recognising and being aware of the specific learning environment they find themselves in. This awareness enabled learner nurses to identify with a specific role – whether it is being a student in the academic environment or a learner nurse in the clinical practice environment – when expected to do so and then to take responsibility and be accountable for their actions in assuming a specific role. PNs expected learner nurses to demonstrate their responsibility towards the employer, the patient and their colleagues in clinical practice. Responsible learner nurses will not make excuses for their late-coming on duty due to financial circumstances or transport issues. Instead, they will be able to find the means of overcoming such issues preventing them from not being there for the patient. In the clinical wards, these learner nurses are responsible for integrating theory with their clinical skills in the practice environments without compromising the safety of the patient. The findings indicated that PNs and learner nurses should be responsible and accountable for their actions and omissions concerning the care needs of patients and should not blame others when things go wrong. Learner nurses could also take responsibility for their own learning when they are in the clinical wards by showing that they are interested to learn (e.g. by asking questions). PNs are able to guide and direct learner nurses in the clinical placement facilities by orientating new learner nurses to the wards. Nurse educationalists and PNs could take responsibility for setting professional boundaries and having a professional relationship/interaction with learner nurses by being responsible users of technology in the clinical practice environment. Responsibility ensures that attention is given to what needs to be done and also ensures that people operate from a sense of duty without being told what to do. Responsibility leads to accountability (Brown & Ferrill, 2009:6).

❖ *Altruism (service)*

Altruism (service) refers to nurses who have a concern for the welfare and wellbeing of others. Altruism is the expression of selfless concern for others when there is no obvious reward except the belief that someone else will benefit from one's concern or actions (Shaw & Degazon, 2008:45). Some *learner nurses,* on entering the profession, indicated their personal reliability by having the desire to become a nurse who is committed and professionally capable to deliver a service to mankind (personal reliability). Learner nurses could be service-minded and have a desire to be altruistic. These are important aspects of personal reliability when demonstrating that they are there for the needs of the patients and others and by doing more than is required of

them (Grice, 2013:9). Learner nurses should be able to develop an attitude of being service-orientated when they are attending to patients in the placement facilities instead of being concerned about their personal needs (selflessness) (i.e. having their books signed, concern over having a job or using cell phones for personal matters). They should be dedicated to the interest of patients and others, and put someone else's interest ahead of their own when they feel tired, overworked, threatened, vulnerable or under pressure (Brody & Doukas, 2014:983).

❖ *Courage*

The most important attribute in striving for quality nursing care is courage. All nurses should have the courage to present the truth, i.e. revealing that something is wrong and suggesting how it could be fixed (Dunbar-Jacob, 2016:9). *Learner nurses* summed up their expectations of professional behaviour by verbalising that if nurses, who have undergone professional education and training, adhered to the nursing standards and behaviours, honoured the code of conduct for nurses and applied what they have learned, it could ensure that nurses remained professional, made moral judgments and showed courage. These participants realised how important doing the right things while in clinical practice were by committing to the ethical framework of the profession. Right from the start, first-year learner nurses were exposed and sensitized to their professional role as nurses by learning about the ethical-legal framework of nursing, which included the concept of the courage to comply to the professional standards and code of ethics for nurses. Nurses should find the courage to question actions and take action to build a just society. Therefore, courage means that one should stand up for what one believes is right. Brown and Ferrill (2009:6) are of the opinion that distinguishing between right and wrong demonstrates courage to act according to certain work conditions.

The *learner nurses* expected clear standards and the display of the vision and ethical guidelines at the respective healthcare facilities, thereby encouraging the value of courage. While in the placement facilities, learner nurses observed that the vision and ethics for that particular facility was not visible and therefore not known to the staff. Courage provides the framework for remaining true to personal values, yet open to different opinions on ethical principles. The public and healthcare team members expect nurses to encompass the values of knowledge, skill, honesty, altruism and courage (O'Brien, 2016:69).

6.2.2 Interpersonal communication style of nurses with all stakeholders in the external environment

Interpersonal communication style is defined as how we interact with others. A person`s style and behaviour is impacted by their personalities, their values and the environment they live and

work in, and the styles of those they interact with (Foster & Stadler, 2013:2). In the clinical practice environment, interpersonal communication style has a direct effect on how learner nurses perceive the quality of communication they receive from PNs and nurse educationalists. It is important that the learner nurses understand the communication style of professional nurse practitioners, especially when professionalism and communication are taught to them (Lifchez & Redett, 2014:297). *Learner nurses* across the four years in the undergraduate programme verbalised their discontent with the communication style of seniors. They stated feeling demoralised, insulted and humiliated by nurse educationalists and professional staff, often resulting in them leaving the undergraduate nursing programme. There was an expectation among *PNs* that colleagues must treat learner nurses well by being friendly and more caring towards the learner nurses and making them feel welcome in the wards. A study by Leape et al. (2012:2) state that 31% of nurses reported that they know of a nurse who left the profession because of insulting, demeaning communication styles. They felt that the PNs harmed their character (personal reliability) and the professional relationships between patient and nurse by reprimanding them in front of patients and other staff. One of the most important factors in creating an effective educational (learning) environment is PNs' provision of friendly, appropriate feedback at an appropriate time in a private place (Esmaeli, Cheraghi, Salsali & Ghiyasvandian, 2013:6). Professional nurses should be aware of their communication style when they interact with learner nurses. In order to communicate effectively with others, PNs should apply a more accommodating style of communication that demonstrates warmth and sincerity and provide a non-threatening environment for learner nurses (Foster & Stadler, 2013:2).

Gossiping was described as occurrences which happened often and which caused *learner nurses* to suffer emotionally and psychologically. First-year learner nurses, in particular, described how they experienced emotional and psychological abuse every time PNs exposed their mistakes in front of other staff members. Gossiping about the mistakes of the learner nurses was perceived as not being honest or upfront. It made learner nurses feel humiliated, bullied (also see 6.2.2) and victimised in the clinical placement environment and created mistrust in patients about the learner nurse. Employees who feel victimised in their work environment may find it difficult to trust others (Ellwart, Labianca & Wittek, 2011). Negative gossip in the workplace can also cause consequences similar to victimisation such as limiting work-related success and preventing a sense of belonging (Ellwardt et al., 2011:2).

6.2.2.1 *Displaying verbal and non-verbal communication skills*

Effective communication skills not only contribute to building relationships and reaching goals reflecting cultural beliefs and behaviour (Jooste, 2017:19), but they also improve dignity and

respect in healthcare organisations and institutions (Rouse & Al-Maqbali, 2014:2). Verbal communication includes forms of dominant language, contextual use of language and paralanguage. On the other hand, non-verbal communication includes eye contact, facial expressions, body language and clock versus social time.

In the healthcare environment, nurses interact with a diverse group of people from different backgrounds. Undergraduate learner nurses are the future of the nursing profession, therefore it is important to address the impact of language barriers on healthcare inequalities in the undergraduate nursing curriculum (Houle, 2010). Referring to South Africa as a diverse country with different languages, *learner nurses* said that language was a barrier to communication in the clinical placement facilities and could be an obstacle in their professional development during their undergraduate training programme. This is consistent with a finding by Houle (2010) where a majority of nurses reported that language barriers are a significant impediment to quality care and a source of stress in the workplace. Incomplete nursing assessments, misunderstood medical information, and the lack of therapeutic relationships between providers and patients are problems encountered when there is limited English proficiency among role players (Butts, 2013:93; Houle, 2010). In this study, participants reported on the use of Afrikaans as the language of choice in healthcare facilities in the Western Cape Metropole. *Learner nurses* mentioned that PNs should acknowledge the diversity in language and become more receptive and trusting towards the learner nurses. They verbalised that PNs communicated the patient's treatment plan in a language universal to all healthcare professionals involved with the patient. First-year participants described that PNs should convey body language that is congruent with their verbal communication because they are sending out a professional message by using themselves as channels of communication. The manner in which PNs connected with the learner nurses did not show that they cared about the learner nurses. The learner nurses explained that they will become more receptive to the messages of the PNs if they can sense true caring in the body language of the professional nurse. These forms of non-verbal communication vary among cultures and should be considered an important aspect in the undergraduate nursing programme, since learner nurses from diverse backgrounds interact with peers, nurse educationalists, PNs and patients from diverse languages and cultures (Douglas, Pierce, Roesenkoetter, Pacquiao, Callister, Hatter-Pollara, Lauderdale, Milstead, Nardi & Purnell, 2011:93). *Nurse educationalists* observed students to be loud in the classroom. This is a form of verbal communication that includes paralanguage variations such as voice tone and volume (Douglas et al., 2011:330). *Professional nurses* did not find language barriers to be a challenge.

6.2.2.2 *Assertiveness (interpersonal compatibility)*

Assertiveness is a communication skill all nurses must possess because it allows them to bring their point of view across without being aggressive. Demonstrating respectful interpersonal compatibility, e.g. through effective communication and good relationships among professionals, contributes to quality patient care and positive service provider outcomes (Norgaard et al., 2012:2). *Learner nurses* experienced PNs in the clinical facilities as not being approachable and open to communication. Not being approachable made learner nurses feel reluctant to partake, less confident and not assertive enough to approach the sisters in the wards with their learning needs and to ask questions. Approachable and affirming behaviours are essential interpersonal skills needed by PNs (Rouse & Al-Maqbali, 2014:7).

Nurse educationalists mentioned the need for learner nurses to have good communication skills and emphasised that assertiveness and being advocates for their patients were important focus areas of learner nurses' professional development of communication. Professional nurses as secondary agents should thus guide learner nurses in their professional development by acting assertive in addressing issues pertaining to e.g. the code of conduct for nurses, work ethic (punctuality and the use of cell phones in the workplace environment). This will require PNs to provide learner nurses with educational opportunities that instil assertiveness, such as delegating nursing responsibilities to learner nurses during their clinical placements in the healthcare facilities. PNs should at all times maintain a non-threatening learning atmosphere by encouraging learner nurses to ask questions in the ward. When the learner nurse asks questions, PNs should display a positive attitude and not humiliate the learner nurse (Muller, 2009:334).

Learner nurses also experienced a lack of confidence especially when they were expected to communicate their learning needs to the PNs. *Learner nurses*, however, mentioned that they were often shouted at and humiliated in front of others when they made a mistake, which made them less confident to perform patient care duties. The experiences of *nurse educationalists* were, however, that sometimes when professional ward staff experienced pressure, learner nurses showed unprofessional behaviour by being rude to vulnerable patients who were in pain and disorientated. On the other hand, *learner nurses* mentioned suffering emotional abuse by being bullied throughout their four-year training by the professional staff (bullying is also mentioned under 6.2.2) in the workplace environment. Workplace bullying can be regarded as recurrent interpersonal interaction that comprises intimidation, aggression, victimisation, emotional abuse and psychological mistreatment (Jamieson, Mitchell & Le Fevre, 2015:464). Living with bullying resulted in learner nurses developing submissive behaviour instead of being assertive (interpersonal compatibility). The *learner nurses* described that the disrespectful treatment

towards them by the professional staff in the clinical facilities resulted in them losing confidence to communicate openly. Improved assertive communication creates a more respectful workplace culture and decreases the frequency of nurse-nurse violence (Stagg, Sheridan, Jones, & Speroni, 2013, in Rouse & Al-Maqbali, 2014:9).

6.2.2.3 *Total image, professional dress code and demeanour reflected in practice and classroom*

Professional nurses are members of a professional discipline with a social mandate to uphold high-quality professional care standards with regard to the image, dress code, appearance and conduct of the nurse, as well as the delivery of nursing care services (Porr, Dawe, Lewis, Meadus, Snow & Didham, 2013:6). In this study, *nurse educationalists* (NEs and CS) expected undergraduate learner nurses to display professionalism in the classroom as well as at the clinical practice facility. The participants expected that elements of professionalism should be evident in how the learner nurses dress, communicate with others, and behave among their peers and in front of their seniors in class. Professionalism is primarily conveyed by the professional nurse's appearance, which remains a powerful symbol of professional identity (especially during the first encounters with patients) but also encompasses nurse character attributes, behaviours and adherence to a professional code of ethical conduct (Porr et al., 2013:2).

Learner nurses, nurse educationalists and PNs described their experiences of the total image of the nursing profession. The descriptions were made in relation to professional dress code and demeanour, which directs to appearance, total image, conduct, behaviour and character. It seemed that participants associated the correct dress code with a positive professional image. They considered the outer appearance and image to be important, because it matters how the patient sees the nurse in a healthcare practice environment (Porr et al., 2013). The nurse's uniform portrays and gives the impression of professional identity to the new learner nurses (Alino et al., 2012:25). *Professional nurses* in some clinical placement facilities also placed great value on appearance. It was regarded as inappropriate for male nurses to wear earrings during clinical learning in the practice environment, leaving the impression that the nurse is careless. When nurses are careless about how they dress, it seems as if they have no self-respect, that they devalue appearance or that they do not care about the impact of their appearance on the professional image of the organisation (Pagana, 2009:38).

Nurse educationalists associated dress code with neatness and belonging and were concerned about learner nurses who did not regard wearing the proper dress code as important. Learner nurses need to be directed to conform to wearing the nurses' uniform and should adhere to a

clear policy regarding hair and proper dress codes (Alino et al., 2012:25). *Nurse educationalists* also described that wearing a uniform with proper identification instilled trust (personal reliability) and confidence in the minds of the public and contributed to the wellbeing of the patient. It is a responsibility of the nurse to have an appearance that builds trust (personal reliability) in the public eye (Cardillo, 2009:30). The patient is able to assess the PN's professional identity, attitude, mood and character attributes such as level of trustworthiness, based on the professional nurse's outward appearance and non-verbal cues (Porr et al., 2013:6). The patient feels relaxed and safe when they can easily identify who is taking care of them.

Nurse Educators mentioned the link between professional behaviour in class and the behaviour observed in the clinical placement. The focus here was on whether the learner nurses from the HEI, could be easily identified when they were followed up by the nurse educationalists in the clinical placement facilities. Learner nurses could be positively identified by nurse educationalists who visit learner nurses for clinical supervision in the clinical placement facilities when they are wearing epaulettes and name tags when performing nursing duties (Mukumbang & Adejumo, 2014:5). Wearing distinguishing devices as a means of identification was an expectation raised by PNs in the practice environment where the learner nurses were placed for clinical learning (Lehna et al., 2009:198). One's appearance, and specifically how one is dressed, is a major non-verbal cue that assists patients to discern the approachability of those who provide a healthcare service to them (Porr et al., 2013:2).

6.2.3 Realisation of essential role modelling in different settings

Being a role model is setting a positive example and portraying a person whose attitudes and values are assimilated by learners (Felstead, 2013:223). *Learner nurses* described professionalism and said that it should start with the nurse leaders and that they should be role models for the profession. The learner nurses in this study stated that it was important for them coming into the profession to see examples of role models who are committed to how they look. PNs who role model a professional image, inspire and motivate the learner nurses to perform nursing duties (Alino et al., 2012:16). In both the academic and clinical environments, *nurse educationalists* described instances in which learner nurses did not behave professionally. Their behaviour on campus was seen as rowdy and by partaking in strike action, they were regarded as unprofessional. Irresponsible behaviour was also experienced in cases where learner nurses did not take responsibility for their own learning by being curious and asking questions. However, learner nurses actively participate in the learning process and are able to make positive behavioural adjustments when they have the necessary preparedness and a critical-analytical attitude (Muller, 2009:335). Learner nurses were also regarded as unprofessional when they

neglected their academic and clinical duties. The professional behaviour role modelled in the classroom lays the foundation for attitudes and behaviour that learner nurses may adopt in stressful clinical settings (Baldwin, Mills, Birks & Budden, 2013:3). *PNs* at selected clinical placement facilities also generalised that the undergraduate learner nurses from the HEI where the study was conducted, displayed a lack of professional behaviour.

6.2.3.1 *Orientation to clinical placement environments*

Student orientation to clinical placement is an essential component for creating a successful learning environment for learner nurses (Dimitriadou, Papastavrou, Efstathiou & Theodorou, 2015:2). *Learner nurses* felt that PNs did not equip them with the necessary information to adjust to a new working environment. Learner nurses described feeling lost in a new work environment due to the poor organisational structure in the absence of an orientation programme to make them knowledgeable about the expectations in a new ward. They experienced abandonment as the PNs don't have time to support them to make positive adjustments in the clinical learning environment. *Professional nurses* acknowledged that e.g. workload and pressures prevented them from making time to guide and orientate the learner nurses as newcomers to the wards. They acknowledged the importance of having a stable affect even though they suffer emotional stress and experience pressure in the wards. A calm demeanour revolves around the ability of the professional nurse to handle stressful situations in the clinical wards (Ennis, Happell & Reid-Searl, 2015:59). The shortage of nursing staff contributes to greater workloads, which increases the risk of malpractice and the likelihood of error, especially for the learner nurse who is a new-comer to the ward, left without guidance and supervision in the clinical placement environment (Jooste, 201:61).

It is important to have an orientation programme for new students to ease their transition from university to the clinical practice environment, to facilitate the integration of theory and practice and to enhance knowledge and skills of the undergraduate student (Charleston, Hayman-White, Ryan & Happell, 2007, in Hooper, Browne & O'Brien, 2016).

6.2.3.2 *Conduct and commitment to patient care*

Commitment refers to a combination of attitudes that reflect one`s dedication to a role (Cloete & Jeggels, 2014:2). In this study, commitment refers to the attitudes that PNs and learner nurses reflect with regard to patient care.

Learner nurses described instances where PNs neglected their duties in the wards and showed that they were not committed to the care needs of the patients. They also recalled instances in

which PNs were unprofessional by engaging in social media while on duty and condoning unprofessional behaviour of other staff members. *Professional nurses* working in the patient care wards where the learner nurses were placed experienced the same attitude in undergraduate learner nurses who were not committed to patient care, and who did not obey and adhere to the rules and protocols of the wards. Participants mentioned that learner nurses had a careless attitude by not demonstrating that they have the patients' best interest at heart, e.g. by using cell phones when they were supposed to care for the patient. The findings, however, indicated a more laissez-fair attitude of PNs who allowed subordinates to decide for themselves what to do in the patient care wards. Muller (2009:158) describes a laissez-faire leadership style as giving followers the freedom of choice to do what needs to be done with resultant empowerment of the followers to function independently.

6.2.3.3 *Conforming and adapting to unethical and unprofessional behaviour*

Learner nurses may constantly find themselves torn between the demands of their educators to implement or apply what they have learned in theory and pressure from practising nurses to conform to the constraints of real life clinical situations (Ahtisham & Jacoline, 2015:443). *Learner nurses* expressed the importance of recognising and being aware of the specific learning environment they find themselves in, being able to identify which professional role to play and then taking responsibility and being accountable for their actions. They also described how easy it was to conform to the examples of unprofessional behaviour and misconduct in the clinical placement environment. Learner nurses furthermore said that when they found themselves in the clinical environment, they tried to resist being influenced by the negative behaviour of the professional staff. This brought them to the realisation that they should be (self) leaders by taking initiative and becoming responsible for their own learning instead of just following the (poor) examples of others in the hospital environment. This realisation not to conform but to rather be self-leaders is an important development of the self-management approach that refers to the process of influencing oneself. It considers behaviour-focused strategies, controlling and self-regulatory components and self-motivation aspects whereby one's thoughts and behaviour are aligned with the achievement of set goals (Furtner, Sachse & Exenberger, 2012:295). The learner nurses were focused on self-direction. They described the importance of being guided by the practice standards of nursing because it guides and directs their professional conduct in nursing practice. In the same way, *PNs* realised that they have a commitment to influence learner nurses in order to effect positive change. Students are influenced by differing practices and behaviours during their training, which might be a problem when reinforcement of the negative behaviour

influences the adoption of certain undesired behaviour in similar practice situations (Felstead, 2013:223).

- ❖ *Clinical supervisors', nurse educators' and professional nurses' experiences of unprofessional behaviour*

Professional behaviour is assumed to be reflective of the underlying cognitive, attitudinal, personality and characteristic dimensions of professionalism (Goldie, 2016:953). Feelings of disappointment were experienced by especially first-year *learner nurses* who verbalised that nurse educationalists acted unprofessionally by demoralising them, breaking down their character and affecting the professional relationships between the learner nurse and the patient. They described how they felt mistrusted by the patients when the nurse educationalists humiliated them in front of the patient for their wrongdoings. *Professional nurses* had a role in enhancing or strengthening the professional behaviour of learner nurses by demonstrating professional behaviour in their attitude, behaviour and commitments. The characteristics of a role model could refer to approachability, and the ability to instil confidence, create a relaxed atmosphere, be available when needed, act as a student advocate, tolerate student' mistakes, show confidence in student abilities and respect student opinions (Baldwin et al., 2013:3). Providing timely, honest and positive feedback to students are professional traits of good nurse academics' role modelling behaviour that facilitate the growth of the students' professional identity (Baldwin et al., 2013:3).

6.2.4 Support mechanisms to promote professionalism in learner nurses

Effective support mechanisms are essential to enable student nurses to cope with their role as learners (Jack & Wibberley, 2013:7). Undergraduate *learner nurses, nurse educationalists and PNs* described how the learner nurses could be supported by the NEs, CS and PNs to develop professionalism in the nursing practice.

6.2.4.1 *Gaining appropriate clinical competence in practice*

Competence is defined as the ability to do something well, the quality or state of being competent (Mazurek Melnyk, Gallaghner-Ford & Fineout-Overholt, 2014:7). Competencies are a mechanism that support professionals in providing high-quality, safe patient care. *Learner nurses* verbalised that they were not given adequate learning opportunities to practice their clinical skills according to the particular year level outcomes. From their perspective, using opportunities in the clinical practice environment allowed them to gain confidence and ensured that they were skilled at the end of their professional training. They related clinical competence in practice by linking professionalism with knowledge and research. For some *learner nurses*,

competence related to the culture of nursing within its framework of respect for mankind, and adhering to the code of ethics and code of conduct. Feelings of fear of not being ready and competent at the end of their professional training were specifically expressed by fourth-year learner nurses. Evidence from a study by Weinman et al. (2008) shows that anxiety and fear for others delay personal growth.

*Nurse educationalist*s described that the learner nurses did well academically, but lacked the necessary confidence in the practice environment, e.g. being able to communicate effectively with patients. Interpersonal skills were seen by nurse educationalists as an important element of competency in the professional training of learner nurses. This was consistent with another study that emphasised the importance of the interpersonal skills of nurses (Calman, 2006). *Nurse educators and clinical supervisors* did not agree on what they regarded as competence and what was expected from the learner nurse. There was a perception from CS that more attention was given to theoretical competence. Smith (2012) states that differences in opinion about what nursing competence is, could compromise and have implications for the assessment of learner nurses.

Professional nurses referred to clinical competence as the knowledge and clinical skills expected to have been accomplished by learner nurses at their particular year level in the undergraduate nursing programme. An interesting observation was made by the participants who perceived learner nurses as more theory-orientated than non-degree learner nurses. This could be interpreted that university learner nurses take up early managerial and leadership roles during their professional training by being more critical and analytical, as described in the response above. Competencies are regarded as functional adequacy and the capacity to integrate knowledge and skills with attitudes and values into the specific contexts of nursing practice (Meretoja & Koponen, 2011:414).

6.2.4.2 *Improving organisational structures*

Learning in practice is reliant on good partnerships with academic institutions and healthcare organisations to ensure that dialogue about what contributes to learning in practice is occurring at all leadership levels (Henderson et al., 2011:9). Participants suggested that there should be a clear structure and professional guidelines that direct the learner nurses' professional conduct in practice. Improving the organisational structure to enhance professionalism in the undergraduate learner nurses is described under the sub-categories: i) increasing human resources, learning resources, space and time and fair workload; ii) malpractice: challenges with organisational

structure (human and learning resources, space and time; iii) monitoring and evaluation programme; and iv) student selections for motivated and committed students and practitioners.

a. Increasing human resources, learning resources, space, time and fair workload

Being given the necessary time to access advice and support could assist learner nurses with e.g. coping emotionally during the undergraduate programme (Jack & Wibberley, 2013:7). From the experiences described by the *learner nurses*, it became clear that undergraduate learner nurses needed to be assisted to develop and mature professionally. They described the need for support structures to be put in place. Learner nurses verbalised that they experienced personal challenges as well as emotional trauma while they were in the clinical practice environment. They expressed that a councillor who understands the unique emotional and academic challenges at individual level in the academic undergraduate nursing programme should be available for and accessible to learner nurses at the HEI. Learner nurses also verbalised that they sometimes needed a mentor with whom they could discuss personal issues. *Nurse educationalists* confirmed and understood the real challenges which learner nurses faced. It is essential that NEs recognise these challenges and ensure that attention is given in the curriculum to emotional work. Continued monitoring of the emotional as well as the physical learning environment is necessary to ensure that the needs of learner nurses are met (Jack & Wibberley, 2013:7; Henderson, Cook, Creedy & Walker, 2012). In this study, *nurse educationalists* realised that they should be proactive (commitment to excellence) and that the grievances of the learner nurses should be listened to. In this way they could facilitate the desired professional outcomes in the learner nurses. Similarly, *PNs* agreed that nurses have the right to voice their grievances, concerns and needs in a safe environment (context). Such a platform will also provide them with the emotional support and give them an opportunity to communicate the challenges they face in the clinical practice facilities. *PNs* felt that more exposure to the clinical practice environment would improve the integration of the learner nurses' theoretical knowledge and clinical practice skills (professional capability). Learner nurses could become more proficient (capable) in the professional practice by getting more exposure to or experience in the clinical practice environment (Min & Kim, 2013:261). The above findings from this study was consistent with another study where students expressed the need to improve opportunities for learning and increase the time in which to complete procedures in the clinical learning environment (Lawal, Weaver, Bryan & Lindo, 2015:36). The lack of time for opportunities to develop competencies could adversely affect the learner nurse's learning and ultimately the care rendered to patients (Lawal et al., 2015).

- *Malpractice: Challenges with organisational structure (human and learning resources, space and time)*

Malpractice refers to the behaviour of a professional person's wrongful conduct, improper execution of professional duties, or failure to meet the standards of acceptable care, all of which might result in harm to a patient. In other words, it refers to acts of negligence or incompetence on the part of the professional (Brock, Nicholson & Hooker, 2016:3). All nursing professionals, regardless of whether they are learner nurses or PNs, have a duty to care for the patient, and if his or her violation of duty caused injuries or death, the nurse may be held liable. Non-adherence to appropriate standards of care; lack of delegation of routine work responsibilities, not following policies and procedures and the misuse of equipment are some of the topics that have prompted malpractice lawsuits against nurses (Huang, Sun & Lien, 2015: 23). In this study, participants have experienced challenges in the academic and clinical learning environment that may lead to cases of malpractice and that may influence the education and learning of learner nurses. These challenges will be discussed under i) human resources; and ii) learning resources (simulation), space and time. Huang et al. (2015:23) agree that malpractice is the negligent conduct of a professional and state that it is defined by duty as established by a professional relationship; breach of duty which concerns acts of commission or omission in violation of nursing care; a physical injury and causation whereby the nurse's breach of duty caused the plaintiff's injury.

Human resources

Health care institutions have a problem with shortage of staff due to cost containment and high staff turnover, causing nurses to experience significant workload increase (Chen & Lou, 2014:434). *Learner nurses* described how hospital staff took shortcuts to get through the workload of the day. These experiences created emotional stress such as tension and feelings of frustration within the learner nurses as they were unable to apply the theoretical knowledge learned in the academic environment in the clinical practice environment. A sense of helplessness and rejection were also experienced by the hospital staff when these learner nurses become a burden in their execution of their daily tasks (Chen & Lou, 2014:434). Workload relief by means of increasing human resources and adequate learning resources could support learner nurses in the application of theoretical knowledge in the practice environment.

Learning resources (simulation), space and time

Undergraduate nursing students experience challenges with learning in clinical settings in which resources are poor or inadequate for their learning needs (Msiska, Smith, Fawcett &

Munkhondya, 2013:41). Simulation is a flexible teaching method that can be adapted to both the programme requirements and students' learning needs (Wall, Andrus & Morrison, 2014:127). *Learner nurses* explained the difficulty they experienced with simulating a real life situation and still expected to be skilled in the clinical practice environment. They described facing negligent patient care, which could sometimes occur due to a lack of proper teaching tools and equipment. Learner nurses should be able to transfer classroom learning to the clinical practice environment (Wall et al., 2014:128).

Monitoring and evaluation program

Nursing students spend much of their training in clinical settings, therefore the process of clinical education and evaluating the students' clinical practice have critical importance in ensuring safe practice (Zare, Purfarzad & Adib-Hajbaghery, 2013:140). The authors mention that NEs and CS have the responsibility to evaluate the students' performances and judge their competence. On the other hand, however, students are similarly encouraged to make use of self-evaluation. Monitoring students' behaviour through self-evaluation checklists can help educators to identify the strengths and weaknesses of the curriculum, help the students enhance their learning strategies, assist them to become independent, and help them to select higher goals and to try harder to realise these goals (Zare et al., 2013).

Participants suggested that in order to improve professionalism, policies should be applied to monitor and evaluate the learner nurses for positive outcomes in professional behaviour. *Learner nurses* mentioned that in the hospital setting they were more prone to make mistakes and therefore needed clinical monitoring by having the support of a mentor or clinical supervisor available immediately. When PNs (nurse educationalists and PNs) are *proactive* (commitment to excellence) and take initiative, they apply their knowledge and skill to monitor and assess learner nurses to improve the desired outcomes of professionalism. They also verbalised the need for nurse educationalists to advocate and intervene on their behalf in the clinical settings so that they can achieve their required learning outcomes. Learner nurses, especially those in their second year, mentioned the pressure which they experienced when working in the wards and described that they needed more emotional support from the nurse educationalists who accompany them in the wards. Humour was mentioned as a strategy that should be exercised in the clinical learning environment to assist them to cope with pressures and to relieve stress (Moscaritolo, 2009:20). In addition, learner nurses in their fourth year described the responsibility of the hospital authorities to provide the necessary resources for professional development.

The *learner nurses* felt that the HEI and the healthcare institutions (HCIs) should collaborate (Msiska et al., 2013:41) to ensure positive patient care outcomes by integrating theory and practice and facilitating excellence and professionalism. Participants also mentioned that it might be relevant to assess and evaluate the relevance of some of the professional conduct rules in an era where change is inevitable. Assessment, or the collection of information about student learning and achievement, is part of an effective educational process for accountability or basis of improvement. NEs can use a wide range of methods to assess competency and clinical performance to support the progress of students (Poindexter, Hagler & Lindell, 2015:36). *Nurse educationalists* described strategies, like awarding learner nurses with honour and praise, to facilitate their professional development. A portfolio of the learner nurses' progress throughout the four-year training programme will assist educationalists to evaluate their own leadership and ascertain whether they were successful at guiding and directing the learner nurses to develop professionalism. According to The South African Nursing Education Stakeholders (2012), NEs take responsibility for the overall quality of the nursing students' clinical learning and therefore NEs should take an active clinical preceptor role (Nursing Education Stakeholders Group, 2012:4).

Professional nurses in the healthcare facilities mentioned the presence of preceptors in the wards to guide and mentor the learner nurses. Tenza (2015:51) confirms that having preceptors available as a resource for learning, and the supervision and guidance of students in the clinical practice environment ensures effective learning, as they could give feedback about student performance. Mentors should be available in the clinical placement area to monitor and supervise learner nurses in collaboration with the PNs who will give feedback regarding issues of conflict of interest (Msiska et al., 2013:41). The availability of mentors will thus ensure that students achieve their learning objectives. The role of the nurse educator as a mediator between academic and clinical environments and their visibility in clinical practice is of major importance in supporting students' clinical practice (Tenza, 2015).

Selecting motivated and committed students and practitioners

Participants felt that the HEI where the undergraduate learner nurses were trained should recruit learner nurses who are committed and inspired to learn. *Learner nurses* in their third year experienced that some of their peers did not want to do nursing, but stayed in the undergraduate nursing programme against their will. They described that learner nurses should be *self-directed (professional capability),* take responsibility for their own learning and have a desire to obtain knowledge in nursing. *Nurse educationalists* said that they expected learner nurses to be motivated and take responsibility for their learning. Participants referred to the clinical

placement environment where learner nurses should show that they were willing to learn by approaching the sisters (PNs) in the wards with their learning needs. In the same way, *PNs* described that they expect learner nurses to be self-directed and committed to obtain knowledge in nursing. They stated that nurses must have a thirst to know more by identifying gaps in their knowledge and be motivated to learn. Instilling values of self-directed responsibility for learning is essential because it represents an argument for the integration of knowledge skills and values (O'Sullivan, Van Mook, Fewtrell & Wass, 2012:64).

6.2.4.3 *Mentorship in practice for academic and emotional support*

Mentorship is a one-on-one learning relationship between new and senior employees, based on specific courses or learning objectives by the institution involved. The relationship between mentor and mentee facilitates personal and professional development in both and involves an integration of nursing roles that support nursing education (Chen & Lou, 2014:434).

- *Academic support for learner nurses*

The experiences of *learner nurses* were that they struggled academically and that they were in need of more academic support and clear year level outcomes in order for them to perform well. Learner nurses in their first year of the undergraduate nursing programme suggested that there should be clinical support from available mentors who can assist them at any time and whom they can rely on as a second voice to intervene on their behalf. Fourth-year learner nurses expressed the need for the availability of CS at each hospital. The need for support was strongly felt, especially among the second-year learner nurses who became aware of the high risk activities and great responsibilities they encounter in the wards. Similar results were found where learner nurses needed support by CS in the clinical placement environment (Diogo, Rodrigues, Caeiro & Sousa, 2016:77). Mentors could be utilised to assist new nurses in practice and to facilitate professional socialisation. Mentorship programmes could furthermore help nurses to apply theoretical knowledge to clinical practice, reduce work stress and distress regarding realities in practical work, and improve competence (Chen & Lou, 2014:433).

- *Emotional support for learner nurses*

Emotional support, according to Ntakana (2011:94) is essential to overcome the prevalence of mental health problems among learner nurses. *Learner nurses* described that they are exposed to diseases and death in the hospitals, which cause them emotional stress. *Learner nurses* mentioned that support structures in the form of counsellors should be available to deal with the unique needs of learner nurses. Similarly, *nurse educationalists* (CS) noticed the pressure and

challenges of the learner nurses in the clinical placement facilities. Participants felt that they should be available to act as a support structure when learner nurses experience problems in the clinical wards. Stress-related problems affect students' emotional wellbeing and therefore indirectly affect their academic performance (Ntakana, 2011).

6.2.5 All nurses should be mindful in nursing practice

Mindfulness is "an integrative mind-body approach that helps people change the way they think and feel about their experiences, especially stressful experiences. It involves paying attention to our thoughts and feelings so we become more aware of them" (Brass, 2016:21). *Learner nurses* described their thoughts of becoming professional by being considerate towards the cultural diversity of others when working with patients and colleagues in a clinical practice setting. Participants became mindful of the cultural backgrounds of others and realised that being culturally sensitive contributes towards effective teamwork and collegiality. Mindfulness is being open to all thoughts, actions, sensations and emotions (Bach & Grant, 2009:104) and to attend to our own experience with interest and kindness (Brass, 2016). It means being able to realise or recall and "self-awareness" which means clear comprehension of what one does at all times (Panyapatipo, n.d.:32).

6.2.5.1 *Self-awareness and self-realisation to internalise and develop professional behaviour in the learner nurse*

Learner nurses could become aware of their personal and professional behaviour through self-awareness and self-realisation. Internalising professional behaviour is the process by which individuals assimilate the shared norms and the values of the profession over a period of time. Although it is expected that professionals internalise the profession's collective values, this internalisation does not always occur. The lack of internalisation is most likely a result of conflict between an individual's personal values and the profession's collective values (Francis & Dugger, 2014:132).

a. Self-awareness

Learner nurses in their third and fourth year became aware of the basic human values of each individual. They became aware of who they were and where they come from. The participants described how their personal values and norms are being shaped by their upbringing. They furthermore indicated that nurses enter the nursing profession with basic values of respect, punctuality, kindness and good manners and that they should maintain these values throughout the undergraduate nursing programme. This awareness by learner nurses of their cultural background is described by Moll et al. (2015) as a process by which one is able to refocus on the

present experience after one's thoughts wandered from the past to future. This increased self-awareness can allow individuals the opportunity to decide how to respond to a specific situation, for example stress in the workplace environment, rather than automatically responding in a potentially unhelpful manner (Moll et al., 2015:37). Awareness is also complemented by the cultivation of an attitude of non-judgement towards oneself, which subsequently cultivates compassion for others by creating greater acceptance of feelings and thoughts (Moll et al., 2015:37).

b. Self-realisation

One of the spiritual benefits of mindfulness, which is closely related to meditation, is the attainment of self-realisation (Csaszar & Curry, 2013:4). The findings indicated that cultural background can't be changed but participants came to the realisation that there should be a desire to modify unwanted behaviour and to act in accordance with the professional values of nursing. In some cases, it should be kept in mind that behaviour that is acceptable in some cultures, might not be acceptable to some members of the nursing profession and might be regarded as unprofessional conduct. In these instances, conflict might occur if the learner nurse's personal values and the professional values are not the same. Therefore, a modification of the individual nurse's values would be necessary to bring about positive behavioural change, required for harmonious interpersonal nurse-patient and nurse-colleague relationships in the profession. Participants confirmed that one should have humility and think of others. The *nurse educationalists* also made reference to the inherent personal values and outlooks of learner nurses as important elements of professionalism. The participants verbalised that they expect learner nurses to turn the values inward and have personal integrity so that they can be trusted and counted on. Personal values, such as compassion and humility, were mentioned as important elements for self-development and building character. For the *NEs (lecturers)*, professional (and personal) development centred on building the character of the learner nurses (which involves authenticity) so that others can count on them.

6.2.6 Recognition of the teaching and learning (educational needs) processes involved in the professional development of the new generation

The findings indicated that teaching professionalism required agreement on a cognitive base, which could include a definition of the profession, and descriptions of the attributes of the professional and the relationship of the profession to the society which it serves. While it should be kept in mind that this cognitive base should be taught explicitly, the programme should extend throughout the continuum of the professional education and passing it should be

obligatory for progression to the next level (Cruess & Cruess, 2012:264). The formal curriculum of nursing is set by the education standards and competencies of nursing councils who regulate the training of nurses. Organisational or cultural influences in practice environments limit the available time staff can spend with students (Felstead, 2013:227). Felstead (2013) states that the most appropriate way for students to learn what it means to be professional, is to see it in action. However, the didactic way of teaching in universities or institutions of higher learning makes it difficult for students to see professionalism and expectations thereof in a meaningful way. NEs often set expectations for work patterns and behaviours that will influence the development of the student's professionalism, such as starting early or finishing late. This behaviour, for example, serves to demonstrate the correct manner in which a professional is expected to deliver services, even when these may be unrealistic expectations (Felstead, 2013). Teaching and learning in healthcare involve a dual relationship, conducted between two people, with the majority of learning acquired informally via role modelling (Felstead, 2013:223).

Kupperschmidt (2001), in Lavoie-Tremblay, Leclerc, Marchionni and Drevniok (2010:3) defines a generation as an aggregate of people who share birth years, a collective persona, a common location in history, or similar backgrounds. The generations are classified into veterans (born 1925–1945), baby boomers (born 1946–1964), generation X (born 1965–1980) and generation Y, also termed Generation Net, Millenials and Nexters (born after 1980). These four generations are currently in practice and generation Y is currently entering the nursing programme. When four different generations work together in the nursing environment, challenges occur and therefore an understanding of the idiosyncrasies or the characteristics of each group is essential (Lavoie-Tremblay *et al.*, 2010). In this study, for example, professional appearance was regarded as an important responsibility by nurses from the "old school" more so than the (younger) new generation. *Learner nurses* described themselves as the new generation. They mentioned that teaching strategies on professionalism in nursing must focus on the latest advancements and be relevant to the new generation learner nurses entering the profession. Learner nurses need to understand that professional behaviour or conduct refers to the manner in which a nursing practitioner should behave while acting in his/her professional capacity (SANC, 2013:9).

6.2.6.1 *Diversity in culture, background, social economic environment and changing times (the use of technology)*

The nursing profession faces multiple challenges in a changing era. Society, politics, technology and environmental factors are changing the 21st century professional nurse's scope of practice (Esterhuizen, 2016:14). *Learner nurses* experienced personal, emotional, social and academic

difficulties and challenges while studying. These challenges could hinder the professional development of learner nurses. Nurse educationalist considered factors such as background, cultural diversity, societal rules and norms, environmental influences and changing times as challenges impacting on the professional development of the learner nurse. They recognised that nursing education should be current. A *nurse educator* verbalised that with changing times, the use of technology in the 21st century, as the method of communication of the learner nurse, should be considered to be included in the criteria for the profession and that professionalism should be redefined. The way in which nurses were educated in the 20th century are no longer adequate for dealing with the realities and complexities of today's healthcare environment (Mannino & Cotter, 2016:1).

The findings suggested that by being proactive *(commitment to excellence)*, nurse leaders could take action to prepare learner nurses to cope with the societal demands and socio-economic challenges which nurses face in an ever-changing, diverse environment. *NEs* raised the concern that although nursing is moving with the times, learner nurses should be aware of and taught the risks of using technology in recordkeeping and storing patient information, such as jeopardising patient confidentiality. Advances in technology requires nurses to have capabilities and know limitations and safety features of a variety of technological devices and to be able to use them in healthcare and nursing practice (Erasmus, in Jooste, 2017:62). It is the responsibility of academics (NEs) to ensure that their students are aware of safe and effective online communication (Morley, 2013:69). Innovative practices should prepare learner nurses for transition into professional nursing practice (Mannino & Cotter, 2016:4). The use of technology has been noted to be valuable and highly appreciated by students who are able to access a university and peer support while they are working individually in the clinical placement environment (Morley, 2013:69).

6.2.6.2 *Scaffolding learning (reinforcement each year)*

Scaffolding, according to Wilson and Devereux (2014:91), is the support educators and others provide learners in their development and which stimulates a critical and independent orientation to meaning-making. More senior nurse professionals were viewed as role models who support the younger learner nurses to develop professionalism in the undergraduate nursing programme. Leadership qualities were present in the fourth-year *learner nurses* who took on the responsibility to transfer their knowledge and mentored the first-year learner nurses. On the other hand, *NEs* acted as a support for learner nurses by introducing the professional values and code of conduct in the formative years of their training and continuing to inspire them as they progress to the senior year.

In the clinical practice environment, mistakes by learner nurses are inevitable and honest feedback by PNs must focus on corrective measures which build confidence and personal character and ensure professional development. Learner nurses should be evaluated and provided with feedback from PNs on shortcomings in their leadership styles in nursing practice, in order to improve the profession. Feedback at the task level includes verification of the accuracy of the work or how well the task is being performed. It gives students the confidence to engage in tasks and to improve nursing competencies in clinical practice (Van den Bergh, 2013:13). Feedback from students enables early detection of concerns and provides an opportunity to offer support to learner nurses as needed (Salyers, 2014:9). Feedback mechanisms are inherent strategies for assessing learning. In the context of learning, successful feedback builds confidence in students, motivates students to improve their learning, provides students with performance improvement information, correct errors and identifies strengths and weaknesses (Pattalitan, 2016:699).

Collaboration is a process in which learner nurses learn from one another (Van den Bergh, 2013:11). First-year *learner nurses* described the importance of being professionally groomed by their senior peers and state that it contributes towards collaboration and improvement of professional nursing. PNs should give feedback to nurse educationalists as their peers from the HEIs in the form of reports to monitor the progress of learner nurses in the clinical placement wards (as part of being proactive in the professional development of the learner nurse). Pattalitan (2016:699) notes that peer collaboration and feedback is crucial for learning as it requires detail and needs to be meaningful, supportive and developmental. This description of feedback redirects student learning in a collegial manner.

Simulation extends from human actors' role playing through to artificial simulators. Simulation learning suggests structured reflection on nursing practice to bridge the gap between educational theory and practice (Wall et al., 2014:128). *Learner nurses* said that simulation in the current undergraduate programme did not adequately prepare them for the practice environment, as the resources used for simulation did not mirror the "real thing". Learner nurses were taught about professionalism but did not know how to apply it. The continued use of simulation as a learning strategy could provide opportunities for the student to learn and practice while developing a deeper understanding of professionalism. It enhances student learning by engaging them in situations that mirror real life clinical circumstances (Wall et al., 2014:129).

6.2.6.3 *More experiential learning to identify with and internalise professional values*

Structured opportunities for gaining experience and reflecting on it should be provided to allow learner nurses to discuss professional issues and internalise them over the course of their

professional training program. Failure to provide adequate learning opportunities for learner nurses to competently and safely care for patients could result in a nursing graduate who has not met the required standards and competences of the profession (Lawal et al., 2015:36). *Learner nurses* mentioned that the professional values were addressed only during theoretical assessments and that the professional values taught to them were not internalised and applied in the clinical practice environment. Cruess and Cruess (2006:206) state that while teaching the cognitive or knowledge-base of professionalism, the process of socialising it is much harder. Therefore it is suggested that professional values are best learned, not in a classroom in the academic environment, but through experiential learning which encourages self-reflection and "mindfulness" or "reflective practice". Reflection is a way in which professionals bridge the gap between theory and practice, and in which the individual engages their experience to create and clarify meaning for themselves (Pesut, 2014). *Learner nurses* said that they could be responsible for their own learning by realising that reflection on theory and practice is important for integrating learning. Reflection is a tool for integrating theory and practice, and for developing a learner's professional identity from a combination of experience and reflection on practice (Cruess & Cruess, 2006:205).

6.2.6.4 *Consistent reinforcements to promote professionalism: teaching strategies in practice and theory*

Nurse educationalists described that although professional practice is taught in the undergraduate nursing programme, consistent reinforcements is necessary to promote professionalism. Strategies such as complimenting and praising, and using sound judgement in rewarding and applying disciplinary measures for unprofessional behaviour, were applied. Nurse educators should not discriminate (social justice) against persons (learner nurses) with e.g. mental challenges (e.g. stress and depression), but should rather demonstrate their personal reliability in being honest and truthful to the learner nurse when assessing them, especially when their physical challenges might influence their performance and affect patient care delivery. *Professional nurses* should treat everyone equally and with fairness (social justice) without discriminating (social justice) against religion or the institution where students study. By showing fairness in the care of others, PNs (agents) use their own intrinsic dignity to accept that each person is unique, and has shortcomings and imperfections. *Learner nurses* described the importance of nurses caring for the holistic needs of others, which include having respect for a person's religion. They focused on fairness and equality (social justice), meaning that when there is interaction between the nurse and the patient, or among nurses, each person should be treated with respect. First-year *learner nurses* in particular, expected fairness and uniformity when they were taught and assessed by educationalists. Clinical supervisors should be available in the skills

laboratory to guide them to practice within their scope of practice. Social justice (moral courage), is another value inherent in professional behaviour and refers to the upholding of moral, legal and humanistic principles in all actions. It underpins the decision-making about the equitable distribution and allocation of healthcare services and resources (such as education), and creating a safe workplace (Shaw & Degazon, 2008:45).

6.2.6.5 *Educators and Clinical Supervisors should work towards bridging the gap between theory and practice*

The gap between nursing theory and nursing practice creates challenges for nurse educationalists (Wall et al., 2014:127). From the *student's perspective,* the theory-practice gap has created confusion and uncertainty about their roles and practice. This was confirmed in another study in which learner nurses were faced with discrepancies between what is taught in the classroom and nursing as it is practiced in the clinical practice environments (Ajani & Moez, 2011:3938). The findings from this study were that *learner nurses* could not apply what they were taught in the classroom setting, as the profile of the undergraduate learner nurse has changed over the past four decades. With the shift from clinical focus to being academically driven, nursing schools are required to be vigilant in ensuring that learner nurses are able to effectively meet the clinical objectives and competently bridge the theory/practice gap (Lawal et al., 2015:33).

- *Empowerment*

Empowerment plays a central role in nursing. The central idea around it is related to the acquisition of power (as a result of the work conditions offered by the institution) by the individuals so as to effectively accomplish their work (Teixeira & Barbieri-Figueiredo, 2015:152). Nurse educationalists should play an empowering role by demonstrating professional behaviour through adherence to the professional policies and guidelines of nursing. *Nurse educationalists* suggested that one of the ways to bridge the gap between theory and practice is to be specific about the expectations around professionalism in the respective year levels. *CS* told first-year learner nurses what is expected from them in terms of professionalism right from the beginning of their training, so that by the time they reach third and fourth year, they already know what the expectations are.

6.3 CONCLUSION

The findings of the cross analysis revealed that the experiences of professional behaviour varied among the different generations of nurses. Essential role modelling of the professional behaviour was limited to certain settings and individuals. Suggestions on how learner nurses could be

supported by NEs, CS and PNs in the clinical practice environment to improve nursing professionalism for nursing practice at the end of their formal four-year training at the HEI included: i) the need for clear structure and guidelines; ii) the selection and recruitment of committed and motivated learner nurses; iii) scaffolding of learning; iv) self-awareness through the learner nurse's internal locus of control; and v) teaching and learning professionalism in the 21st century. Attention was drawn to the new generation, while the traditional historical heritage of the profession was acknowledged. In Chapter 7 the conceptual framework (derived from this study) to be used to improve professionalism in learner nurses and prepare them for professional nursing practice, is presented.

CHAPTER 7

CONCEPTUAL FRAMEWORK FOR NURSE EDUCATIONALISTS AND PROFESSIONAL NURSES TO FACILITATE PROFESSIONALISM AMONG UNDERGRADUATE LEARNER NURSES FOR NURSING PRACTICE IN THE WESTERN CAPE

7.1 INTRODUCTION

In Chapter 4 and 5 the findings of the learner nurses, nurse educationalists and professional nurses (PNs) were described as three separate cases, and in Chapter 6 the findings of the cross analysis described the common themes that emerged as the overall case. This chapter outlines the conceptual framework, to be used by nurse educationalists and PNs, for supporting learner nurses to enhance professionalism in nursing practice in the Western Cape. A conceptual framework is an abstract mental structure made up of concepts and statements, integrated into the structure (Arries, in Jooste, 2017:269). Triangulation and integration of the key concepts from the findings of the cross analysis of learner nurses, nurse educationalists and PNs (see Chapter 6) formed the conceptual framework. The survey list of the Practice Orientated Theory of Dickoff et al. (1968) was used to organise the concepts (the reasoning map for linking and mapping the identified concepts) (Figure 7.1). This survey list intends to provide answers to six key questions for prescriptive theory (Meleis, 2012:129). The key concepts in the conceptual framework incorporate the concluding statements from the findings and supporting literature. In addition, the framework is grounded in the meta-theoretical and theoretical assumptions of the research (see Chapter 1). The reasoning map addresses the following questions (Dickoff et al., 1968:423):

a) Who or what performs the activity (agent)?

b) Who or what is the recipient of the activity (recipient)?

c) In what context is the activity performed (framework)?

d) What is the energy source for the activity (dynamics)?

e) What is the guiding procedure, technique, or protocol for the activity (procedure)?

f) What is the endpoint of the activity (terminus)?

These six concepts (agent, recipient, context, dynamics, procedure and terminus) formed the integral parts of the conceptual framework. Figure 7.1 shows the integrated framework, using the findings from the learner nurses, nurse educationalists and PNs (Phase 1) of the study.

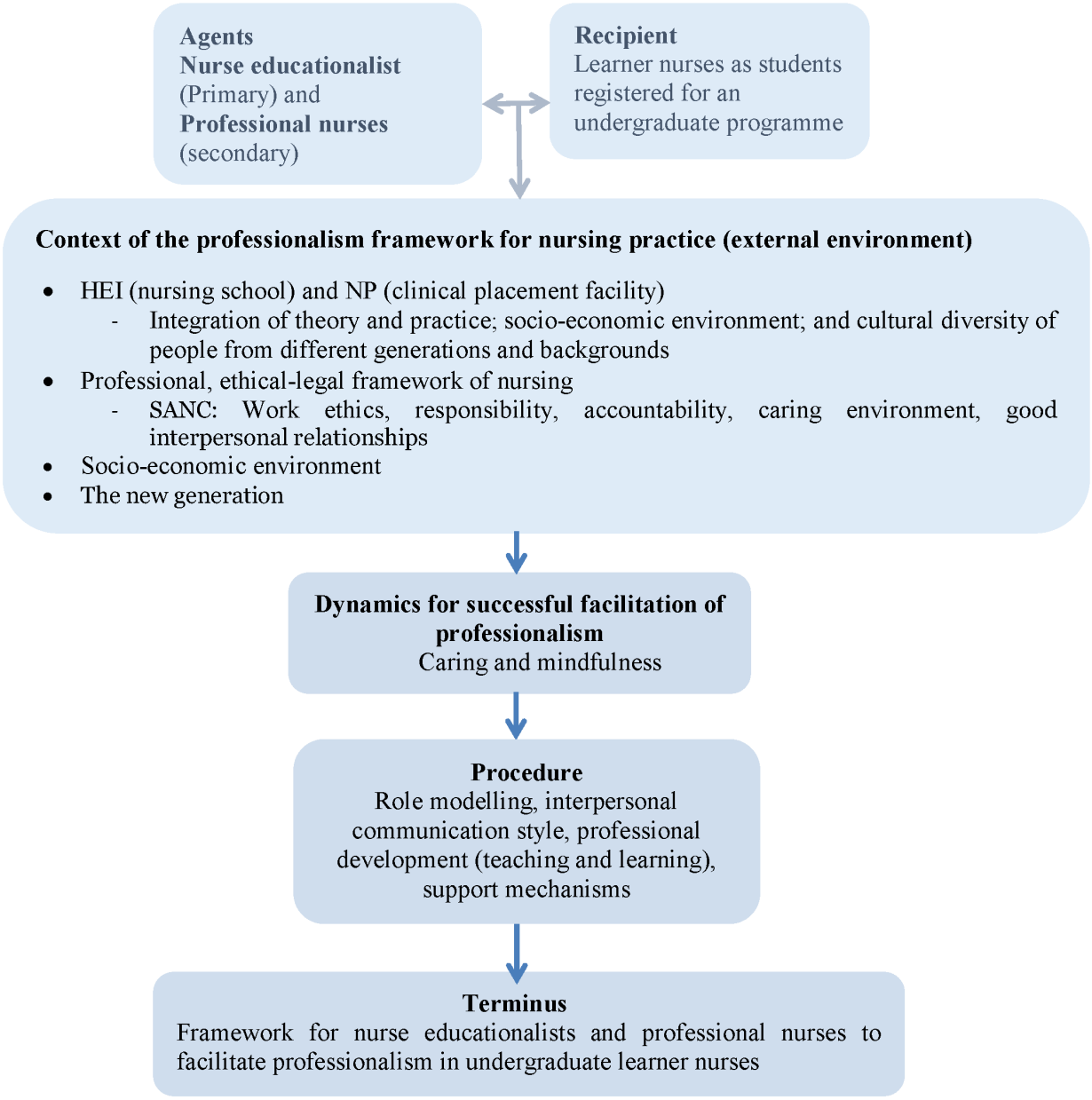


Figure 7.1: Framework for nurse educationalists and professional nurses to facilitate professionalism among learner nurses for nursing practice in the Western Cape (adapted from Dickoff et al., 1968)

Phase 2 was to develop the framework that involved synthesis, re-synthesis and making sense; and integrating concepts into a framework. Chapter 7 deals with describing the framework (Section 7.2).

7.2 CONCEPTUAL FRAMEWORK

7.2.1 Context of professionalism

The learner nurse (recipient), nurse educationalists (primary agents affiliated with a SoN in a HEI) and PNs (secondary agents) interact in a professional ethical and legal nursing practice in public HCIs in a low socio-economic and culturally diverse community in the urban city of Cape Town (see Section 3.3.4). Nursing is practiced and incorporates the new generation in changing times in the 21st century. Learner nurses are thus influenced by the external environment during training, namely: i) the academic higher education institution (HEI); and ii) the nursing practice (NP) that is continuously changing (see Figure 2.1).

Context of the professionalism framework (external environment of the agent and recipient)

- Higher education institution (HEI) (nursing school) and nursing practice (NP) environment (clinical placement)
- Integration of theory and practice through collaboration
- Socio-economic environment and cultural diversity of people from different generations and backgrounds
- Professional, ethical-legal framework of nursing
- South African Nursing Council
- Work ethics, responsibility and accountability
- Good interpersonal relationships
- Caring environment
- The new generation

Figure 7.2: Context of the professionalism framework

7.2.1.1 *The higher education institution and the nursing practice environment*

The higher education institution or university is an academic environment which employs nursing academics and CS to teach a four-year basic nursing degree to undergraduate students. This institution is one of four universities in the Western Cape. The university where the study was conducted is strategically situated in the previously disadvantaged community of Bellville where the majority of people are Coloured and Afrikaans speaking. The socio-economic circumstances of learner nurses could impact on professional behaviour (professionalism). Goastellec (2010:13) confirms that a student's socio-economic background could affect their educational experience. The student with a disadvantage during his or her training at a HEI, i.e those with lower socio-economic background is also likely to repeat or dropout from the institution.

Many students come from the poorer communities in the Western Cape Province and many others arrive from the Eastern Cape Province and neighbouring countries such as Zimbabwe, the Congo, Nigeria, adding to a rich, multicultural and social diverse academic environment of which learner nurses are part. The NPE where these students are placed for clinical practice during the four-year training programme consists of public healthcare facilities that fall within the Department of Health in the Western Cape Metropole municipality. These facilities have been accredited for clinical practice by the South African Nursing Council (SANC, 2016). Accreditation is important because it serves in setting quality standards and uniformity in a health system and it is regarded as the most commonly used external mechanism for standards-based quality improvement in health care and NP (Health Reform Note 2, 2010:1).

7.2.1.2 *The South African Nursing Council*

The School of Nursing at the HEI has been approved as a training institution by the SANC, the regulatory body for the education and training of all categories of nurses in South Africa (SANC, 2004–2015). Regulation R425 of 22 February 1985, as amended, prepare learner nurses to qualify as PNs after studying at a HEI. Primary agents from various educational institutions develop their own curriculum under the directive of the SANC. These students are placed in clinical accredited facilities of the Department of Health in the Western Cape Metropole, in which CS and lecturers (primary agents) accompany learner nurses in general, community, midwifery and psychiatric settings according to placements and hours prescribed by the SANC. Placements of learner nurses (recipients) are steered by PNs (secondary agents). Nursing education institutions and NP need to be mindful of their shared responsibility towards improving the professionalism of all nurses in a multicultural environment.

7.2.1.3 *Professional, ethical-legal framework of nursing*

- *Background to practising nursing within the South African professional-legal framework*

Nursing practise takes place in a variety of settings in a context of continuous change. It is dynamic and therefore it must have the capacity to adjust appropriately to the changing circumstances and environment in which nursing care is rendered. Safe NP requires nurse practitioners to apply knowledge and skills while simultaneously exercising sound, moral judgement (Jooste, 2010:61). Erasmus in Jooste (2017:67) explains that individuals have legal (innocent until proven guilty) and moral rights that are grounded in ethical principles and rules (the right to life). Moral rights derived from customs, traditions and ideals are not always upheld by legal rules (Fry & Johnstone, 2006:31).

The Constitution of South Africa (Act 108 of 1996) is the supreme law of the country and determines that the health (nursing) professions are governed or regulated by law (Geyer et al., 2010:28). The authors state that nurses are accountable for their professional knowledge of basic legal concepts. The Bill of Rights, which reflects the values inherent in society and the basic rights of individuals, is set out in Chapter 2 of the Constitution (Erasmus, in Jooste, 2017:67).

Nurses in South Africa are expected to understand and internalise the core values of nursing, which enable them to practise nursing safely, competently and accountably. It is the Constitutional Right of the public to have access to healthcare services, including nursing care services. It is therefore an obligation of all nurses in the country to comply with and adhere to the legal requirements of the profession. Prescribed standards and criteria of the HEI and SANC should be met before learner nurses can be registered to practice. This further ensures that nurses practice with competence and safety (Geyer et al., 2010:37).

All nurses enter into an unwritten, yet binding, contract with the community they serve. This contract is based on the trust that the profession inspires in the community through the application of its specialised knowledge and competence. The nursing profession is obliged to ensure that this trust and competence is maintained throughout their professional nursing practise (Erasmus, in Jooste, 2017:69). Malpractice, misconduct, incompetence and negligence compromise safe NP and are punishable by law. The Nursing Act (Act No 33 of 2005), through legislation, exercise control over the delivery of an ethical and competent nursing service to the community and safeguard the wellbeing of the public. It furthermore provides for the education and training of adequately qualified nurses, and ensures safe nursing care to the public. Nursing practice is supported by professional regulation and is grounded in practice standards and ethical values (SANC, 2014:1). SANC guides and directs members of the profession to render

professional and safe nursing/midwifery practice under the scope of practice (Regulation 2598) for every level of nursing and to identify the standards of practice and competencies. Both primary and secondary agents have been equipped with the competencies to ensure that safe and quality nursing care is maintained through the ethical-legal framework within which nursing is practiced. The Nursing Act, the Acts and Omissions and the scope of practice regulations form the three main pillars of the legal nursing framework in South Africa (Geyer et al., 2010:57).

- *Work ethics, responsibility and accountability*

A strong work ethic is essential in nursing and regarded as a quality that students and PNs should possess. It needs to be an integral part of a nurse's outlook or worldview. Regardless of whether in training or in the practice environment, nurses need to incorporate a work ethic in his or her thought processes to ensure success in patient care outcomes. Approaching and carrying out nursing tasks and responsibilities in a professional manner, being able to think through difficult situations, and performing to the best of their ability should be an invariable part of nursing (Rochelle, n.d.). The academic learning environment and the clinical NPE are both responsible for the professional development of the learner nurse and two-way communication between them is essential. The SoN is one of the departments of a Faculty of Community and Health Sciences within the university setting that selects and admits learner nurses from the pool of candidates who come from these communities and who meet the minimum admission criteria as required by the university. The primary agents (educators and CS as nurse educationalists) are employed in a SoN and facilitate the integration of theoretical and clinical learning opportunities of learner nurses in the classroom, clinical skills laboratory at the HEI or clinical practice. The clinical practice environment should effectively be used as a resource for learning. Professional nurses are employed by the Provincial Government of Health in the Western Cape.

In nursing, there must reciprocity (collegiality) in services rendered between NP and nursing education. HEIs provide a service to healthcare institutions (HCIs) (context) by training undergraduate learner nurses to become PNs. In the same way, HCIs render a service to HEIs by providing placement opportunities for undergraduate learner nurses. During their training in the respective year levels, learner nurses (recipients) must apply both their theoretical knowledge and practical skills when they are in the clinical learning environment. All agents (nurse educationalists and PNs) are expected to bridge the gap between theory and practice in the clinical placement facilities to ensure professional capabilities (competence) of learner nurses. Collaboration between different nursing education institutions and NP is needed to ensure consistency in the professional learning outcomes of all learners because it creates uniformity and belonging among the learner nurses. It therefore seems that there should be

collaboration/cooperation between HEIs and NPs and that both should have commitment to excellence. Collaboration has been identified as a core value of the New South Wales Ministry of Health Government (New South Wales Government, 2012) and as a professional competency by professional bodies (ICN, 2012). Therefore, all nurses should understand the value of collaboration. Successful collaboration may thus contribute to nurse satisfaction and improve patient outcomes and efficient use of nursing resources (Lamont, Brunero, Lyons, Foster & Perry, 2014:2).

Equality and non-judgemental treatment of agents from different nurse training institutions are essential for achieving learning outcomes and gaining competence in theory and practice. In nursing, everybody should be treated equally and therefore nursing education and training standards should be equal for all nurses. However, equality acknowledges diversity in relation to equality, where different needs, situations and goals of others are recognised (Baillie & Matiti, 2013:7). At the respective year levels of training, learner nurses (recipients) are expected to meet the learning objectives and be proficient in carrying out nursing care competencies at a lower level of thinking before they can progress to a higher level of learning.

Agents are responsible and accountable in an ethical, professional and legal framework. Agents (nurse educationalists and PNs in practice) should inspire work ethics in followers (recipients) by conducting themselves appropriately in a professional manner. Searle et al. (2009:302) describe professional ethics as "an internal moral dimension of attitude and behaviour in which the (nurse) practitioner takes into account the consequences of her professional actions and the criteria which bear upon the choice of action". Accountability implies autonomy and choice. Scott, Matthews and Kirwan (2013:9) state that when no alternative to inadequate nursing care can be provided due to shortage of staff, then choice does not exist. Employers of healthcare providers and nurse leaders who demand that nurses carry out their patient care duties, should therefore take responsibility to ensure the necessary resources, work culture and environment that is required to facilitate such accountability.

Specifically in clinical practice, PNs and learner nurses have certain responsibilities and should perform their duties within their legal scope of practice. The scope of practice for the PN includes responsibilities and accountability in ethical and professional dimensions, clinical practice and the quality of care (Jooste, 2017:52). All agents (nurse educationalists and PNs in practice) remain accountable for tasks delegated to students (recipients) in practice. Secondary agents should be responsible and accountable for their acts and omissions concerning the care needs of patients and should not blame others when things go wrong. Professional nurses should

take responsibility for taking the lead in quieter times (e.g. weekends) and demonstrate positive behaviour in the workplace. On the other hand, the HEIs and NP both have the authority to impose disciplinary measures in the case of misconduct by learner nurses.

- *Good interpersonal relationships*

In the healthcare environment, all nurses (agents and recipients) need to be mindful of interacting and building relationships with people from diverse backgrounds (Douglas et al., 2011:325). Professional nurses (secondary agents) with different cultural backgrounds and ethnicities have a duty or responsibility to care for others, including learner nurses (recipients) who also come from different cultural backgrounds and have individual and unique needs and basic human rights (e.g. the right to practice own religion). Nursing care should be offered as a service to humankind. Nurses' relationship with people, colleagues, peer students and patients, as well as their personal and professional approach to the way nursing tasks are performed, are influenced by the nurse's philosophy. The reason that a dedicated nurse should have a philosophy is to direct his or her vision and values in respect of choices and actions in nursing. Relationships are based on a universal language in the healthcare environment that will also enhance the professional development of learner nurses (recipients). The nursing programme is offered in English, however, the home languages of agents and recipients are diverse. Douglas et al. (2011:324) state that nurses should have knowledge of the impact of language on individuals and therefore it is essential that HEIs and healthcare organisations provide the structure and resources necessary to evaluate and meet cultural and language needs of learner nurses and patients.

The learning environment requires constant teaching and learning innovation (Subhan, 2014:202). Agents should strive to be at the forefront of change in an ever-changing and dynamic society. Change is inevitable and agents should adapt to changing times. New developments and the 21st century generation influence the teaching at HEIs, and also that of the nursing school who train undergraduate learner nurses. With global technological advancement, Kaddoura (2011:1) reiterates that the nursing profession is evolving and requires that nurses be taught in a manner that would ensure that they become critical thinkers capable of caring for patients of the 21st century. Within the context of nursing education and training in South Africa, agents should be mindful to respond to the changing needs, developments and expectations in healthcare. The learning environment should promote a culture of good interpersonal and professional relationships between agents and recipients. In NP, the context of an atmosphere of trust (reliability) is also needed between the learner nurse (recipient) and the patient where the (learner) nurse has confidence in what she is doing.

- *Caring environment*

Nursing should be promoted as a caring profession in which a friendly environment is created by the PNs (secondary agents) for the learner nurses as followers. Current NP focuses on creating caring environments for nurses, patients and families within today's complex health care organisations (Davidson, Ray & Turkel, 2011:1). A professional environment is created when the care of the patient is the first consideration of a PN. Agents should act as role models for student learners and therefore personal matters should not interfere with patient care duties. The learning environment should be created in such a way that it is a positive experience for learner nurses, where an exchange of knowledge and information takes place without fear of being judged or labelled. Learner nurses should be welcomed into a friendly, positive environment (context) during orientation to new settings, so that they can familiarise themselves with the expectations in the patient care wards.

7.2.1.4 *The new generation*

There is a need to focus on training a new generation of learner nurses. We live in a different and changed era. The nurse growing up in the 21st century will have to possess a philosophy to life that is different to those who grew up in an earlier era. Today's workforce is more diverse in terms of age than ever before and unique characteristic differences play a major role in people's experiences at work where generations tend to understand each other and are comforted by one another (Jones, Warren & Davies, 2015:8). Different generations of nurses should, however, have the same understanding of what professionalism means and how professionals should apply themselves in practice. The 21st century generation, also known as Generation Z (born between 1995 and 2007) is described as the New Silent Generation which marks the rise of the information age, internet and dot com bubble. It also marks the era of digital globalisation (List of Generations Chart, n.d.). Friedman (2005) explains that the digital world has broken down boundaries between people. In the interpersonal relationship between the agent and the recipient, professional boundaries are expected to be maintained despite advances in information technology. Universities should be responsible for the training of the new generation of nurses by enforcing responsible usage of innovative practices and technology such as cell phones. Universities should be up to date with the latest innovative learning strategies and developments to train a new generation of learner nurses. The Nurse's Pledge should therefore contain statements of moral principles which are upheld by the nursing profession and should be aligned to the new generation who deliver nursing care in clinical practice.

7.2.2 Agent: Who or what performs the activity

In this study, the agents are nurse educationalists (NE) (primary agents), including nurse educators or lecturers and CS and PNs (secondary agents). The PN (secondary agent) works in close collaboration and in partnership with the nurse educationalists (primary agents) to bridge the gap between nursing theory and NP, and to ensure that the learning outcomes for learner nurses are met. The agent, both primary and secondary, is a holistic person with a body, mind and spirit (Davidson et al., 2011:1; Gessner, n.d.) with three domains or dimensions, namely connection domain (interpersonal compatibility, competence domain (professional capability) and character domain (personal reliability) described as the *internal environment, and who functions in an interactive and integrative manner in an external environment* in the urban city of Cape Town Metropole (see Figure 7.3).

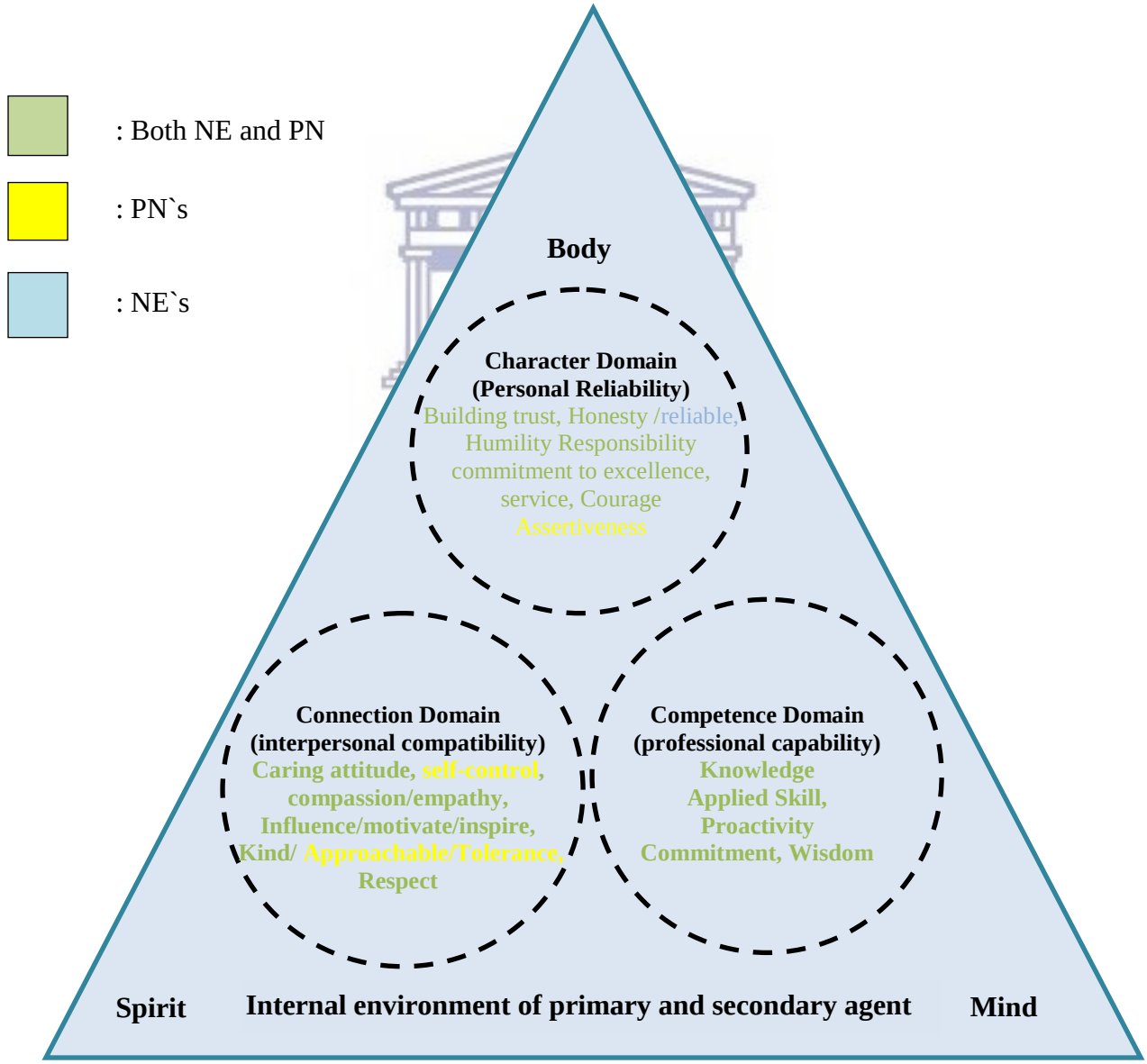


Figure 7.3: The internal environment of the agent

A healthy *body* is needed to perform required nursing tasks and responsibilities in the academic and NPEs. The agent is physically available to the learner nurse and demonstrates openness in communication. Agents show their communication skills by actively listening and by verbally and non-verbally addressing the needs of the learner nurse. The agent is sometimes placed under physical strain and is overworked because of a lack of physical resources in the workplace environment. When professional staff is under pressure in the workplace environment, they could experience emotional stress and job dissatisfaction. When working under such circumstances, it is often difficult for professional leaders to maintain a stable affect. They must therefore be able to manage conflict appropriately (ACN, 2015:9).

The mind of the agent, known as the psyche, includes emotions and all intellectual processes. The emotions of the agent include affection, desires, feelings and moods. Intellectual processes refer to the cognitive state or ability of a person, which includes thinking, judgement, problem solving, decisions, reasoning, perception and consciousness (awareness) (Shephard, 2016:15). *Emotions:* Primary and secondary agents show affection in the form of being considerate towards the holistic needs of others (the recipient). Being affectionate also includes demonstrating warmth and friendliness towards the recipient. When connections of emotional affection are present within nurses, it is believed that the work then becomes more fulfilling for these nurses when taking care of others (Scott et al., 2013:4). *Intellectual processes*: The agents in this study are competent professionals with distinct roles who apply their minds and are able to make sound judgements in the execution of their daily functions.

The spirit refers to the agents' moral and emotional nature and their ability to feel kindness, compassion and empathy for others and to experience wellbeing. It refers to the interconnectedness and the relationships with other human beings, being non-judgemental and accepting that each person is unique (Shephard, 2016:101).

Nurse educators (primary agents) teach learner nurses about the values of the profession in the classroom and expect the learner nurses to turn the values inward, a process central to personal integrity, so that the learner nurse could be trusted and counted on when not under supervision. The agent has different roles to play and has certain characteristics (values) that equip him or her to guide the recipient towards professionalism. The values of the agent, depicted as processes of the mind, body and spirit in the internal environment, include the harmonious interplay between personal and professional values and embody the nursing professionalism. In the nursing profession, the personal values of the nurse practitioner can affect patient care outcomes and therefore the level of congruence between the nurses' personal values and the professional values

should foster positive and therapeutic outcomes for the client (Thomas, 2013:19). These characteristics equip him or her to carry out the role of leader, educator, role model, advocate, collaborator, councillor and mentor, as discussed below.

7.2.2.1 *The characteristics of the agent*

The characteristics of the agent are described in accordance with the professionalism taxonomy of Brown and Ferrill (2009). Primary (nurse educationalists) and secondary agents (PNs) have a shared responsibility to assist the recipient (learner nurse) in developing health (professionalism).

- *Connection domain (interpersonal compatibility) of the agent*

Interpersonal compatibility refers to the connectedness of nurse educationalists and PNs with learner nurses during their encounters in the classroom and NPE. Mutual respect is needed for the effective interaction between a nurse educator and learner nurse. *Nurse educationalists,* as primary agents, should value respect for one another as a component of professionalism, a part of the training programme. On the other hand, they should be mindful by taking into consideration that learner nurses come from varied communities, with cultural and socio-political influences in these external environments, when teaching the essentials of professionalism. In the clinical learning environment, *PNs* should show that they care by being sensitive and understanding of the cultural diversity of learner nurses and their individual and unique needs. When PNs demonstrate empathy towards cultural differences in the clinical placement facilities, learner nurses felt that their differences were being understood. Learner nurses behave differently in the academic environment as compared to their behaviour in the clinical practice environment, therefore nurse educationalists should also understand that the professional behaviour of learner nurses is context specific. They should furthermore be aware that professionalism will be internalised over time within the learner nurse.

Nurse educationalists should be able to encourage and inspire learner nurses by creating a learning environment, despite various challenges which could potentially impact on the learner nurses' professional development. They could e.g. always be on time for their professional duties. Clear learning outcomes are needed to prevent conflicting messages and to motivate and inspire learner nurses to learn. Nurse educationalists, are professional role models who are able to demonstrate interpersonal compatibility or connectedness by inspiring learner nurses in developing professional behaviour. Clinical supervisors could, for example, inspire learner nurses by being role models of respectful behaviour who uphold the efforts of the profession. Primary and secondary agents (nurse educationalists and PNs in practice) have a responsibility to

inspire work ethic in learner nurses by conducting themselves appropriately in a professional manner. Professional nurses could motivate learner nurses by creating a positive work atmosphere that enables these learner nurses to serve the needs of others in the nursing practice environment. Professional nurses should inspire learner nurses to bring across their point of view by listening to them and thus motivating the learner nurses to feel part of the team. Professional nurses should inspire confidence in learner nurses (recipients) by being accessible in their interaction with learner nurses in the patient care wards. In the clinical learning environment, *learner nurses* join a team of professionals to learn about professional practice. Learner nurses want to become members of the clinical team during their clinical placement, by acquiring the attributes of the professional nursing team with whom they interact and therefore they focus on "fitting in" to practice environments (Henderson, Cook, Creedy & Walker, 2012:6).

Respectful behaviour by the primary and secondary agents towards learner nurses enables followers to be receptive and give their cooperation to staff in the healthcare facilities instead of retaliating when they are not treated well. Respectful behaviour is a moral value, and showing respect for others is regarded as central to all aspects of professionalism (Leape et al., 2012:2). Professional nurses could talk to learner nurses with respect and dignity during e.g. orientation or if they make a mistake. Professional nurses should respect the religious (spiritual) needs of others (patients/learner nurses) as a basic human right. Effective interaction between seniors and members of staff requires PNs to connect with learner nurses by showing respect and tolerance in the clinical practice environment. Tolerance should be role modelled through the kind, respectful demeanour of PNs who should create a welcoming atmosphere for the new learner nurse.

Compassion/caring about others: Nurse educationalists and PNs (all agents) should demonstrate compassion and care towards the learner nurses by communicating with them in a language which they understand and can relate to. It is important in healthcare in particular that messages are not misunderstood by learner nurses and that they carry out nursing tasks and responsibilities effectively. Compassion can be described as a sensitivity to any distress together with the commitment, courage and wisdom do something about it (Royal college of Psychiatrists, 2015:2). Professional nurses should be sensitive to the diversity in language of the learner nurses during clinical placement in the healthcare facilities. Demonstrating compassion by being sensitive towards diversity in the workplace, can improve the efficiency of staff by enhancing cooperation between individuals and teams in healthcare. Compassion is a deep awareness of the suffering of another, coupled with the wish to relieve it. It requires that staff give something of

themselves. When fatigue and organisational circumstances create workplace stress, it becomes more difficult for staff to feel and show compassion (Middleton, 2011:7).

Empathy: Nurse educationalists and PNs should understand the emotional and psychological needs (part of holistic needs) of the learner nurse. When empathy is demonstrated for the holistic needs of the learner nurse, the nurses become receptive to the professional input from the nurse educationalist in the classroom and clinical learning environment as well as to the input of the professional nurse in the NPE where the learner nurse is placed for clinical learning. *Kindness*, one of the fundamental values of nursing (Peate, 2012:16) is expected from PNs. Kindness is also demonstrated when the PN shows consideration for the cultural differences of the learner nurses (recipients) who come from diverse backgrounds and whose language, religion and socio-economic differences have been indicated as challenges. PNs should show consideration for these differences in their interaction with the learner nurse by being culturally sensitive towards them (learner nurses). PNs who consider the cultural differences of learner nurses enhance the work performance of the learner nurses or their followers in the clinical practice environment. They should also create an environment of team spirit in the wards where the learner nurses feel welcome and part of the professional team. Feeling part of the professional nursing team, and experiencing a sense of belonging and tolerance from others, were found to be important to learner nurses during their clinical placements (Bang et al., 2011:72). The PN should demonstrate this behaviour when he/she is tolerant towards the shortcomings of learner nurses (recipients) who are new to the patient care wards. When the agent is tolerant towards the learner nurse as recipient, she/he shows an understanding that the recipient is a unique individual and therefore becomes accepting of the fact that the recipient is new to the clinical learning environment.

Approachable: The agents should be approachable and portray an attitude that allows the learner nurse to feel free to communicate and interact with the professional nurse regarding learning needs in the clinical placement facility.

Influence: Influence, according to Brown et al. (2009:6), is the functional foundation of leadership. Leaders lead people with the goal to make productive the specific strengths and knowledge of each individual (Drucker, 1999, in Kardos, 2012). *Nurse educationalists and PNs* are leaders who serve the (learning) needs of their followers (learner nurses). Servant-leadership is grounded in humility (see heading on humility below). Professional nurse leaders hence should be concerned about positive (learning) outcomes for learner nurses and should be accepting of criticism from followers (learner nurses) and admit that they are sometimes at fault

when they are not there for the learning needs of the learner nurses. Senior nurses take responsibility to modify their behaviour to bring about positive change in respect of positive nursing care outcomes and to uphold the efforts of the nursing profession. Leaders can't lead without followers (Bjugstad, Thach, Thompson & Morris, 2006:305). The agents (nurse leaders) in the study were able to use their influence to motivate and inspire followers (learner nurses) to reach their goals in becoming healthy professional nurse practitioners, even though circumstances in the HCIs are challenging and complex (Kardos, 2012:5). Power and authority should be used by all nurse leaders to influence learner nurses to achieve the vision of the healthcare facility and the health care goals and objectives of wards. *Nurse educationalists and PNs* are required to motivate the learner nurse when they enter the undergraduate nursing programme by providing them with clear professional guidelines of what is expected of them as learner nurses, so that they can develop professionalism. Primary agents should therefore be seen as leaders who positively influence learner nurses (recipients/followers) to be passionate to learn about nursing. They should encourage learner nurses to acquire nursing knowledge by being self-directed and showing commitment to learn what needs to be learned and to perform nursing tasks. The PN, on the other hand, should influence the learner nurse by motivating and inspiring them to achieve the goals and objectives of the healthcare facility where they are placed. PNs who act self-confident in their delegation of nursing responsibilities influence learner nurses (recipients) positively. Self-confidence is a crucial practice element in nursing education and practice. With the aim of facilitating trusted care of patients in the healthcare setting, nursing professionals should exhibit self-confidence as they are regarded as experts in the field of nursing (Perry, 2011: 211). The interaction between learner nurses and agents should have a positive influence on building a positive professional relationship. This relationship should be based on building/developing professional character.

Self-control and a caring attitude: The PN as secondary agent is expected to function well and to lead the recipient towards professionalism (health) by being in control of his/her emotions and maintaining a stable affect amidst challenges in the external environment. When PNs lead by example, they become role models who demonstrate interpersonal compatibility through self-control by e.g. maintaining a stable affect under work pressure. Although self-control and self-regulation are used synonymously, self-regulation could be used in a collective sense with reference to how professions such as nursing establish and monitor standards for practice (Hershberger, Zryd, Rodes & Stolfi, 2010:36). Most PNs function under difficult and stressful circumstances in the healthcare facilities (hospitals), especially when there is a shortage of staff and when the wards are busy. They should be able to demonstrate grace under pressure and continue to carry out their functions in a calm manner without shouting and showing unkind

behaviour towards recipients. Professional nurses in practice are expected to delegate tasks in a controlled manner to learner nurses, as self-control is an essential value of interpersonal compatibility. When nurses are upset, their capacity to function as carers could be jeopardised. They should be mindful of their responsibility (personal reliability) to orientate learner nurses, as well as their ability to stay calm (self-control) under workload pressure (interpersonal compatibility), especially when the patient care wards are full and busy. Secondary agents should apply mechanisms of self-control by having a caring attitude towards learner nurses. Self-control is an important aspect of human behaviour and interpersonal interaction that constitutes nursing professionalism. Consideration of the role of self-control may also assist NEs to understand and promote professionalism in learner nurses (Hershberger et al., 2010:36).

- *Character domain (personal reliability)*

Brown et al. (2009:6) describe the character domain as the domain which leads to personal reliability of the person who in this study is referred to as the agent. Character, the key to trustworthiness, requires a sense of right or wrong, based on moral and ethical professional standards. *Personal reliability* reflects on the character of the primary and secondary agents who are able to demonstrate that they can be trusted and depended upon by the learner nurses for support when they are in the clinical placement facilities. *Clinical supervisors* should demonstrate that they are trustworthy and can be depended upon by the learner nurses in the clinical placement facilities and are able to intervene and be the voice for the learner nurses in the wards. As part of their personal reliability towards learner nurses, *nurse educationalists* should be fair (social justice) and apply consistent assessment and evaluation procedures in their assessment/judgement of learner nurses/others. When assessing learner nurses with physical (visually impaired/blind) and mental (stress and depression) frailties for example, NEs should not discriminate, be fair and demonstrate their personal reliability in being honest and truthful. This is especially true when learner nurses' physical challenges might affect or influence their academic performance and affect patient care delivery. Professional nurses will be able to instil confidence in learner nurses (recipients) when they entrust the learner nurses with performing nursing care duties at the appropriate level of learning in the undergraduate nursing programme.

Learner nurses require PNs to demonstrate *humility* (a value of personal reliability). When learner nurses make mistakes in the clinical patient care wards, they expect PNs to demonstrate humility to them by reprimanding or disciplining them in a private area and not in front of the patients. *Professional nurses* should be able to show humility by having regard for the feelings of learner nurses when they e.g. give feedback about nursing tasks performed by learner nurses. Feedback is essential for the student`s professional growth, provides direction and helps to boost

their confidence as well as their motivation and self-esteem. Hence giving feedback that is supportive and constructive, guides learner nurses in their journey to clinical competence (Matua, Seshan, Akintola & Thanka, 2014:25). In instances when the feedback is punitive, it could be given in a space away from others so that the learner nurse does not feel exposed in front of others. Humility, demonstrated in such instances by the professional nurse, was important for building trust relationships with others, especially the learner nurse. Furthermore, PNs could demonstrate humility by apologising to learner nurses for their shortcomings during times when the wards are busy and they are unable to attend to the learning needs of the learner nurses.

Responsibility and commitment to excellence: Both primary and secondary agents have a responsibility to be committed to excellence in caring for the needs of the learner nurse in their professional development, with positive patient care outcomes being the primary goal. The agents are responsible to guide and direct the recipients to develop professionalism by demonstrating the principles of professional conduct to the recipients. Agents are expected to role model the professional rules and code of conduct in the form of the proper dress code for nurses, being punctual, being there for the recipient and by the way they behave in the clinical practice environment. Agents are responsible for adopting the work ethic of the institution that employs them. Responsibility as a value of personal reliability demonstrates to learner nurses that PNs are reliable and can be counted on to carry out the daily nursing duties and responsibilities.

Service: Professional nurses in the placement facilities are responsible and accountable for their acts and omissions concerning the care needs of patients and should not blame others when things go wrong. They should demonstrate their responsibility and commitment to excellence when they perform patient care duties. This could be achieved when the professional nurse does the right thing even when no one is looking or by refraining from practices of misconduct such as taking shortcuts to get through a heavy workload. They should also not allow learner nurses to do as they please, which often occurred over weekends when PNs as leaders demonstrated behaviour consistent with a laissez-fair leadership style.

Trust/being reliable: In the professional relationship with the learner nurse, the agents create an environment in which the recipient feels safe to interact with the nurse educationalist and the PN. The nurse educationalist (primary agent) is responsible for supporting the learner nurse and showing the learner nurses that they can rely on them in the clinical placement facility. Nurse educationalists are responsible to adhere to scheduled clinical supervision times. They are thus

expected to honour appointments and be on time, especially when learner nurses have scheduled clinical assessments to be completed. In the clinical placement wards, the PN is expected to create an environment in which the recipients (learner nurses) can become confident in their interaction with other professional workers and patients.

Honesty: As primary agents, nurse educationalists have a duty to assess the professional conduct and academic performance of learner nurses throughout the training programme at the HEI and are expected to do what is right in their assessment of the learner nurse. They are required to be reliable persons who have the courage to give honest information to learner nurses about their academic progress or performance. Agents should be as truthful as possible without demotivating the learner nurse. They should not discriminate against persons with physical or mental frailties, but also does not instil hope or create expectations within the learner nurse who do not have what it takes to perform the physical tasks required for the execution of professional nursing care. A visually impaired learner nurse, for example, is unable to accurately read instructions, observe and inspect, work out medicinal dosages and draw up injections (John Hopkins University, n.d.).

Courage/assertiveness and social justice: As primary agents, NEs are role models who professionally groom and prepare learner nurses for NP by giving guidance and direction (leadership) in the classroom and clinical placement environments in terms of e.g. wearing the appropriate dress code. Nurse educators should monitor and assist learner nurses to achieve the desired learning outcomes and should use appropriate learning material for successful academic performance. Nurse educationalists should be aware (mindful) of their own shortcomings, realise that they should take responsibility for their own behaviour and be role models who uphold professionalism. Modification of personal behaviour may be needed and the nurse educator should demonstrate the courage to do what is right in the interest of the profession and setting an example to the learner nurses. They should also take responsibility (personal reliability) to advocate nursing professionalism in the profession by having the courage (personal reliability) to change or modify unwanted personal behaviour (e.g. being loud) and to do what is right in the interest of the profession. They should also role model respectful behaviour in the academic environment towards learner nurses, treat them with dignity and not demean them. *CS (primary agents),* on the other hand, should demonstrate to learner nurses that they are reliable by being courageous and doing what is right in the interest of the learner nurse in the clinical practice environment. They should be available to intervene on behalf of the students when mistakes are made or when participants are prevented from performing learning outcomes which do not match the specific year level in the patient care wards. *Professional nurses* should have the courage to

impose disciplinary actions (context) against the wrongdoings of learner nurses. Courage is reflected in the personal reliability of the professional nurse and requires him or her to use his or her knowledge and skill (professional capabilities) in the right way. Thereby they can guide and direct learner nurses to adhere and conform to the rules (context) of the profession in order to achieve the desired behaviour of what is acceptable and not acceptable in clinical practice. *Professional nurses* as secondary agents should thus guide learner nurses in their professional development by being assertive (interpersonal compatibility) in addressing issues pertaining to the code of conduct for nurses i.e. work ethic (punctuality and the use of cell phones in the workplace environment). They should thus have the courage to correct subordinates (learner nurses) while in clinical practice in order to achieve the desired professional behaviour. In providing learner nurses with educational opportunities, PNs should be *assertive* by delegating nursing responsibilities to learner nurses during their clinical placements in the healthcare facilities. PNs are expected to be confident and *assertive* in their communication (delegation) of nursing responsibilities to the recipient (learner nurse) as part of creating educational opportunities for the learner nurses during their clinical placement in the patient care wards. *Social justice:* By showing fairness (social justice) in the care of others, PNs use their own intrinsic dignity to accept that each person is unique, has shortcomings and imperfections, come from different backgrounds, speak a variety of languages and is sometimes not understood.

- *Competence domain (professional capability) of the agent*

The competence domain represents the basic or standard professional expertise, according to Brown et al. (2009:4). Nursing knowledge and skill should be applied and is required in order for a nurse to function at an acceptable level of competence in the NPE. Nurse educators as primary agents demonstrate *professional capability* in their commitment to excellence when they teach learner nurses the values of professionalism in theory in the classroom. They also facilitate positive professional behavioural changes in learner nurses by means of teaching and learning strategies that support the integration of these values in clinical NP. Positive behavioural changes (outcomes) in learner nurses could be achieved when NEs apply strategies such as rewarding positive professional behaviour and punishing undesired behaviour in privacy. They are thus expected to have *wisdom* and use their discretion (critical judgement) as part of their professional capabilities in making decisions about granting exceptions to the rules or imposing discipline on learner nurses, but only after careful analysis of the situation or circumstances. Nurse educators should be *proactive* (an essential element of their professional capability) by applying their knowledge and exercising sound judgement (wisdom) in applying strategies of reward and punishment, thereby encouraging positive professional outcomes in the behaviour of learner

nurses and ensuring excellence or quality in nursing care practice. Nurse educationalists are required to take action and be proactive in a changing environment by using innovative teaching strategies which prepare learner nurses for the 21st century in the NPE. The findings indicated that attaining wisdom as a focal point in a nursing program was essential. An effective way to facilitate the acquisition of wisdom among undergraduate learner nurses is mentoring (D'Antonio, 2014:105).

In nursing, nurses should be skilled and flexible to use information technology in the best interest of the patient. In being proactive, agents are therefore required to take action that prepares 21st century learner nurses for the job market in which technology plays an important role. This can be attained by creating a supportive platform for example for learner nurses to voice their grievances. In collaboration with primary agents, PNs could be *proactive* by giving feedback to HEIs in the form of reports that monitor the progress of the professional development of learner nurses in the clinical placement wards. Agents should be proactive and take initiative by applying their knowledge and skill to monitor and assess (evaluate) desired learning outcomes in the learner nurse (recipient). Secondary agents collaborate with primary agents (nurse educationalists) by giving positive feedback about the progress of learner nurses in the clinical placement facilities to ensure positive outcomes in patient care. *Knowledge and applied skill:* All nurses have a knowledge-base on which their NP is built. Having knowledge without knowing how to practically provide effective patient-centred nursing care is of little use. All agents should have the necessary professional capability (competence) as a committed professional to impart the professional knowledge and skills of the nursing profession on to the learner nurse (recipient). Agents are therefore required to be committed to share and communicate their knowledge with the learner nurses in the clinical placement facilities to ensure positive patient care outcomes. Clinical supervisors should influence learner nurses if they want to effect change in the learner nurse's behaviour, especially when processes such as demonstrations in the skills laboratory is employed for the integration of knowledge and skills. Clear messages between CS and learner nurses (recipients) should be inspiring and motivating so that CS (primary agents) are able to influence learner nurses (recipients) (interpersonal compatibility). In this way, CS help learner nurses to find personal meaning and value in what they are doing as it inspires passion and brings out the best in the learner nurse (Stapleton, Henderson, Creedy, Cooke, Patterson, Alexander, Haywood & Dalton, 2015:4). The professional relationship between CS and learner nurses should be friendly and professional, and foster learning and the transfer of knowledge. Professional nurses as secondary agents, though, should have the courage (personal reliability) to use their knowledge and skill (professional capabilities) to guide and direct learner nurses to adhere and conform to the rules of the profession in order to

instil the desired, acceptable behaviour in learner nurses. This could be achieved when they encourage learner nurses (recipients) to apply their theoretical knowledge and practical skills in the clinical learning environment, as well as when PNs share and communicate their knowledge (competence) with learner nurses. *Professional nurses* should demonstrate their professional capabilities by having critical and analytical thinking skills (*wisdom*). These skills are required for management and leadership roles in nursing and guide the professional nurse in his or her demonstration of organisational skills and delegation of responsibilities to followers (recipients). Brown and Ferrill (2009:2) describe wisdom by stating that it encompasses the full spectrum of analytical thought from abstract reasoning to basic applications of common sense. Agents apply judgement in their decision-making when discretion is used to reward good behaviour and punish unwanted professional behaviour, especially where both good and bad behaviour occur in similar circumstances. Agents should for example know where to draw the line when a learner nurse keeps on being late because of unreliable public transport and a learner nurse who is late for the first time because he/she had to walk because there was no public transport on that particular morning. It could be interpreted that educationalists must use their own judgement and common sense in applying rules and guidelines of conduct to meet professional ethics and conduct responsibilities, as well as comply with legislative and organisational policies, processes and guidelines (Teacher Registration Board (TRB), 2015:1). When agents interact with learner nurses via social media networks, they are expected to use common sense as professional principles apply to these networks as well. Agents connect with learner nurses but should use their discretion when engaging with learner nurses on social media networks such as BBM (Black Berry Messaging) or Facebook. All agents should focus on the professional capability of learner nurses that is enhanced by knowledge and self-directed learning. In addition**,** agents should be committed to be *self-directed and inspired to learn* what they need to learn. All agents should stay abreast of the latest developments and be aware of changes in a new nursing era. They should therefore be knowledgeable about information technology, which has become a necessity in HCIs across the world. Agents are self-directed in that they take initiative in their own learning by identifying what needs to be learned and having an eagerness to be informed about the latest developments in the global arena.

7.2.3 Recipient: Who or what is the recipient of the activity?

The recipient is a learner nurse within the student community of a university and occupies different roles. The recipient is a holistic being who interacts and functions within an internal environment and an external environment. The internal environment consists of the body, mind and spirit, whereas the external environment refers to the i) professional, ethical-legal nursing

practice environment; ii) HEI (academic environment); iii) nursing practice environment; iv) socio-economic-cultural environment; and v) the influence of the 21st century generation on the professional behaviour of the recipient.

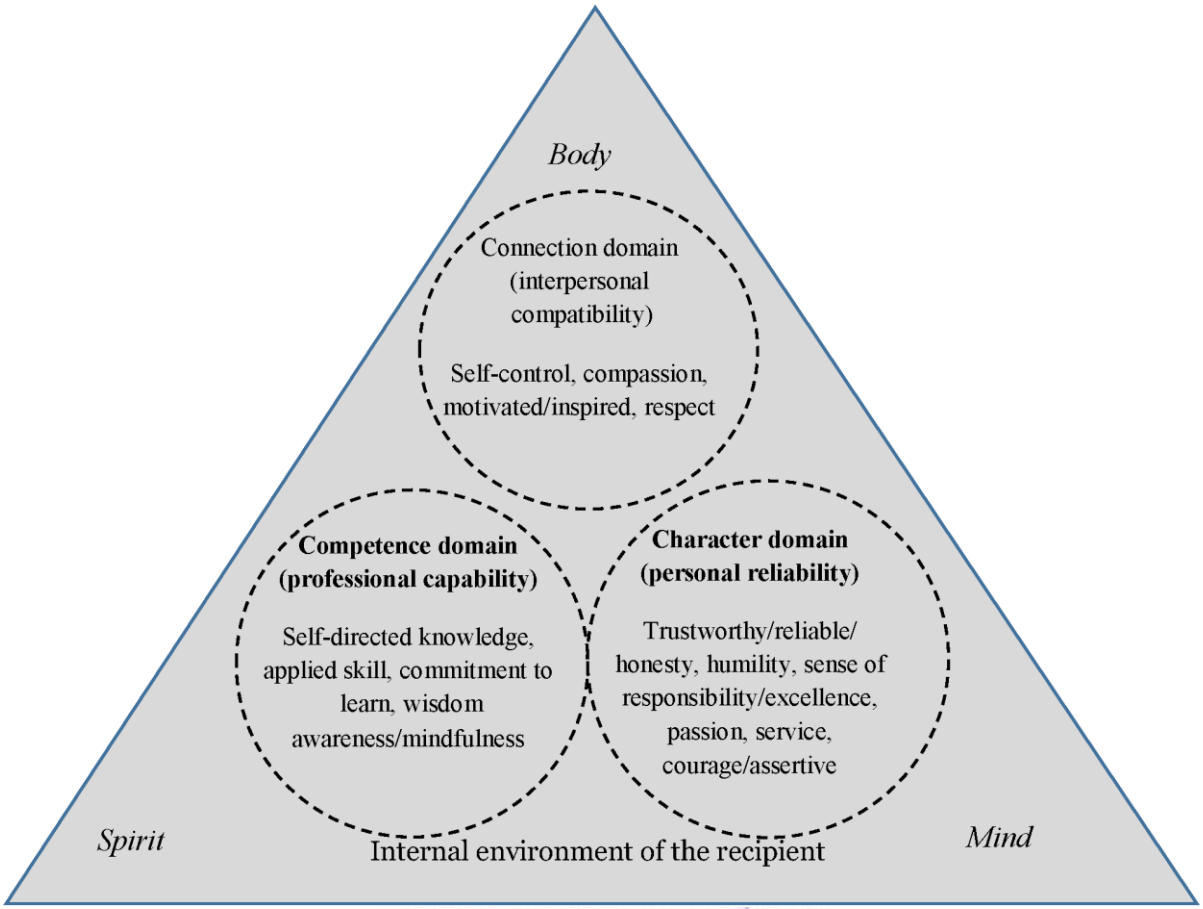


Figure 7.4: The internal environment of the recipient

The *body* includes physical structures and biological processes of the recipient. The body of the recipient is present in the classroom at a university/ HEI, as well as in the clinical placement facility in the healthcare environment. Thus, when in a healthy physical state, recipients are able to interact with peers, nurse educationalists, PNs and patients in the academic as well as the clinical healthcare environment where learning takes place while a professional nursing care service is rendered. Physical disabilities or challenges such as being visually impaired (blindness) could affect the learner nurse's ability to be successful at the undergraduate programme and might impact on the nursing care service delivery of such learner nurses.

The *mind* of the recipient includes emotions and all intellectual processes. The emotions of the recipient include affection, desires, feelings and moods. *Intellectual* processes refer to the cognitive state or ability of a person which includes thinking, judgement, problem solving,

decisions, reasoning perception and consciousness (awareness). The intellect, in other words, includes competence and the processes of thinking, analysing, interpreting and understanding. *Emotions:* The recipient is exposed to diseases and death while in the clinical placement facility. In the absence of available support structures in the form of nurse counsellors, the learner nurse suffer and fear emotional stress and depression which negatively affect their academic progress and cause many learner nurses to drop out. The recipient might also be an adult learner with a family who needs personal support to stay in the programme. Another emotion which was expressed was the fear of being judged or labelled. They also feared being inadequately skilled and incompetent post-graduation. *Intellectual processes:* The recipients are receptive to the acquisition of knowledge and skills throughout their four-year professional training in the undergraduate programme. Knowledge obtained in the classroom setting in the academic environment is processed through self-directed learning, as required from adult learning and applied in the clinical practice environment in the healthcare facility where the recipient (learner nurse) is placed for clinical learning.

Spirit refers to the recipient's relationship with 'God' or a higher being, and provides the moral foundation on which the nurse's value system is based. In this study, the recipient expressed the need that their spiritual needs and those of patients should be met, which emphasises that the human being should be respected as a person created by God. The focus here is on the spiritual or immaterial part of a human being. Humility and human dignity is demonstrated when the recipient is committed to care and demonstrate an altruistic desire to serve the needs of others.

The recipient has responsibilities and should demonstrate certain characteristics that will facilitate the development of professionalism, thus being prepared for professional NP. The recipient as a novice in the practice environment is not a mature professional practitioner and must still be socialised professionally to make the expertise, norms and values of the profession his or her own (Muller, 2009:7). Committed and motivated young leaders who are inspired to study nursing to influence (connection domain) the community should be selected (social justice) by HEIs. The recipient (learner nurse) is a grade 12 learner who enter a HEI with the vision of registering at the SANC in the first three months after entering an undergraduate programme.

Recipients interact in a healthcare environment in which they build relationships with people from diverse cultural backgrounds and religions. Equal treatment and fairness is applied as learner nurses are allowed to practice their religion without infringement on this basic human right in the clinical learning environment. The professional relationship between e.g. CS and learner nurses should be friendly but professional and foster learning and the transference of

knowledge. Learner nurses could expect to learn the proper professional conduct from agents as leaders, who transfer learning within the respectful boundaries of a professional relationship.

7.2.3.1 *Characteristics of the recipient*

As a person with a body, spirit and mind (internal environment), certain characteristics of the recipient (learner nurse) should be acknowledged, during the journey towards becoming a professional nurse. The characteristics of the recipient are described in accordance with the professionalism taxonomy of Brown et al. (2009) with three domains or dimensions, namely the connection domain (interpersonal compatibility), competence domain (professional capability) and character domain (personal reliability) (see Figure 7.4).

Interpersonal compatibility is important, as when entering the profession, learner nurses display their passion (the desire) to undertake the programme in nursing and wish to respectfully serve the needs of others (see personal reliability). Learner nurses should have *compassion* for others and treat them with respect and dignity. Compassion remains core and seen as a fundamental nursing value (Peate, 2012:16). In the clinical environment it starts with good basic care (e.g. making sure that the patient`s feeding needs are addressed) and can be equated to respect and dignity. It however, goes beyond essential care to encompass empathy, recognition of the uniqueness of another individual and the willingness to enter into a relationship in which the knowledge as well as strengths and emotions of both the patient and the caregiver can be fully engaged (Middleton, 2011: 23). They (learner nurses) should be seen providing compassionate care. This care should be delivered by nurses with the appropriate skills, knowledge attitudes and values (Peate, 2012:16). The learner nurse should be able to demonstrate to the public his or her ability to compassionately care. PNs who were involved with the learner nurses in the clinical learning practice where they were placed observed that patients valued the learner nurse who is able to go the extra mile for them. Mutual respect is needed for the effective interaction and polite communication between nurse educator and learner nurse. Mathevula and Khoza (2013:6) confirm that good communication, friendliness, kindness and mutual respect are important aspects of creating a positive classroom environment. Positive relationships are based on mutual respect. In clinical practice, mutual respect is important for working relationships and thus requires mature nurse professionals and willingness from learner nurses to work closely together to enhance teamwork (Van Wyk, Heyns & Coetzee, 2015:96). *Respect* is reciprocated and cooperation should be given by learners to seniors. Respect is an essential element that influences and enhances the relationship between educator and student (Mathevula & Khoza, 2013:5). Learners should be prepared to be respectful and not show resistance in difficult situations with agents. For effective communication and to improve the interpersonal

professional relationship between all role players in the clinical practice environment, learner nurses should be confident about what their learning needs are and demonstrate that they are self-directed and motivated to learn. The learner nurse is still learning how to be professional in their interactions with others. They are expected to exercise *self-control* when they experience stressful situations in the academic environment, as well as when conflict situations arise between the learner nurse and the professional nurse in the clinical placement facilities. Also referred to as self-discipline, self-control involves the management of thoughts and emotions. Self-control is required for the management of negative emotions or stress (Hershberger et al., 2010: Learner nurses should be in control of their emotions when they are upset at times when the NEs and PNs do not treat them with dignity and respect. Dignity is demonstrated when individuals exercise (self)control, display self-confidence, demonstrate respect, make choices and feel involved in the decision-making that underpins the care they render (Practice Review, 2010:21). They will be able to demonstrate that they are in control of their emotions when they can adapt to changing situations in the clinical placement facilities when wards are busy instead of retaliating against PNs. They should develop control over their emotions (self-control) even when they are upset or when disrespectful behaviour is shown to them by seniors. Learner nurses are persons with personal, social and academic challenges and therefore need emotional support. They could e.g. depend on CS (primary agents) to advocate on their behalf in practice. Their own spiritual needs will not overrule those of their patients, thus showing consideration for patients to have their needs fulfilled during their care. *Kindness* is a central concept of care which remains one of the core values of nursing (Peate, 2012:16). Kindness has been mentioned by the recipients as one of the basic values nurses should have when they enter the nursing profession (Debbarma, 2014:186). *Influence (learn to lead oneself)* is needed when the learner nurse demonstrates self-leadership that entails *motivation and inspiration* to learn. The learner nurse is expected to be passionate about wanting to acquire nursing knowledge and skills. The learner nurse is able to do this by intrinsically motivating him- or herself to know more.

Professional capability should be demonstrated by learner nurses who are self-directed and committed to learn what needs to be learned about nursing throughout the professional nurse training programme. This will include applying and integrating their *knowledge and practical skills* to deliver effective and safe patient-centred nursing care. A learner nurse will need to apply affective, psychomotor and cognitive skills to become a competent nurse. Learners should be aware or mindful (underlying dynamic) about the cultural differences and backgrounds of others (Baillie & Matiti, 2013:7) and need to understand and respect others because it could influence their views and philosophy in the work-life while caring for patients, and could build teamwork and collegial relationships with others. During the course of the programme, the learner nurse

should gain knowledge about other people's (e.g. patients') cultures in order to create a feeling of self-worth and being understood. Recipients become *self-directed* leaders who influence themselves positively by taking personal responsibility for adjusting their behaviour towards positive outcomes. *Wisdom* is needed. A person who possesses wisdom demonstrates intellectual, social and emotional qualities with interplay of thought, emotion and motivation. A wise nurse could be concerned with the needs of others and not focus on own personal needs (D'Antonio, 2014:105). This recipient as learner nurse assumes various roles when they occupy the academic environment and the clinical practice environments. In the academic environment, the recipient wants to be a student in the general university campus community. In the clinical practice environment, the recipient is expected by the agent to behave as a professional when performing nursing tasks. When the learner nurse is able to distinguish between these two roles, they exercise sound judgement and make wise decisions about how to conduct themselves in different settings. For this role change to take place within the learner nurse, a certain level of *wisdom* is required to differentiate between the two learning environments. Recipients demonstrate that they have the professional capability to make a judgment about their own professional conduct during the fulfilment of the respective roles. *Autonomy* is demonstrated when the learner nurses are allowed to exercise freedom of choice in making decisions about their learning. The recipient is responsible and accountable for their own behaviour, depending on the role (student or nurse) they exercise at a given time in their life. Recipients can choose how to conduct themselves and are expected to be respectful towards their peers in the classroom, the nurse educationalists, and the PNs in the wards where they are placed. The current challenges of the nursing profession, demand nurse educationalists and PNs to review the autonomy of nurses and to understand the manner nurses present themselves and relate to other members of the health team and with society (Da Silva & Pedro, 2010:212).

Learner nurses who enter the profession have *personal reliability (character domain)*. Personal reliability includes being responsible and holding oneself accountable when things do not go as planned (Grice et al., 2013). They should have the desire *(passion)* to become nurses who are professionally capable (committed) to deliver a service to mankind. *Service*: Learner nurses should be of service to the patients when they attend the healthcare (NP) environment for clinical learning. It is expected that learner nurses display an altruistic desire to serve the holistic needs of the patients during their placement in the wards and not only provide physical nursing care. Learner nurses should want to be of service to others (Brown & Ferrill, 2009:6). Learner nurses are expected to talk to patients and assist them instead of keeping themselves busy on their cell phones. He or she should be a *reliable* person and somebody that can be trusted. When learner nurses engage with the patient in the clinical placement facility, they start building a trust

relationship with the patient who expects them to be there for him or her by caring for his or her needs. Furthermore, learner nurses are expected by nurse educationalists and PNs to act ethically and to maintain standards of *honesty and integrity* as part of their personal reliability. Integrity in learner nurses has been promoted by endorsing the core nursing values which enhances the quality of patient care and outcomes (Schmidt, 2014:7). Learner nurses should keep meticulous records of their attendance in the clinical placement facilities and avoid actions which might impose disciplinary measures against them, e.g. forging signatures of PNs as a means of providing evidence of clinical attendance at the clinical placement facility. The recipient will be held liable and be disciplined for unethical conduct should he or she be found guilty of forging clinical attendance records. In other instances, learner nurses were expected to confront unethical actions in others and not conform to practices of misconduct e.g. when secondary agents take shortcuts with patient care just to get through the targets of the day. When such behaviour is observed, the learner nurse is expected to take a principled stand even if they will be unpopular with the professional staff in the wards. The learner nurse, by maintaining standards of honesty, demonstrates the ability to be trustworthy (John Hopkins University, n.d.). The learner nurse's ability to progress to higher levels of character or personal reliability depends on whether he or has a *humble* attitude (Brown & Ferrill, 2009).

Responsibility/commitment to excellence comes to the fore during the professional training programme, as the learner nurse carries out nursing tasks and responsibilities within their scope of practice. They should not feel that tasks are beneath them nor should they be concerned about receiving rewards or recognition. A learner nurse in their senior years of training should for example not feel that offering a bedpan to the patient is degrading or of less importance. The humble learner nurse should show concern for the patient so as to reach positive patient care outcomes. The learner nurse learns to become a responsible person, as required by nursing law, in the undergraduate nursing programme. They learn that they should honour and obey the commands of agents and diligently carry out the nursing tasks and responsibilities which have been delegated to them. This demonstrates a *commitment to excellence* on the part of the learner nurse who has a sense of responsibility when they perform the necessary nursing care tasks and responsibilities. The learner nurse should therefore not refuse to carry out the delegated nursing responsibilities given to them. Learner nurses should also demonstrate responsibility towards the patient, employer and other allied and healthcare professionals by their commitment to be on duty and be on time to attend to the needs the patient. Learner nurses in an undergraduate nursing programme are expected to take responsibility for their own learning. They are thus required to take initiative by approaching secondary agents specifically in the clinical placement facilities about their learning needs and ask questions when they are unclear about the

expectations when they are in the academic and clinical practice environments. *Assertiveness* is a communication skill that all learner nurses should possess to bring their point of view across without being aggressive towards others. When learner nurses interact with senior nurses in the clinical practice environment, they are expected to use this skill by communicating their learning needs politely to the professional nurse in the patient care wards. For effective communication and to improve the interpersonal professional relationship in the clinical practice environment, learner nurses could be confident about their learning needs by being self-directed and motivated to learn. It was expected that learner nurses demonstrate *assertiveness* by communicating their rights as learner nurses in a polite manner to the professional staff in the clinical practice environment. The learner nurse is able to demonstrate *moral courage* in their willingness to stand up for and act according to his or her ethical beliefs when moral principles are threatened, regardless of the perceived risk (Lachman, Murray, Iseminger & Ganske, 2012:24).

In the face of difficult circumstances, such as academic workload pressure and a shortage of appropriate and adequate material resources (skills laboratory equipment), the recipient displays the courage to maintain professional behaviour without e.g. entering in strike actions. In other instances, the recipient (as an individual from a cultural background that might differ from other nurses) is able to demonstrate courage in modifying his or her personal beliefs and values when they are in conflict with the professional values of the nursing profession.

7.2.3.2 *The role of the recipient*

Follower

Learner nurses are followers of nurse leaders who guide and direct them to health or wellness (professionalism). Followers are guided when they ask questions and leaders are able to clarify the answers so that followers are clear on the expectations of the leaders in terms of professional behaviour in the NPE (Hersey & Blanchard, in Bjugstad et al., 2006:310). Followers are directed on the right path by leaders when they perform nursing tasks. The followers (learner nurses) are expected to follow or carry out the instructions and their performance should be monitored by the leaders (nurse educationalists and PNs).

Self-leader

Nurses (recipients) are self-leaders who motivate themselves and are committed to effect change in their own behaviour. In a rapidly changing environment, it is important that the recipient acquire self-leadership through self-influence. The recipient should be goal-directed, apply self-control measures and have intrinsic motivation (Furtner, Sachse & Exenberger, 2012:295).

Learner (self-directed)

The recipient enters the academic and practice environment as a learner who should have the passion and eagerness to learn what needs to be learned about nursing. The recipient identifies shortcomings in their own learning and what needs to be learned with regards to their learning outcomes. During the undergraduate professional nurse training programme, the recipient becomes self-directed and takes initiative to confidently communicate these learning needs to the agent (in the academic and clinical practice environment) with whom they build an effective interpersonal professional relationship. As a self-directed learner, the recipient engages in a process whereby he or she is able to initiate, with or without the assistance of others, their own learning needs; formulate their learning goals; identify the human and material resources for learning; choose and implement appropriate learning strategies and evaluate learning outcomes. In a constant changing environment, it is important that learner nurses become self-directed to enable them to develop in dependent learning skills and a sense of responsibility and assertiveness that are essential qualities for a nurse` career. It is suggested that the expectations in professional behavioural outcomes could be only be achieved once learner nurses become self-directed learners (Mulube & Jooste, 2014:1776).

7.2.4 Underlying dynamics: What is the energy source for the activity (physical, biological or psychological)?

The dynamics for the successful development of professionalism for the NP are the factors in the specific context that contribute to a successful outcome. Professionalism refers to the conduct and qualities that describe behaviours that are expected of the members of the profession.

Healthcare professionals such as nurses demonstrate professionalism by attitudes, knowledge and behaviours that reflect a multifaceted approach to the regulations, principles, and standards underlying successful clinical practice (Tanaka, Yonemitsu, Kawamoto, 2014:549). The important underlying dynamics that promote professionalism among learner nurses are being caring and mindful (see Figure 7.5).

Underlying dynamic
Caring Mindfulness - Self-awareness - Self-realisation

Figure 7.5: Underlying dynamics facilitating nursing professionalism

7.2.4.1 *Caring*

The quality of caring facilitates professionalism among undergraduate learner nurses and relates to beneficence (doing good), which is categorised as the core value of nursing and part of the ethical aspect of reality (Jooste, 2017:6). Nursing should be promoted as a caring profession in which a friendly environment is created by the professional nurse (agent) for the learner nurses as followers. Caring is about people and is viewed as a behaviour that comes from a feeling, concern or interest in someone. This concern and interest contributes to the worth and dignity of a person, which is regarded as an ethical concept of doing good to others (Muller, 2009:20). Both academic and professional staff (agents) is expected to always treat learner nurses (recipients) with a kind and warm attitude in both the classroom and clinical learning environment.

In the clinical learning environment, PNs (agents) must show that they care (caring), by being sensitive (having empathy) to the diverse learner nurses (recipients) and their individual and unique needs. It means that agents should have affective empathy by "caring about" the person's (learner nurse's) circumstances in order to care for that person, thereby showing emotion or feeling (Marcum, 2013:3). The agent uses his or her ability to care for the recipient through understanding that the recipient is a unique individual who is vulnerable in the clinical practice environment. The mature professional practitioner (agent), according to Muller (2009:10), should thus reflect a caring ethos, which includes empathy.

Professional Nurses should display a caring attitude towards followers or learner nurses (recipients) through encouraging effective communication and thus ensuring that patient needs are attended to. In addition to the principles (elements) of professionalism, the caring agent demonstrates politeness, friendliness, a welcoming attitude, willingness to treat others with courtesy and consideration (included in the South African Batho Pele principles) and a passion for nursing (Reid, 2012:218). The caring agent will be able to lead the recipient who is in need of care to health (enhancement in professionalism). All nurses should have a caring and compassionate (interpersonal compatibility) attitude towards patients to make them feel comfortable. On the other hand, agents should demonstrate compassion towards the recipient by being respectful in communication and treating the recipient with dignity. Caring also includes being there for the person (support for the recipient or learner nurse) in the undergraduate programme, respecting the recipient irrespective of the circumstances in which nursing care takes place in the workplace environment and having regard and concern about how the recipient experiences his or her "world of health" (professionalism) (Muller, 2009:21). Professional nurses specifically in clinical practice (secondary agent) as role models, should be committed to serve

the needs of others and have a caring attitude so that learner nurses (recipients) feel free to approach them in clinical practice.

Muller (2009:21) confirms that compassion, competence, confidence, commitment and empathy are key characteristics of a caring profession. Professionalism is evident when a person is accountable, and demonstrates a commitment to excellence and to serve and respect others. By carrying out the fundamental principles within the professional ethical and legal framework of nursing, a caring ethos, rooted in the philosophical basis of nursing in South Africa, the attributes of professionalism, human rights (Constitution of South Africa, Act 108 of 1996), the Patient's Rights Charter (DoH, 1997) and the Batho Pele Principles (1996) are upheld. This study brings to the fore a combination of the theories of caring of Watson (2008), Ray (2010), Coffman (2010) and Ray and Turkell (2010). Watson's (2008) theory of caring centres on caring as a moral ideal and harmony of mind, body and soul. Ray (2010), Coffmann (2010) and Ray and Turkell (2010) describe caring as a relationship between human and spiritual caring dimensions (spiritual, ethical, humanistic, social) and the organisational context of hospital health care systems (with its economic, political, technological and legal dimensions).

7.2.4.2 *Mindfulness as an underlying dynamic of professionalism*

Mindfulness is described by Halliwell in Brass (2016) as "an integrative mind-body based approach that helps people change the way they think and feel about experiences. It involves paying attention to our thoughts and feelings so we become more aware of them and better able to manage them". Thoughts affect attitude and behaviour. The mind is powerful and learning to choose thoughts that support self-healing is vital to wellbeing (professionalism) (Crane & Ward, 2016:392). Mindfulness is closely related to meditation. It is described as maintaining an awareness moment-by-moment of thoughts, feelings, bodily (physical) sensations in the surrounding environment and reactions to them. It invites the person to pay attention to the aforementioned in a conscious way and thus discover opportunities for change (Crane & Ward, 2016:393). Underlying professionalism, is mindfulness (self-awareness) in self-leadership. Its relevance in this study would thus be on leading oneself to health (professionalism) by cultivating awareness of the unity of the mind, body and spirit, as well as ways that unconscious thoughts, feelings and behaviours can undermine emotional, physical and spiritual health (Crane & Ward, 2016). The essence of self-healing is for the nurse to engage in activities and responses that promote wellbeing in mind, body and spirit. Learner nurses are expected to be mindful of their responsibility (as self-directed learners) to take responsibility for their own learning, and to internalise and develop professional behaviour for clinical practice. Learner nurses (recipients) should voice their learning needs by being self-directed (professional capability) and taking

responsibility (personal reliability) to recognise (be aware of) what needs to be learned. Crane and Ward (2016) mention that self-responsibility helps the nurse to be a more positive change agent in the health care organisation and patient care. When nurses are aware of who they are and where they come from, it is easy to adjust or modify behaviour. In nursing, mindfulness of cultural differences and backgrounds is important in understanding and respecting others because it influences one's view and philosophy in life. Nurses (agents and recipients) should be aware of the underlying dynamic of being mindful of the cultural differences of others as it builds teamwork and collegial relationships with others. They should also be aware (mindful) of their own values stemming from their cultural background. Agents should be mindful of individual cultural values as they might influence (interpersonal compatibility) the values of the profession. All nurses must have the courage to do what is right or ought to be done when there is conflict between the personal values and the profession values. When personal and professional values differ, the nurse need to modify his/her behaviour to bring about positive change in respect of positive nursing care outcomes. Congruency in the verbal and non-verbal communication of agents will show that they as leaders are fully aware/mindful and has the followers' best interest at heart. All nurses should be mindful of having compassion for others and treating them with respect and dignity. Professional nurses should be mindful of their behaviour towards patients and their professional treatment of learner nurses.

In the higher education setting, nurse educators (primary agents) should be mindful of the socio-political influences of the country on the professional training of learner nurses (Baillie & Matiti, 2013:7). With times changing, nursing education and practice should stay abreast of new uses of technology in teaching and learning, and e.g. the use of information technology for patient recordkeeping purposes. On the other hand, PNs as leaders (secondary agents) in clinical practice should be mindful of their responsibility (personal reliability) to orientate learner nurses to new settings in the institution. Professional nurses should also be mindful of the learner nurses who are new to the wards by acknowledging them as part of the team and making them feel welcome. They should be mindful and show personal reliability by demonstrating humility in serving the learning needs of followers/learner nurses. On the other hand, learner nurses should be aware (mindful) of embedded learning outcomes in the nursing curriculum, which is a requirement for the clinical practice environment.

7.2.5 Procedure: What is the guiding procedure, technique, or protocol for the activity (processes)?

The procedure is the specific processes needed for professionalism among undergraduate learner nurses. Nurse educationalists and PNs use these processes to facilitate professionalism among undergraduate learner nurses (see Figure 7.6):

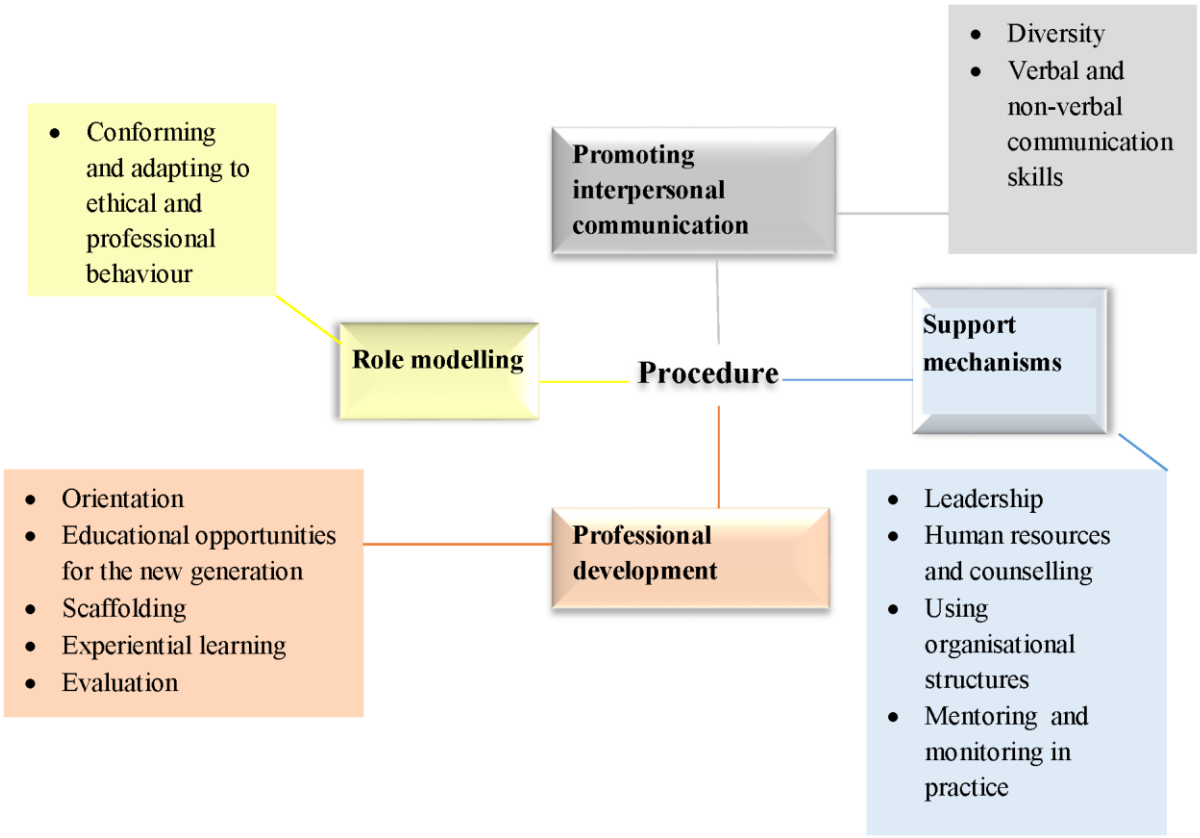


Figure 7.6: Procedure

The procedures which nurse educationalists and professional nurses should use to guide and direct learner nurses towards professionalism are: i) role modelling; ii) promoting interpersonal communication; iii) professional development; and iv) support mechanisms.

7.2.5.1 *Role modelling*

Role modelling is an overarching activity that encompasses everything a person does in his or her being and acting as professional (Boerebach, Lombarts, Keijzer, Heineman & Arah, 2012:1). Role modelling occurs when the agent facilitates or promotes the attainment and maintenance of health (professionalism) in the recipient (Twentyman & Eaton, in Jooste, 2017:218). Felstead (2013:233) states that these expectations may influence who recipients choose to be their role

model and influence their professional development. Role modelling enables the agent to uphold and share the values of the profession with the recipient. The agent as role model has been socialised into his or her role. According to Searle and Pera (1997:213-214), the role model has characteristics which were described as expectations by the recipient. These characteristics describe the agent (as role model) as someone who:

- should hold a respected position in society;
- has rights and responsibilities to create an environment in which standards of professionalism are promoted and maintained;
- observes the laws of the country;
- continues to develop professional competence so as to keep up to date with new developments e.g. in information technology;
- interacts with recipients in a respectful and dignified manner;
- is confident as a professional in carrying out nursing duties;
- is competent and uses nursing skills based on professional knowledge; and
- controls his or her emotions in stressful situations.

The agent is expected to be a positive role model who is conscious of body language and facial expression, show enthusiasm for the nursing profession and inspire recipients. As a role model, the agent should give constructive criticism to the recipient and not humiliate or embarrass recipients in front of others (Twentyman & Eaton, in Jooste, 2017:218). In nursing, both clinical practice and academic staff i.e. PNs and nurse educationalists as agents, should be seen as role models because nursing education and professional socialisation in NP are combined or integrated (Felstead, 2013:226).

Role models, i.e. nurse educationalists and PNs in practice, ensure that learner nurses gain confidence throughout their training programme so that they have acquired the right knowledge, skills and attitudes on completion of their qualification. Nurse educators as role models should professionally groom and prepare learner nurses for NP by giving guidance and direction (leadership) in the classroom and clinical placement environments. Thus, in an empowering environment (context), learner nurses are guided with clear professional policies and guidelines by nurse educationalists (e.g. CS) who inspire learner nurses when they continue to uphold the efforts of the profession, such as wearing the appropriate clothes and identification required for NP in the clinical environment. Professional appearance is important and is regarded as a

responsibility by the nurses from the "old school" (role models), more so than the (younger) new generation.

In practice, professional nurses are required to lead by example and act as role models of professional behaviour. They should create a welcoming atmosphere for learner nurses who are new to the ward by having a kind and respectful demeanour. The professional nurse thus role models tolerance in such behaviour and is able to inspire (interpersonal compatibility) and motivate the learner nurses to be part of the team. As role models, PNs should therefore positively influence subordinates or learner nurses by ensuring harmony in the workplace environment. This is achieved when PNs lead by example and role model interpersonal compatibility through self-control by maintaining a stable affect under work pressure. At the highest level of interpersonal compatibility, PNs should be able to influence learner nurses by showing them the right conduct, and encouraging a practice of honesty and integrity as they direct the learner nurses to become professional practitioners.

- *Conforming and adapting to ethical and professional behaviour*

Modelling of professional behaviour and attitudes are observed and recreated through the process of adaptation. When listening and watching the behaviours and professional demeanour of others, learning occurs through critical reflection (Regan, 2012:4). Members of the profession learn to identify what others expect from them and deliver on those expectations due to the social contract of the profession. New members to the profession adapt their perspectives to conform to the shared goals of the profession. Therefore when learner nurses observe others in the NPE, it reinforces the positive benefits of cooperation and collegiality, the perceived benefits and rewards of group membership. In addition conforming to group norms brings with it a welcome sense of belonging (Regan, 2012:4). Learning also occurs through the concept of understanding and grasping what people say or do. Making the unfamiliar familiar and identifying what patterns and codes are in use are important steps to learning how to conform and adapt behaviour. When learner nurses enter the profession they should adapt to the academic and clinical practice environment. Role reversals of the learner nurse in the undergraduate nursing programme is inevitable and takes place when the learner nurse enter a community of adult learners from being a high school learner and simultaneously have to be socialised into the professional culture of nursing. In the academic and clinical practice environment learner nurses should observe the professional behaviour of nurse educationalists and PNs who role model the professional culture of nursing. Professional nurses should guide learner nurses to adhere and conform to the rules of the profession in order to achieve the desired behaviour in the learner nurse of what is acceptable and unacceptable behaviour in clinical practice. Learner nurses

should thus be empowered by nurse educationalists and PNs to resist poor practice examples and adapt to different policies and practices in the healthcare facilities. With this goal in mind, having clear professional policies and guidelines in place would guide the learner nurse in the placement facilities on how to behave in the practice environment.

7.2.5.2 *Promoting interpersonal communication*

The academic learning environment and the clinical nursing practice environment are both responsible for the professional development of the learner nurse. Communication between HEIs and NP is essential to facilitate the professional development of learner nurses, especially when professional interaction between agent and recipient considers innovative means of communication and the use of technology in the 21st century. Communication is an important aspect of the practical component in the clinical learning environment. In nursing practice, communication should take place with respect for socio-cultural diversity. All nurses should be considerate and understand the feelings of others who are unable to express themselves because of e.g. the language they speak. A common or universal language enables diverse individuals to understand one another and prevents distortion of meaning. Interpersonal compatibility in communication is therefore needed between the agent (nurse educationalists and PNs) and the learner nurse (recipient). *Learner nurses* described their expectations about communicating (see 6.2.2) in a professional, culturally diverse clinical learning environment that required active listening, especially because of the different languages spoken in the clinical placement facilities. Professional nurses should advocate for a universal language to be spoken in all healthcare facilities so as to prevent undesired patient care outcomes due to misunderstandings. When being listened to, nurses' self-esteem and patient outcomes are improved (Rouse & Al-Magbali, 2014:7). Therefore, collaboration between students and healthcare professionals is essential for demonstrating how effective communication can lead to better patient care outcomes (Maninno & Cotter, 2016:3).

The nurse educationalists, professional nurse and the learner nurse engage in a relationship where there is constant exchange of information. Communication therefore forms the core component of this relationship. Communication that takes place in this relationship is important for collaboration between the respective agents, the subsequent integration of the theoretical environment with the clinical practice environment and the facilitation of cooperation and teamwork. These are essential aspects of professional practice (Du Plessis, Jordaan & Dali, in Jooste, 2017:205). Agents who create a work environment of team work (where there is trust among staff members) are friendly, open to communication or approachable, and supportive.

This atmosphere helps to foster positive role modelling behaviour towards recipients (followers) who are new to the nursing profession.

- *Diversity*

All people are unique, which means that agents interact with recipients from diverse cultural backgrounds with diverse values and perceptions concerning learning needs or goals and speak different languages, therefore it is unavoidable that conflict will occur in the academic and practice learning environment. The relationship between agent and recipient is developed and sustained through interpersonal communication. For this relationship to be effective, it is necessary to develop self-awareness because it contributes to an awareness of not only the agents' goals in leading the recipient to professionalism, but also helps the recipient to become aware of his or her own learning needs in developing professionalism. Wood (2007:211) suggests that agents should be comfortable with differences in needs within relationships and that they should engage in negotiating these differences in a respectful manner. Wood (2007) also emphasises the importance of investing in relationships by means of commitment and trust in order to develop self-awareness and a constructive expression of feelings. Awareness of diversity thus occurs when nurses reflect on their own cultural identity, know their own cultural values and beliefs and recognise the differences within their own cultural group (Jeffreys, 2008:37). Professional groups form their own sub-culture, especially in their language and communication habits. They therefore tend to be separated, even when they are working with other team members in the same organisation (Ghadirian, Salsali & Cheraghi, 2014:7). Within the cultural context of this study, professionally mature agents should be skilful communicators who have an understanding of the messages from the recipient and show respect to recipients of other cultures. With this in mind, agents acknowledge that they have a role and function in a changing environment where information technology is growing fast and of which recipients, as the new generation, are part of.

- *Verbal and non-verbal communication*

Nurses are expected to use culturally competent verbal and non-verbal communication skills to identify clients' values, beliefs and unique health care needs. They strive to comprehend clients' needs through effective listening and attentive body language (Douglas et al., 2011). Acknowledgement of each other may be displayed verbally and non-verbally for example in the body language of the agent as it communicates that the agent is available to the learner nurse (recipient). It means that the agent is here for the learner nurse to listen not only to the learning needs, but also to the personal needs of the learner nurse. Bunch (1999) explains that "presence

contribute to trust, leadership and collaboration". It is only achieved by being fully present in mind, body and being fully attentive to what is going on around the person. Not listening and being judgemental can obstruct the interpersonal relationship between the agent and the recipient. Agents demonstrate that they are there for the specific needs of the recipient and they provide a platform for recipients to freely verbalise any grievances or dissatisfaction. Agents are: understanding of the uniqueness of the recipient, approachable and open to communication, and caring.

The interpersonal relationship between the agent and the recipient is not without barriers and is complicated by obstacles in organisational structure, and cultural and generational differences. These barriers can give rise to conflict between the agent and the recipient. Roussel, Swansburg and Swansburg (2006:204) suggest that conflict can be managed through progressive and non-punitive discipline. Agents are expected to be consistent in their punishment and should not have favourites. The agent is furthermore expected to be firm when recipients are not punctual in the academic and practice environments and should stick to their decisions. Punctuality is a form of courtesy and showing respect for others (Mathevula & Khoza, 2013:5). Agents should use their ability to handle conflict in a way that builds respect, trust and confidence in the recipient.

7.2.5.3 *Professional development*

Professional training and development is essential in achieving excellence in nursing (Singh, 2015:6). Neophytes or new learner nurses who enter the nursing profession, have certain expectations of what a professional nurse should do and how a nurse should behave when they start their professional training programme (Felstead, 2013:223). The primary agents who students meet are the nurse educationalists (nursing lecturers and CS at the HEIs) and the PNs (secondary agents) in the clinical placement facilities, as well as senior learner nurses in the same undergraduate training programmes. The work of nurse educationalists and PNs, seen as mentors in the academic and practice environment, is considered important in supporting the professional development of the learner nurse and assessing their competencies (Papastavrou et al., 2016:3).

The HEI should acknowledge the importance of training learner nurses to become PNs, and therefore should provide adequate learning opportunities. Rigorous enforcement of rules is one way of assisting learner nurses with their professional development and achievement of the desired level of professionalism. First and second-year learner nurses should be informed about the expectations around professionalism through entering into a contract for professional development over the four years of nurse training programme. Nurse educators should reward (praise) learner nurses in their fourth year of the undergraduate nurses training programme when

they can show proof of their professional development throughout the undergraduate nurses training programme. Committed PNs who are exclusively responsible for overseeing the professional academic and clinical development of learner nurses in the hospitals are needed.

- *Orientation*

To orientate is to adjust to new circumstances and surroundings (Charleston et al., 2007). In the context of nursing, orientation refers to a course that introduces a new situation or environment. The main reasons for orientation are to enhance skills and knowledge, to facilitate the integration of theory and practice and to ease the learner nurses' transition from university life (academic) to the clinical setting (practice environment). Providing learner nurses with a comprehensive, practical orientation upon arrival is a key responsibility of clinical placement sites. Without proper orientation, learner nurses spend valuable time seeking mentorship and trying to orient themselves to the site rather than gaining valuable professional experience (Birks, Bagley, Park, Burkot & Mills, n.d.:20). Mentorship, for instance, has been relied upon as a support mechanism for learner nurses and is also the main vehicle for the activities associated with learning, teaching and assessment of NP (Bettinger, Boatman & Long, 2013:93). Orientation of new learner nurses by PNs in the hospital environment is essential to prevent misunderstandings and ensures that learner nurses know what is expected of them in the wards. During orientation, learner nurses should be welcomed into the professional team. This sense of belonging is linked to the facilitation of positive learning experiences that are critical to the professional role of the nurse (Birk et al., n.d.:23). Professional nurses (secondary agents) should support learner nurses in the clinical sites and create a warm and friendly environment by treating them with respect and dignity.

- *Educational opportunities*

Students generally learn by following the example of their educators who create the sense that role modelling is part of the educational process (Felstead, 2013:226). Educationalists and PNs (primary and secondary agents) are able to influence the professional development of learner nurses' (recipients') clinical skills, competence and professionalism by creating opportunities for learning in both educational environments. In this study, learner nurses valued PNs who created opportunities for learning during their clinical placement, but their capacity to fully benefit from the learning opportunities was hampered by limited exposure to clinical practice. This is similar to study findings by Birks et al. (n.d.:21). Agents as role models should foster professional values in recipients (learner nurses) and embody a standard of excellence that learner nurses can imitate (Wright & Carrese, in Felstead, 2013).

The strategy of feedback should be used by PNs when they focus on corrective measures in cases where mistakes by learner nurses are inevitable. Constructive feedback in the right context builds confidence and personal character and ensures professional development. The role of constructive feedback is to help the learner nurse consistently to achieve high quality performance in a process whereby the educator is evaluating the learner`s skills and behaviours, the learner (Thomas, Robert & Arnold, 2011:233). Continuous reinforcement of what professionalism entails is essential for the professional development of learner nurses. Academic staff (nurse educators/primary agents) at the HEI should use processes for learning such as reinforcement (procedure) of essential skills needed for patient care in NP. Therefore, reinforcement, reward and appreciation are actions that should be used by nurse educationalists and PNs to motivate learner nurses to reach positive outcomes in behaviour and to develop professionally. The strategy of reward is, for example, used by NEs for proof of professional behaviour and to assist learner nurses to develop professionalism.

- *Scaffolding*

Scaffolding learning involves a transition area where learners can improve their learning with help from more experienced people. In the nursing education context, scaffolding strategies include feedback, simulation, collaboration and role modelling (Bjork, Christiansen, Havnes & Hessevaagbakke, 2015:136). Scaffolding learning is part of educational opportunities that also include continuity and reinforcement of the professional values throughout the undergraduate nursing programme. Scaffolding learning in the form of annual reinforcement, as well as more experiential learning in clinical practice, is essential in learner nurses' identification with and internalisation of professional values. The clinical practice environment should effectively be used as a resource for learning.

- *Experiential learning*

Experiential learning is needed to enable learner nurses in the clinical setting to identify with and reflect on what they have been taught in theory at the university and for their professional development. The application of a variety of teaching methods in nursing education is used to suit the varying learning styles of learners during the different stages of maturation (Kolb & Kolb, in Subhan, 2014:17). According to Kolb and Kolb (2005), knowledge is developed through the acquisition and transformation of experiences, with the focus being on the process of learning (Subhan, 2014:17). It is important that nurse educationalists guide learner nurses through the different maturation stages and encourage them to progress from a stage of concrete to abstract conceptualisation (Kolb & Kolb, in Subhan, 2014). In this study, nurse educationalists

and PNs acknowledged that the current learner nurses are the younger generation of nurses and that they must adapt to a changing 21st century to meet the learning needs of learner nurses (Subhan, 2014:205). Reflection is an important part of learning and self-development as it enables the learner nurse to improve on his or her own practice by integrating theory and practice. Learner nurses could, however, enhance the integration of theory and practice (hence improving professional competence) by increasing their exposure to practice. This exposure is essential to professional development, because it creates opportunities for learning. At the same time, learner nurses could benefit from receiving bedside (on the spot) or in-service training in the healthcare facility. Furthermore, learner nurses from HEIs could positively contribute to the professional image of nursing and could develop professionally, provided that they get more practical exposure. Increasing the students' practical exposure could be achieved through a block system that divide up the students' time into time in the classroom and time spent in wards in clinical practice.

- *Evaluation*

Evaluation is about improving the students' learning. Students are the central focus of teaching and learning and as the aim is to improve learning, their evaluations are important (University of Brighton, 2014-2015:4). Primary and secondary agents in the different learning environments should be able to collaborate with each other and use reports as feedback to improve positive professional outcomes in learner nurses. As the primary agents, NEs (primary agents) should use evaluation as strategy to monitor whether their guidance led to the desired professional development of learner nurses (recipients). However, nurse educationalists should be fair (social justice) and apply consistent assessment and evaluation procedures in their assessment/judgement of others/learner nurses throughout the programme. On the other hand, learner nurses should be able to evaluate and give feedback to PNs (secondary agents) on shortcomings in their leadership styles in NP, in order to improve the profession.

7.2.5.4 *Support mechanisms*

Support is referred to as the assistance that should be provided to learners by all nurses, i.e. NEs, CS, PNs and mentors who are able to facilitate learning (Henderson & Eaton, 2012:197). A major obstacle to learning, integral to NP, is insufficient resources, as noted by Henderson and Eaton (2012:198). Departments of Health are now expected to consider what is required by health services of its nurses and how these requirements can be supported, facilitated and funded. Nursing is a vital part of adequate resourcing and a crucial element in care delivery in the existence of a safe effective and humane health service. Nurses therefore should share this

understanding that NP places demands not only on the technical competence of the learner nurse, but also on the personhood of the nurse. It thus demands of the nursing profession to ensure appropriate professional preparation that includes preparation regarding the core importance of sensitive human interaction as foundational to NP with patients, students and colleagues. This conceptualisation of NP will subsequently also place demands health service managers to plan and resource such practice (Scott et al., 2013:10). Furthermore, adequate preparation of undergraduate learners for NP suggests that mechanisms such as the planning of the workload and feedback to maintain nurses' interest and motivation be established in the organisation or institution of learning (Henderson & Eaton, 2012). Support mechanisms for developing professionalism among undergraduate learners' nursing practice are leadership, adequate human resources and counselling, the selection of motivated students, mentoring and monitoring, and evaluation.

- *Leadership*

Leadership is essential to the facilitation of learning and involves the creation of educational opportunities in the clinical learning environment. Nurses should be able to assume leadership roles when necessary in the different contexts of the academic and clinical practice environment, show pride in the profession, advocate on behalf of the profession and adapt to changes in the 21st century (Grice, 2013:9). Professional nurses are influencing learner nurses positively when they are creating an opportunity for learning in the ward/patient care unit. Professional nurses as agents should encourage learner nurses to take the lead and remind seniors of teaching moments in the clinical facilities. According to Jooste (2017), PNs as leaders, should communicate the future picture of managing service more effectively to learners as followers by:

- sharing the vision and mission of the service with them
- setting time frames for their tasks
- being positive, and being open with their followers
- establishing team-building projects in the service
- promoting research strategies in the service
- operating within the legal/ethical/professional framework of the profession and country
- using their listening skills

- *Human resources and counselling*

Human resources are needed in the clinical practice environment to support undergraduate learner nurses. Increased human resources could positively influence the teaching function of PNs in that it contributes to the professional development (procedure) of learner nurses. In the face of workload pressure and a lack of support mechanisms (including resources e.g. human resources and teaching/learning material), nurses should display patience (tolerance) and maintain professionalism under difficult circumstances. However, workload relief and adequate learning resources are needed to support learner nurses in the application of theoretical knowledge in the practice environment. A lack of appropriate learning material or resources would hence not equip the learner nurse with adequate and proper skills to conduct themselves in the appropriate professional manner in the clinical practice learning environment. Quality and safe health care relies on the effective educational preparation of the learner nurse which is dependent on proficient staff and the availability of adequate resources within clinical areas (Henderson et al., 2011:1).

The availability of mentors and more practical exposure seem to provide the required support for learner nurses in the undergraduate programme. Supervision and the availability of mentors provide the necessary support to learners in the clinical practice environment to learn and apply their practical skills correctly. To ensure availability for personal and academic support, CS should be stationed at each hospital and have an office in reach of learner nurses.

Traumatic experiences in the personal and/or professional life of learner nurses influence their professional behaviour. Students need to cope with the academic demands of an integrated theory and practice programme, while at the same time dealing with personal challenges. The availability of a nurse councillor who cares for learner nurses enables vulnerable participants to deal with mental and emotional trauma. Personalised counselling services unique to the emotional needs of nurses (such as academic pressure, being exposed to sensitive and stressful situations (diseases, death), and managing their family responsibilities) are therefore needed for learner nurses. Mentors should be available to support learner nurses with personal matters, as well as with their academic programme, such as dealing with a heavy workload and managing time wisely. Humour is regarded as a strategy to relieve stress and is essential for complete wellbeing of mind, body and spirit (Crane & Ward, 2016:395).

Professional nurses also experience emotional and physical challenges (internal environment) when they are under pressure because of shortage of staff (support structure) in the workplace environment, thus not being able to provide the necessary and appropriate support to learner nurses. Scott et al. (2013:9) confirm that inadequate nurse staffing levels can be dangerous and

pose challenges for the nursing profession. Burnout and exhausted nurses are less likely to be able to be compassionate. When they are under stress because of time and work pressure, they are also likely to focus on completing perceived key physiological needs of patients and leaving other important nursing care such as perceived "less important" psychological support of patients unmet (Scott et al., 2013:9). In this study perceived "less important" nursing care would be that of support to learner nurses. A support structure is needed for learners through which their discontent, unhappiness, concerns and complaints can be voiced. Mentors and nurse leaders should create grievance platforms for learner nurses on which they can freely verbalise their grievances in a safe environment in the clinical placement facilities.

- *Organisational structure*

Nurses' training schools at HEIs should recruit and select motivated learner nurses who are committed to the profession. Learner nurses should be able to integrate and apply their theoretical and practical knowledge in professional clinical practice. To improve their interpersonal professional relationship in the clinical practice environment, learner nurses should be motivated to learn by being self-directed. They should be able to create a learning environment in which they take ownership, act competent, initiate their own learning and are self-motivated while carrying out a positive image of the nursing profession. Therefore, with professionalism, motivated and eager learner nurses are needed in the NP. It is however important that nurse educationalists should be mindful of the age of nursing students when they enter the undergraduate programme as it could impact on the academic success of the student. Although students enter HEIs as adult learners, older students tend to perform academically better than younger students do. A possible explanation is that an older student is often more motivated and committed to succeed due to previous experiences and failures (Roos, 2014:28). Learner nurses should take responsibility for their own learning by approaching the sisters (PNs) in the wards with their learning needs and being motivated to learn what needs to be learned (professional capability).

In the clinical NPE, the organisational structure follows a hierarchy of nurse authorities or nurse leaders (agents) (Lorenzitti, Oro, Matos & Gelbcke, 2014:1107). Subordinates, including learner nurses should uphold the efforts of the profession by respecting (interpersonal compatibility) nurse leaders who are experts in the clinical practice environment and are responsible and accountable to ensure that nurses practice nursing care within the context of NP standards and professional guidelines of the profession, thereby ensuring safe patient care. All nurses, including learner nurses who come to the health facilities for clinical placements, should thus adhere to policies and guidelines in the workplace. Learner nurses should obey the rules and

follow the protocols of the profession and the healthcare institution. PNs in practice are required to ensure that the desired professional behaviour and organisational ground rules are introduced to novice nurses at the start of their training in practice. Professional practice principles, including ongoing education and professional development should be supported at all career structure levels, including at the level of student nurses (Australian Nursing and Midwifery Federation (ANMF), 2015:2). According to the ANMF (2015) structure and number of nursing positions within organisational structures should be arranged so that reasonable workloads and clinical support for all nurses are assured. The resources required to perform all nursing roles should be available.

- *Mentoring and monitoring in practice*

Mentoring of nursing students in clinical placements is important because it enables students to commit to the nursing profession and enhances the status of nursing as a career (Jokelain, 2013:1). Mentoring is defined as to "act like a mentor" that is an influential senior or experienced person giving support to a junior or inexperienced person who is the mentee. In addition, the mentor is described as a wise, reliable counsellor and teacher and a trusted adviser (Jokelain, 2013). Mentoring is regarded as a partnership between the mentor and the mentee (Canadian Society of Exploration Geophysicists, 1994). Building a relationship is an important element of the mentoring process in health and specifically nursing care. Mentors are mature, experienced and professionally advanced. Mentoring allows the matured mentor (the agent) to guide the learner nurse to develop professionalism in the NP by working side by side with the recipient, and not only giving verbal instructions, but also being hands-on and doing the nursing tasks with the recipient (Nkosi, Minnaar & Jooste, in Jooste, 2017:249). Jokelain (2013:3) views mentoring as facilitative actions such as helping, guiding and developing the growth and expertise of the recipient`s (learner nurse`s) skills, knowledge, attitudes and professional attributes. It also involves supporting and encouraging a person to achieve his or her personal and professional goals. The mentor leads the mentee by demonstrating what they expect about clinical competencies in order to develop professionalism in the mentee (learner nurse). A human approach is a principle in mentoring because one person invests time and knowledge in assisting another person`s professional growth and development. Jokelain (2013) states that the developmental process in mentoring builds individual resources via role modelling and facilitation, i.e. like listening, guiding, advising and being a critical friend. Effective mentoring, however, depends on the commitment and motivation of the mentor (agent) and the mentee (recipient). The mentor is able to provide counselling to the mentee during times of stress and

give honest feedback to the mentee about his or her academic performance in theory and practice.

The monitoring of learner nurses in the clinical placement facilities by their mentors is essential for strengthening collaboration with PNs in terms of feedback and improvement of positive behavioural change in learner nurses. Mentors (CS and NEs) should be available to monitor learner nurses in the clinical learning environment. Nurse educators (primary agents) should monitor and facilitate the desired learning outcomes in the learner nurse and use appropriate learning material to enhance successful academic performance. Assessment and feedback are needed for monitoring the learner nurse`s academic progress and the level of competency, knowledge skills and attitude both in the classroom and clinical practice. It is therefore important that mentors are expected to be competent in assessment, evaluation and feedback skills. Educationalists as mentors, should also be mindful of the principles procedures and documents o assessment, such as pass and fail criteria (Jokelainen, 2013:5). Furthermore, as with higher education programmes, the undergraduate nursing programme has to meet external and internal quality assurance, approval and regulatory procedures. The quality of nursing education in South Africa is monitored by the SANC. Monitoring activities are performed periodically by institutional and programme reviews at university level (Jokelain, 2013:9).

7.2.6 Terminus: What is the end point of the activity?

The terminus is the outcome of an activity which confirms whether the goal which has been set for the activity has been achieved or not. For the purposes of this study, the terminus is the framework for nurse educationalists and PNs for facilitating professionalism in learner nurses for NP (see Figure 7.7). The characteristics of the agent and recipient are in line with Brown et al.'s (2009) taxonomy for facilitating professionalism in the learner nurse. All agents have a shared responsibility to assist the recipient in developing health (professionalism). The facilitation of professionalism takes place in a background of diversity. Professional values regarding what is expected of learner nurses should be clear so that they can develop professionalism, which will prepare them for NP after completion of the four-year training programme. Various stakeholders need to teach learner nurses the values of professionalism in the classroom, as well as enforce positive professional behavioural changes by means of teaching and learning strategies to support the integration of these values in clinical NP. Processes needed to facilitate professionalism are role modelling, support mechanisms, professional development and promoting interpersonal communication.

Figure 7.7: Terminus

Terminus

Framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses

The complete conceptual framework is presented in Figure 7.8.

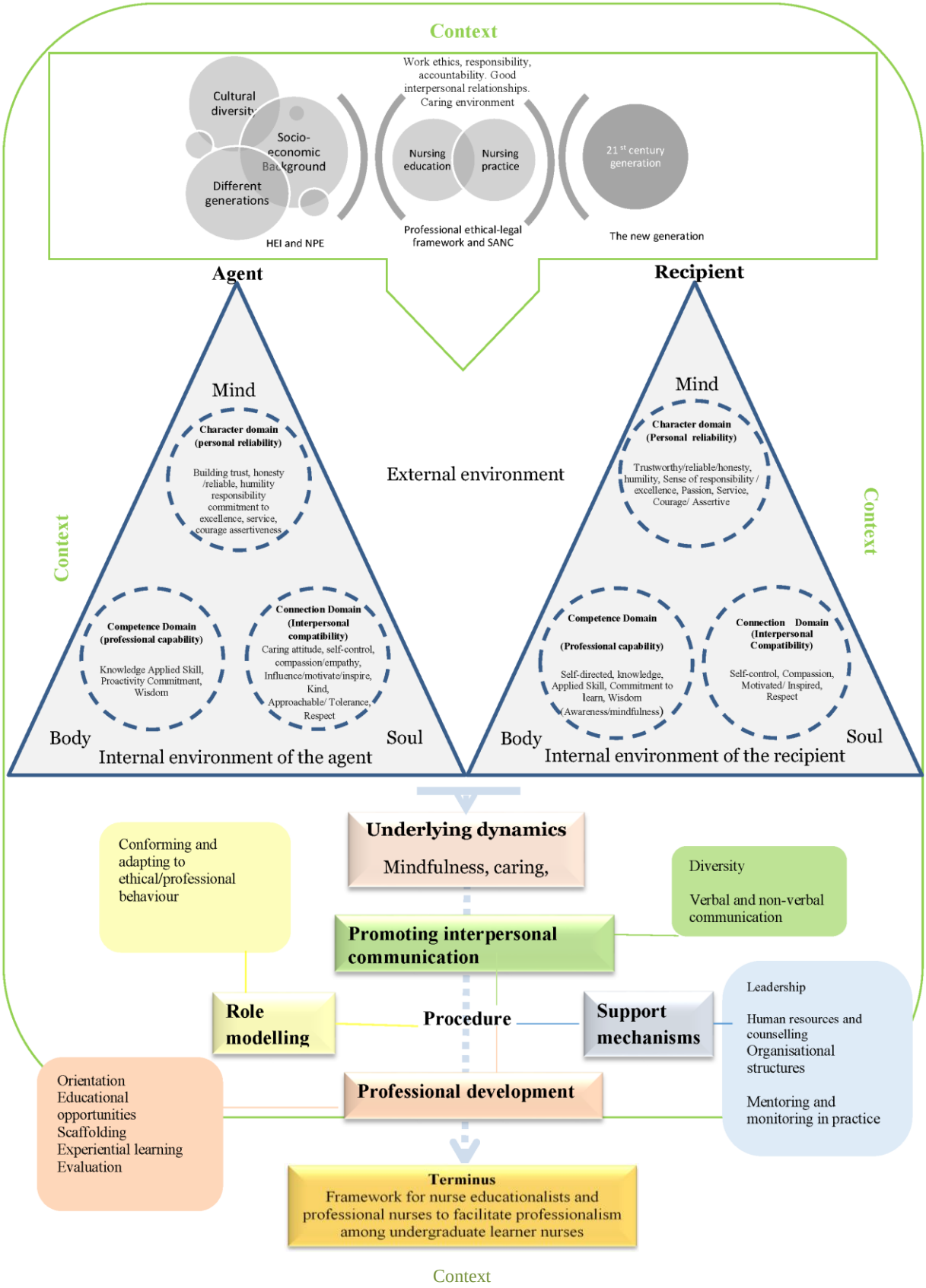


Figure 7.8: Conceptual framework of professionalism for nurse educationalists and professional nurses to facilitate professionalism in undergraduate learner nurses

7.3 VALIDATION OF THE CONCEPTUAL FRAMEWORK

Validation involves the provision of the findings from the study to the research participants to seek confirmation that the researcher's findings and impressions corresponds with those of the participants. It is also done to assess the reactions and comments of the research participants on whether the developed framework would address their needs (Bryman, 2012:391). It was essential to validate the proposed conceptual framework with the nurse educationalists and PNs to ensure that the described concepts made sense to the study participants. Hence, three experts (a nurse educator, a clinical supervisor and a PN) in the field of NP who participated in the study validated the developed framework. The researcher presented the findings to the participants at the nursing school of the HEI where the study was conducted. The presentation and validation with the individuals took between 30–45minutes.

The criteria for validation included the clarity, adequacy, usefulness and significance of the conceptual framework. The participants were asked whether the concepts described in the framework were clear and whether the developed framework could be used by nurse educationalists and PNs to facilitate professionalism in learner nurses. They were also asked whether, in their opinion, the framework was useful and could make an important contribution to nursing education and the NP.

Does the framework provide in the needs for supporting the facilitation of professionalism for learner nurses? Is it clear?

"The conceptual framework for nurse educationalists and PNs does afford the needs to support for the facilitation of professionalism for learner nurses. It is well-structured and clear to understand."

The developed conceptual framework is offered to be used by nurse educationalists and professional nurses to facilitate professionalism amongst learner nurses. Will the developed procedures and actions be sufficient for the purpose it sets out to achieve?

"It is evident that the developed procedure and processes will be sufficient in achieving the purpose of the framework that will guide nurse educationalists and PNs in the facilitation of professionalism among learner nurses."

Is the conceptual framework useful to nursing education and nursing practice?

"The conceptual framework will definitely add value in nursing education and nursing practice."

Does the conceptual framework make an important contribution to nursing practice and nursing education?

"The conceptual framework will definitely make an important contribution in nursing education and nursing practice."

7.4 CONCLUSION

This chapter described the conceptual framework for professionalism to be used by nurse educationalists and PNs in facilitating professionalism in learner nurses in the NP in the Western Cape. The framework is based on the findings from the FGIs conducted with the undergraduate learner nurses, nurse educationalists and PNs. Unstructured individual interviews were carried out with PNs working in practice in the public hospitals in the Western Cape.

The survey list of Dickoff et al. (1968:423) comprise of six key components (agent, recipient, context, dynamics, procedure and terminus) and served as the guide for the discussion of the conceptual framework. The *agent* (nurse educationalists and PNs) was identified as leaders with the roles of mentor, advocate and counsellor, engendering support, role modelling, professional development and interpersonal communication. In addition, the findings emphasised the characteristics that should enable an agent to carry out the identified roles. The characteristics are categorised according to the professionalism taxonomy of Brown and Ferrill (2009) into three domains i.e. connection (interpersonal compatibility), competence (professional capability) and character (personal reliability). These domains host the expected professional values (that should be present in both the agent and the recipient) that may lead to the desired professional behaviour required for professional practice. The researcher discusses the *context* of the study while reflecting on the contextual realities in which nursing education and NP take place (diversity, socio-economic and cultural background, the generational gap, professional ethical-legal framework within which nursing care is carried out and the new generation in the 21st century). The *underlying dynamic* necessary for the attainment of professionalism among undergraduate learner nurses was described in terms of mindfulness and having a caring approach. The *procedure or processes* to be used by the agents were the provision of support mechanisms, good interpersonal style of communication, professional development and role modelling that will lead undergraduate learner nurses towards professionalism.

This chapter ended with description of the validation of the framework. The process that was used in validating the developed framework is described to reflect the responses of the study participants. In the following chapter, the conclusions, limitations and recommendations of the study are briefly discussed.

CHAPTER 8

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

8.1 INTRODUCTION

In the previous chapter, the developed conceptual framework describing the facilitation of professionalism among undergraduate learner nurses by nurse educationalists and PNs is discussed by using the survey list proposed by Dickoff et al. (1968:423). In this chapter, the overview of the research process, conclusions of the study, dissemination plan, guidelines for the implementation of the framework, the limitations of the research, as well as the recommendations of the study are presented.

8.2 OVERVIEW OF THE RESEARCH PROCESS AND CONCLUSIONS

The purpose of this qualitative study was to develop a conceptual framework that can be utilised in gaining better insight into the ways in which nurse educationalists and PNs can guide undergraduate learner nurses towards health (professionalism) in the Western Cape Metropole. Three objectives were set, namely to explore and describe the learner nurses' experience of professionalism during their undergraduate nursing programme at a University of the Western Cape (Phase 1, Objective 1 of the study); to explore and describe how nurse educationalists and PNs can facilitate professionalism among undergraduate learner nurses in NP in the Western Cape (Phase 1, Objective 2 of the study); and to develop a conceptual framework for nurse educationalists and PNs to facilitate professionalism among undergraduate learner nurses for NP in the Western Cape (Phase 2 of the study). The validation of the conceptual framework was then conducted. The first objective was achieved by conducting eight FGIs with learner nurses (from first to fourth year) registered for the undergraduate nursing programme at a HEI in the Western Cape. The learner nurses were from diverse cultural backgrounds in terms of language, religion and ethnicity. Participants were males and females of varied ages, ranging from those coming fresh out of high school to more matured, married learners with families. The learner nurses were placed for clinical practice at accredited HCIs across the Western Cape Metropole. Objective 2 of Phase 1 was achieved by conducting eight FGIs and six individual interviews with nurse educationalists and PNs from the HEI and selected hospitals which were part of the study. Nurse educationalists, the NEs and CS, were involved in the theoretical and clinical teaching and

learning undergraduate programme at the SoN at a HEI in the Western Cape Metropole. The educationalists were involved in the programme teaching across all year levels (from first to fourth year) and were experienced in general nursing science, midwifery, psychiatry and community health service. PNs who were interviewed for the study worked at public hospitals, used for the clinical training of health professionals, and included two academic hospitals, one secondary hospital and one psychiatric hospital. These PNs worked in patient care wards as well as theatre and outpatient departments that provided services which included all the disciplines of nursing (i.e. general nursing, midwifery and psychiatry). The age and experience of the PNs varied from relatively young nurses with no more than five years' working experience, to older nurses with more than 20 years' experience in the practice of nursing.

After data had been collected and analysed, it was clear from the findings that the learner nurses needed support from the nurse educationalists and PNs to assist them in becoming professional in the NP. They expressed the need for role models who have empathy for them as newcomers to the profession who are still learning how to be professional and who treat their not knowing "how" with tolerance. Learner nurses mentioned the importance of orientation so that they can become aware of what the expectations are for the patient care wards where they are placed for clinical practice learning. They stated that they needed a dedicated nurse councillor, appointed specifically for learner nurses, who would understand the needs of the learner nurse in the academic environment. The need for support in the hospital environment was expressed in terms of the availability of CS to mentor and council them, to be their voice and address issues of conflict or misunderstandings concerning their learning outcomes with the PNs. Furthermore, learner nurses expected PNs to allow them to practice their skills at the appropriate level of their training and trust them when they carry out their nursing tasks.

Nurse educationalists and PNs acknowledged the challenges involved in assisting learner nurses to become professional in a changing era marked by the 21st century. They stated that the generation gap should be narrowed to include the needs of the new and old generation. Universities have a responsibility to stay abreast of developments in innovation and technology, hence it was expressed that NEs have a responsibility to include the use of technology for learner nurses within the professional boundaries of NP. The findings made it clear that CS should use discretion when they engage with learner nurses on social media and stay within the professional boundaries of nursing or use formal sites such as e-learning. Other challenges concerned the conduct of learner nurses. Nurse educationalists and PNs stated that they should be considerate of the socio-economic circumstances of learner nurses and use discretion when imposing discipline on learners for unwanted behaviour, especially when learner nurses come late for class

or work. The need for the improvement of the organisational structure looking at the inadequate human resources and academic and emotional support for the learner nurses in the form of mentorship was expressed. In addition, teaching and learning strategies that could lead learner nurses to professionalism were identified as educational opportunities for the new generation, scaffolding reinforcement and bridging the gap between theory and practice.

The findings from Objectives 1 and 2 were synthesised to achieve the third objective of the study, which was the development of a conceptual framework for nurse educationalists and PNs for facilitating professionalism among undergraduate learner nurses in the Western Cape Metropole. The survey list of Dickoff et al. (1968) was used as the reasoning map for describing the developed conceptual framework by using six key elements, namely agent, recipient, context, dynamics, procedure and terminus. The agent as a leader was identified as having different roles in leading the recipients (undergraduate learner nurses) towards health or professionalism. These roles were mentor, advocate, role model and collaborator. Similarly, the self-management and shared responsibility roles of the recipients were identified. The contextual realities in the higher nursing education and NP included diversity in culture, socio-economic background, different generations, professional and ethical-legal practice and the 21st century. The identified procedures were role modelling, interpersonal communication style, professional development and support mechanisms. From the framework, professionalism was described as having a healthy mind, body and spirit, and engaging in the interaction domains that refer to personal reliability, interpersonal compatibility and professional capability.

The last step was to validate the developed framework with input from the research participants. The framework was validated and no modifications to the framework were needed.

In conclusion, the most important underlying dynamic identified in this study for facilitating professionalism in learner nurses were being mindful and caring. These characteristics would provide the support nurse educationalists and PNs need to realise the important role they play in facilitating professionalism among undergraduate learner nurses and in addressing the issues affecting them.

8.3 RECOMMENDATIONS FROM THE STUDY

8.3.1 Dissemination plan

The researcher, supported by her research supervisor, will disseminate the developed framework in the following ways:

The Western Cape Department of Health will be contacted in writing to seek support for a meeting to discuss possible implementation of the framework in accredited healthcare facilities where learner nurses are placed for clinical learning.

The framework will be made accessible to the target population (the learner nurses, nurse educators, clinical supervisors and professional nurses in the Western Cape Metropole) during an information session scheduled at the HEI.

The framework will be presented at seminars and workshops, organised by the researcher, for different nurse professionals involved in the academic and clinical teaching and learner nurses.

It will also be shared with other scholars and academic peers through presentations at scientific research conferences both nationally and internationally.

The findings will be published in a peer-reviewed journal that is available online to further increase the accessibility.

It is expected that the framework will form part of the professional learning component for the training of learner nurses at a SoN at a university in the Western Cape of South Africa.

8.3.2 Recommendations for the agent (nurse educationalist and professional nurses)

The recommendations are suggested as a result of the findings. *Nurse educationalists* in the academic learning environment should inter alia:

- adopt a friendly and respectful approach of communication and ensure that the learner nurses feel welcome and part of the team of nurses when they enter nursing as a profession;
- be available and approachable when learner nurses need support with their academic learning needs and provide emotional support and counselling to all learners who struggle to cope with the compactness of the B.NUR programme and the challenges in their personal life that prevent them from progressing in the programme;
- enforce the code of conduct for PNs in the classroom environment to facilitate the expected professional behaviour and attitude in learner nurses following the B.NUR programme at the HEI in the Western Cape;

- be a voice for learner nurses in the clinical practice environment and advocate on their behalf to align the year level outcomes with the needs of the hospital facilities, thereby avoiding conflict between PNs and learner nurses during their clinical placement; and
- use the framework for orientation of staff in units and learner nurses to create an awareness of professionalism.

Professional nurses in clinical nursing practice should inter alia:

- create a learning environment in clinical practice in which new undergraduate learner nurses (when they are placed in the hospitals for the first time) in particular would feel welcome;
- provide privacy when learner nurses are disciplined for their mistakes in the patient care wards;
- be considerate of the cultural diversity in background, language, socio-economic background and generational gap;
- be available and approachable when learner nurses need support with their clinical learning needs, and provide emotional support;
- foster a culture in which learner nurses feel comfortable to ask questions or look for help when they are in the clinical placement environment;
- provide educational opportunities for learner nurses appropriate for their year level and corresponding year level outcomes for a specific discipline (e.g. second-year learner nurses should be given as much opportunities to gain clinical experience in the administration of intramuscular injections (IMI) as a requirement of safe administration of medication as a year level outcome in GNS);
- ensure the visibility of the vision and mission of the hospital and the patient care ward in which learner nurses are placed as it guides learner nurses to the expected behaviour required for NP;
- provide a proper orientation for learner nurses to ensure that they know what is expected of them and that they get a sense of belonging or feeling part of the team of PNs in practice;

- provide a structured orientation programme that can facilitate the transition of learner nurses from the academic environment to the clinical learning environment;
- care for learner nurses and be mindful of their shortcomings; and
- have inner calm, important to the health of the professional nurse who is working under stressful conditions and for good relationships with learner nurses.

Nurse educationalists and PNs in the respective learning environments of the undergraduate learner nurse should:

- communicate and collaborate to facilitate the professional development of learner nurses (this could be achieved if both HEIs and NP (context) could have the authority to impose disciplinary measures in the case of misconduct of learner nurses);
- have a shared responsibility to assist learner nurses with improving professionalism;
- ensure conflict resolution between personal values and collective values of the profession as this is essential for internalisation;
- be upfront, sincere and honest in their feedback to learner nurses about their mistakes in theory and practice;
- role model the total image, the code of conduct and the expected professional behaviours required for nursing practice; and
- demonstrate the desired attitudes, values and behaviours of professionalism in nursing practice.

8.3.3 Recommendations for nursing practice, nursing education, nursing research and community

The following recommendations are suggested based on the findings:

8.3.3.1 *Nursing practice*

- There is a need for the provision of mindfulness programmes to PNs at HCIs where there is a shortage of staff and increased workloads.

- There is a need for the provision of educational opportunities to accommodate the learning needs of undergraduate learner nurses and those learner nurses from non-degree programmes.

- Healthcare institutions should have structured orientation programmes in place to welcome novice learners to the profession and make the expectations that will facilitate professionalism among learner nurses known. There is thus a need for wards within the healthcare institution to make the vision, mission and goals that lead to excellence in patient care visible to all nursing staff.

- Healthcare institutions need to ensure that the communication policy in all hospitals include the use of a universal language that will prevent misunderstandings that might potentially be an obstacle in achieving excellence in patient care outcomes.

8.3.3.2 *Nursing education*

The findings of this study have implications for nursing education. It is recommended that:

Higher education institutions and nursing education stay abreast of the latest developments in innovation and technology and ensure the responsible use of social media in NP;

nursing education institutions invest in a counselling programme specifically designed for the academic and emotional needs of undergraduate learner nurses (the programme should include a dedicated nurse councillor who will be available on campus to provide the learner nurse with support throughout the four years of the academic undergraduate training programme);

Nurse educators should communicate and collaborate with nurse professionals about the progress of the learner nurse and ensure that the learning objectives meet the nursing care needs of the healthcare institution;

adequate learning resources should be available to provide in the specific learning needs of the learner nurse that will simulate a real life situation as close as possible to reality in the NPE; and

the orientation programme for new nurses includes concepts in the nurses' pledge and code of conduct/ethics (this should be implemented at the beginning of the undergraduate nurse training programme and reinforced at the beginning of each year level as the learner nurse progresses through the programme).

8.3.3.3 *Nursing research*

There is a constant interplay of complex processes between internal and external environments which makes it difficult to facilitate professionalism in compartments of domains, as the processes almost take place simultaneously. Thus, there is a need for further research on how these processes will continue to influence professionalism of the future generation.

The framework will also be presented at the research forum of the Western Cape Department of Health.

The researcher will prepare a further research proposal to implement the framework for evaluation. The evaluation process will be used to further refine the framework. All stakeholders will be informed of the revision of the framework.

8.3.3.4 *Original contribution of the study*

The original contribution of the study is its relevance to nursing education and nursing practice in preparing nursing graduates for their future careers and service in a dynamic, yet unpredictable environment in which the professional values of the nursing profession could be compromised. Furthermore, the study provides input into the implementation of the Provincial Nursing Strategy to address challenges faced by the nursing profession in the Western Cape in facilitating professionalism in professional nursing practice. Nurse educationalists (nurse educators and clinical facilitators) and professional nurses in practice have the responsibility to support learner nurses as competent professionals who will maintain the quality and commitment of the profession. It is also in line with meeting those challenges of healthcare in a developing country that requires nurses to strengthen their professional practice through on-going training (Geyer et al., 2010:28).This study developed an original conceptual framework to assist nursing educationalists and professional nurses to support learner nurses in developing and enhancing professionalism in nursing practice. This conceptual framework is also methodological unique as it incorporates the experiences of participants in three cases (learner nurses, nurse educationalists and professional nurses), representing the main stakeholders in the practice of nursing and education.

According to the Nursing Regulation 425, published in the Government Gazette of December 2011, training programmes must aim to provide professionals with professional values that will enable them to make a meaningful contribution to health services. The conceptual framework

can thus be used in undergraduate training programmes of nursing schools across the Western Cape to equip nurse professionals with a developed sense of professionalism and service ethics that will ensure that they work in an accountable manner, irrespective of their chosen work place.

The research study will thus make a contribution to social change, as the researcher foresees that nursing education as well as nursing practice will benefit from the study when the conceptual framework is implemented into everyday practice.

8.4 LIMITATIONS

Although the researcher recruited more than six to ten participants for the FGIs, some sessions had to be cancelled due to participants not attending as they originally indicated. The researcher then went ahead in the instances where three or four participants showed up and indicated their availability and willingness to partake in the study. Literature confirmed the importance of smaller FGIs (Onwuegbuzie et al., 2009:3; 2010:711). The small number of participants in this study was mainly due to a limited availability of the participants who follow a clash group timetable in a compact undergraduate four-year nursing programme. With the smaller FGIs, participants shared their experiences more freely, and after conducting all interviews, data saturation was obtained.

During the one focus group interview with the CS, the midwifery discipline could not attend and an unstructured individual interview was conducted with a midwifery clinical supervisor to also elicit experiences from the midwifery practice on professionalism.

The researcher strived to follow the methodology of the case study method, with voluminous data and the cross analysis of data being a challenging stage in the study, as also confirmed by Yin (2014:170). After intensive work, the end result was a unique framework that could contribute to the nursing education and practice field in nursing.

The framework is only developed for nurse educationalists and PNs in the Western Cape, but can be used as a resource for other public and private healthcare sectors to further investigate it`s applicability to undergraduate programmes in health professions' education.

8.5 CONCLUSION

This chapter concludes the research report of the study. An overview of the research process was provided and the conclusions from the findings of the study were presented. The researcher

coherently described the conclusions in relation to the main objectives that were set out to be achieved in the study. The researcher maintained her *commitment* to conduct the research study as she reflected on the *importance* and *impact* of the study. The researcher presented as clearly as possible the limitations that were encountered in conducting this research study. Finally, the researcher offered recommendations for the utilisation of the conceptual framework to improve NP, nursing education and nursing research. These recommendations are made in accordance with the findings of the study.

The developed framework is the first of its kind and should be used by nurse educationalists and PNs to facilitate professionalism among undergraduate learner nurses. It is unique because it integrates findings from three cases, i.e. learner nurses, nurse educationalists and PNs. The framework appears to be useful for facilitating professionalism among undergraduate learner nurses. Though developed to be used in the specific context in the Western Cape Metropole area, it can be adopted in contexts with similar contextual realities.

References

Agar, M.H. (1980). *The professional Stranger: An introduction to ethnography*. San Diego, CA: Academic Press.

Aguilar, A., Stupans, I., Scutter, S. & King, S (2012). Exploring professionalism: The professional values of Australian occupational therapists. *Australian Occupational Therapy Journal*, 59, 209-217.

Ahtisham, Y. & Jacoline, S.J. (2015). Integrating Nursing Theory and Process into Practice; Virginia Henderson`s Need Theory. *International Journal of Caring Sciences*, 8(2), 443-450.

Ajani, K. & Moez, S. (2011). Gap between knowledge and practice in nursing. *Procedia- Social and Behavioral Sciences*, 15, 3927-3931.

Ali, Y. & Sazalie, A. (2010). Polite Strategies by Yemeni Females: A socio-pragmatic study. Accessed 10 April 2017 from: http://www.mjal.org/removedprofiles/2013/Polite%20 Request%20 strategies%20 by%20Yemeni %20 Females.pdf.

Alidina, K. (2013). Professionalism in post-licensure nurses in developed countries. *Journal of Nursing Education and Practice*, 3, (5). Available at www.sciedu.ca/jnep.

Alino, J., Aprosta, L.B., Lugod, R.M.I., Montilla, A.R.G., Tabuan, J.C. Jr. & Uba, C.B. (2012). Perceptions of White Uniform in the Nursing Profession. *Advancing Nursing Research*, 4, ISSN: 2094-9537. Doi: http://dx.doi.org/10.7828/anrj.v4i1.198.

Alireza, N., Tate, M., Jonestone, D. & Gable, G.G. (2014). A Framework for Qualitative Analysis of Focus Group Data in Information Systems. 25th Australian Conference on Information Systems, 8th- 10th December 2014, Auckland, New Zealand.

Altiok, H. & Üstün, B. (2014). Meaning of Professionalism in Learner nurses. *American International Journal of Social Science*, 3(6).

American Association of Colleges of Nursing (AACN). (2008). *The Essentials of Baccalaureate Nursing Education for Professional Nursing Practice*. One Dupont Circle. Washington, DC 20036.

Australian College of Nursing (ACN). (2015). *Nurse Leadership*, ACN, Canberra.

American Board Of Internal Medicine (ABIM). *Medical professionalism in the new millennium: a physician charter*. Project of the ABIM Foundation: ACP- ASIM Foundation and European Federation of Internal Medicine. *Annals of Internal Medicine*, 136, 243-246.

American Board of Internal Medicine, *Project professionalism*, ABIM Committee on Evaluation of Clinical Competence, Philadelphia PA (1995).

American Nurses Association (ANA). (2001). *Code of Ethics for Nurses with Interpretive Statements*, Washington, DC, The Association.

American Nurses Association (ANA). (2004). *Nursing: Scope and Standards of Practice*, Washington, DC. American Nurses Publishing.

Anselmi, K.K., Smit Glasgow, M.E. & Gambecia, S.F. (2014).Using a learner nurse conduct committee to foster professionalism among learner nurses. Journal of Professional Nursing, 30(6), 48-4851.

Arif, M.Z.U. (2015). Grievances and Industrial Relations in the Ready-made Garment Industry of Bangladesh with Special Reference to Falcon Group Limited. *Cluster Analysis of Young Online Consumers in Indian Context*, 189. *Anveshak International Journal of Management, 4(2),* ISSN: 2350-0794. Accessed 20 August 2016 from: http://s3.amazonaws.com/academia.edu.documents/43939672/ANVESHAK_July_2016.pdf?AWSAccessKeyId=AKIAJ56TQJRTWSMTNPEA&Expires=1471691939&Signature=cJqMEPXaQ

bnhJACsz9VMrAuZGFk%3D&response-content-disposition=inline%3B%20file name%3DArif.pdf.

Australian Nursing and Midwifery Federation (ANMF). *Education*. Accessed 10 April 2017 from: https://www.anmfsa.org.au/

Babbie, E. (2007). *The practice of social research*, (11th ed.). Belmont:Thompson Wadsworth.

Babbie, E. (2010). *The practice of social research*. Belmont, CA: Wadsworth.

Babbie, E. & Mouton, J. (2010). *The Practice of Social Research*. Cape Town: Oxford University Press.

Bach, S. & Grant, A. (2009). *Communication and Interpersonal Skills for Nurses. Learning Matter*. Great Britain. Cornwall. UK. ISBN: 978 1 844 451 623.

Bahl, A. & Black, G.S. (2011). Demographics and Motivation as Predictors of Student Selection of Intensive Course Formats in an American University. *Interdisciplinary Journal of Research in Business*. 1(8), 10-20.

Baillie, L. & Matiti, M. (2013). Dignity, equality and diversity: an exploration of how discriminatory behaviour of healthcare workers affects patient dignity. *Diversity and Equality in Health and Care*, 10, 5-12.

Baldwin, A., Mills, J., Birks, M., & Budden, L.M. (2013). Role modelling in undergraduate nursing education: An integrative literature review. *Nursing Education Today*. Accessed January 2017 from: http://dxdoi.org/10.1016/j.nedt.2013.12.007.

Bang, K.S., Kang, J.H., Jun, M.H., Kim, H.S., Son, H.M., Yu, S.J., Kwon, M.K. & Kim, J.S. (2011). Professional Values in Korean undergraduate learner nurses. *Nurse Education Today*, 31, 72-75.

Barbour, R. (2007). *Doing Focus Groups*. London: Sage.

Barnett, J.E., Lazarus, A.A., Vasquez, M.T., Moorehead-Slaughter, O. & Johnson, W. B. (2007). Focus on ethics. *Professional Psychology: Research and practice*, 38(4), 401-410.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. The Qualitative Report, 13(4), 544-559. Retrieved from: http://wwww.nova.edu/sss/QR/QR13-4/baxter.pdf.

Berg, K., Kaspersen, R., Unby, C. & Hollman Frisman, G. (2013). The interaction between the patient and the nurse anesthetist immmediatly before elective coronary artery bypass surgery. *Journal of Perianesthesia Nursing*, 28(5), 283-290.

Bettinger, E., Boatman, A. & Long, B. (2013). Student supports: Developmental Education and academic programs. *The Future of Children*, 23(1), 93-115.

Birden, H., Glass, N., Wilson, I., Harrison, M., & Usherwood, T. (2014). Defining professionalism in medical education: a systematic review. *Medical Teacher*, 36 (1), 47-61.

Birks, M., Bagley, T., Park, T., Burkot, C. & Mills, J. (n.d.). The impact of clinical placement model on learning in nursing: A descriptive exploratory study. Australian Journal of Advanced Nursing, 34(3), 16-23. Accessed 25 March 2017 from: http://www.ajan.com.au/ Vol34/Issue3/2Birks.pdf.

Bjork, I., Christiansen, B., Havnes, A. & Hessevaagbakke, E. (2015). Exploring the black box of practical skill learning in the clinical skills center. *Journal of Nursing Education and Practice*, 5(11), 131-138.

Bjugstad, K., Thach, E.C., Thompson, K.J. & Morris, A. (2006). *A Fresh Look at Followership. A Model for Matching Followership and Leadership Styles*. Institute of Behavioral and Applied Management.

Black, B.P. (2014). *Professional Nursing: Concepts & Challenges*. Saunders. Elsevier.

Boerebach, B.C.M., Lombarts, K.M.J.M.H., Keijzer, C., Heineman, M.J. & Arah, O.A. (2012). The teacher, the Physician and the Person: How Faculty`s Teaching Performance Influences Their Role Modelling. *PLoS ONE*, 7(3), 32089. Accessed 29 June 2016 from: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0032089.

Brass, E. (2016). How mindfulness can benefit nursing practice. Nursing Times. 112(18), 21-23.

Breier, M., Wildschut A. & Mgqolozana, T. (2009). *Nursing in a New Era. The profession and Education of Nurses in South Africa*. Cape Town: Human Sciences Research Council Press.

Brennan, M. & Monson, V. (2014). Professionalism: Good for Patients and Healthcare Organisations. Mayo Clinic proceedings, 89(5), 644-652.

Brink, H., Van der Walt, C. & Van Rensburg, G. (2012). *Fundamentals of research methodology for healthcare professionals* (3rd ed.). Cape Town: Juta & Company Ltd.

Britiller, M.C., Ramirez, L.Q., Ramos, F.M.C., Reyes, D.M.C., Salazar, K.D. & Sandoval, J.A.M. (2014). Nurse Educator's Affective Teaching Strategies. *Asia Pacific Journal of Multidisciplinary Research*, 2(1), 6-13.

Brock, D.M., Nicholson, J.G. & Hooker, R.S. (2016). Physician Assistant and Nurse Practitioner Malpractice. *Medical Care Research and Review*, 1-12. Accessed 18 March 2017 from:

https://www.researchgate.net/profile/Roderick_Hooker/publication/305647566_Physician_Assistant_and_Nurse_Practitioner_Malpractice_Trends/links/57a8859708aed76703f6f27c.pdf.

Brody, H. & Doukas, D.(2014). Professionalism: a framework to guide medical education. *Medical Education,* 48, 980-987.

Brown, D. & Ferrill, M. J. (2009). The Taxonomy of Professionalism: Reframing the Academic Pursuit of Professional Development. *American Journal of Pharmaceutical Education*, 73(4), 68.

Brown, P., & Levinson, S. (1978). Universals in language usage: Politeness phenomena. In Bryman, A. (2008). *Social Research Methods*, (3rd ed.). Oxford University Press.

Bryman, A. (1988). *Quantity and quality in social research*. London: Unwin Hyman.

Bryman, A. (2012). *Social Research Methods*, (4th ed.). Oxford University Press.

Burns, N. & Grove, S. (2011). *Understanding nursing research: building an evidence-based practice* (5th ed.). Maryland Heights: Elsevier Saunders.

Bunch, M. (1999). *Creating confidence*. London: Kogan Page.

Butts, J. (2013). *Ethics in Professional Nursing Practice*. Chapter 3. Jones & Bartlett. Not For Sale or Distribution. Accessed 29 July 2015 from: http://www.jblearning.com/samples/0763748986/48986_ch03_pass3.pdf.

Caelli, K., Ray, L. & Mill, J. (2003). 'Clear as Mud': Toward Greater Clarity in Generic Qualitative Research. *International Journal of Qualitative Methods*, 2 (2), 1-24.

Calman, L. (2006). Patients` views of nurses` competence. *Nurse Education Today,* 26, 719-725.doi:10.1016/j.nedt.2006.07.016.

Canadian Society of Exploration Geophysicists (1994). Accessed 16 October 2015 from: http://cseg.ca/assets/files/students/Mentee-Roles-and-Responsibilities.pdf.

Cardillo, D. (2009). *Projecting your professionalism*. Accessed 5 September 2014 from: http://www.nsna.org/Portals/0/Skins/NSNA/pdf/Imprint_FebMar09_Feat_Cardillo.pdf.

Census (2011). Accessed 4 June 2016 from: http://census2011.adrianfrith .com/place/199016101.

Charles Darwin University. (n.d). *Clinical Facilitator*. Accessed 1 June 2013 from: http://www.cdu.edu.au/sites/default/files/faculties-placement/Facilitator%20PD%202013.pdf.

Charleston, R., Hayman-White, K., Ryan, R. & Happell, B. (2007). Understanding the importance of effective orientation: What does this mean in psychiatric graduate nurse programs? *Australian Journal of Advanced Nursing*, 25(1). Accessed 25 March 2017 from: http://www.ajan.com.au/vol25/vol25.1-3.pdf.

Chen, C. & Lou, M. (2014). The effectiveness and application of mentorship programmes for recently registered nurses: a systematic review. *Journal of Nursing Management,* 22, 433-422.

Cleary, S. (2014). *Nurse Whistleblowers in Australian Hospitals: A Critical Case Study. Dissertation*. Deakin University.

City of Cape Town. *Google Maps*. Accessed 10 April 2017 from: https://www.google.co.za/?gws_rd=ssl#q=City+of+Cape+Town+maps&spf=553.

Cloete, I.S. & Jeggels, J. (2014). Exploring nurse preceptors`perceptions of benefits and support of and commitment to the preceptor role in the Western Cape Province. *Curationis*, 37(1), Article nr. 1281, 7.

Coffman, S. (2010). Marilyn Ann Ray`s theory of bureaucratic caring. In M. Alligood & A.

Cohen, L., Lawrence, M. & Keith, M. (2005). *Research Methods in Education*. New York: Routledge.

College of Registered nurses of Nova Scotia. (2012). Professional Boundaries and the Nurse Client Relationship: Keeping it safe and Therapeutic. Guidelines for Registered Nurses. Halifax. Accessed 18 November 2016 from: https://crnns.ca/wp-content /uploads /2015/02/ ProfessionalBoundaries2012.pdf.

College of Nurses of Ontario. (2009). *Professional Conduct. Professional Misconduct*. Reference Document, Toronto, 2009.

Collins, K.M.T., Onwuegbuzie, A.J., & Sutton, I.L. (2006). A Model Incorporating the Rationale and Purpose of Conducting Mixed-Methods Research in Special Education and Beyond. *Learning Disabilities: A Contemporary Journal* 4(1), 67-100.

Constitution of South Africa (1996). *Act No. 108 of 1996*. Accessed 10 April 2017 from: http://www.acts.co.za/ constitution_of_/constitution_of_the_republic_o.

Cornish, J. & Jones, A. (2010). Factors affecting compliance with moving and handling policy: student nurses` view and experiences. Nurse Education in Practice, 10(2), 96-100.

Crane, P. J. & Ward, S.F. (2016). *Self-healing and self-care for Nurses*, 2.3, CE. Accessed 25 March 2017 from: https://www.aorn.org/websitedata/cearticle/pdf_file/CEA16539-0001.pdf.

Creswell, J.W. (2009). *Research Design: qualitative, quantitative and mixed method approaches*, (3rd ed.). United States of America: Sage Publishers.

Creswell, J.W. (2013). *Qualitative Inquiry and Research Design. Choosing among five approaches*, (3rd ed.). Sage. Los Angeles.

Creswell, J.W. (2014). *Research Design: Qualitative, Quantitative and Mixed methods Approaches*, (4th ed.). Sage. London.

Christensen, H., Batterham, P.J., Grant, J.B., Griffiths, K.M. & Makinnon, A.J. (2011). A population study comparing screening performance of prototypes of depression and anxiety with standard scales. *BMC Medical Research Methodology*, 11,154.

Cruess, R .L. & Cruess, S. R. (2006). Teaching professionalism: general principles. *Medical Teacher*, 28, (3), 205-208.

Cruess, S.R. & Cruess, R.L. (2012). Why, What and How. *FVV in OBGYN*, 4(4):259-265.

Csaszar, I. & Curry, J. R. (2013). Loving Kindness Meditation: A Promising Practice for Reducing stress and Increasing Empathy. *Vistas Online*, Article 86.

Curtis, K., Horton, K., & Smith, P. (2013). Student nurse socialisation in compassionate practice: a grounded theory study. *Nurse Education Today*, 32(7), 790-795.

D'Antonio, J. (2014). Wisdom: A Goal of Nursing Education. Journal of Nursing Education; 53(2), 105-107.

Darley, W. (1961). *The professions and professional people*. Nursing Forum 1 Winter. In Searle, Human & Mogotlane (2009). *Professional Practice. A Southern African Nursing Perspective,* (5th ed.). Heinemann.

Da Silva, A.P. & Pedro, E. (2010). Autonomy in Nursing Students`Process of Knowledge Construction: The educational Chat as a Teaching Tool. *Rev.Latino-Am.Enfermagem*, 18(2), 210-216.

Davidson, A.W., Ray, M.A. & Turkel, M.C. (2011). *Nursing, Caring and Complexity Science: For Human-Environment Well-Being*. Springer Publishing Company. New York.

Day, R., Field P., Campbell, I. & Reutter, L. (2005). Students` evolving beliefs about nursing: from entry to graduation in a four year baccalaureate programme. *Nurse Education Today* 25(5), 636-643.

Debbarma, M. (2014). Importance of Human Values in Society. *International Journal of English, Language , Literature and Humanities*, 2, (1). ISSN 2321-7065.

Dempsey, P.A. & Dempsey, A. (2000). *Using Nursing Research. Process, Critica Evaluation and Utilization,* (5th ed.). Lippincott: New York.

Brennan, M. & Monson, V. (2014). Professionalism: Good for Patients and Healthcare Organisations. Mayo Clinic proceedings, 89(5), 644-652.

Department of Health. (1997). *Patients` Rights Charter*. South Africa. Accessed 10 April 2017 from: http://www.doh.gov.za/docs/legislation/patientsright /chartere.html.

Department of Health. (2008). *Nursing Strategy for South Africa.* Republic of South Africa.

Department of Health (2016). Western Cape Government. Accessed 22 April 2016 from: https://www.westerncape.gov.za/dept/health/services.

De Swardt, H. C. (2012). *Guidelines for professional socialisation of student nurses. Dissertation*. University of South Africa.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (2011). *Research Grass Roots. For the social sciences and human service professions,* (4th ed.). Pretoria:Van Schaik.

Dickoff, J., James, P. & Wiedenbach, E. (1968). Theory in a practice discipline: Part II. Practice orientated research. *Nursing research,* 17(5), 545-554).

Dickson, N. (1997). A theory of caring for midwifery. ACMI J, 10, 23-28.

Dimitriadou , M., Papastavrou, E., Efstathiou, G. & Theodorou, M. (2015). Baccalaureate learner nurses` perceptions of learning and supervision in the clinical learning environment. *Nursing and Health Sciences,* 17, 1-6.

Diogo, P., Rodrigues, J., Caeiro, M.J. & Sousa, O.L. (2016). The support role in clinical supervision of learner nurses: Determinant in the development of emotional skills. *Academic Journal of Education Research,* 4(5), 75-82.

Doel, M., Allmark, P., Conway, P. Cowburn, M., Flynn, M., Nelson, P. & Tod, A. (2009). Professional Boundaries: Crossing a Line or Entering the Shadows? *British Journal of Social Work* (14 October 2009), bcp106, doi:10.1093/bjsw/bcp106.

Doheny, M.O., Cook, C.B. & Stopper, M. C. (1997). *The discipline of nursing*. Stamford, CT: Appleton and Lange.

Douglas, M.K., Pierce, J.U., Roesenkoetter, M., Pacquiao, D., Callister, L.C., Hatter-Pollara, M., Lauderdale, J., Milstead, J., Nardi, D. & Purnell, L. (2011). Standards of Practice for Culturally Competent nursing Care. *Journal of Transcultural Nursing*, 22(4), 317-333.

Drucker, P.F. (1999). *Management Challenges for the 21st Century*. New York: Harper Business.

Druckman, D. (2005). *Doing research: methods of inquiry for conflict analysis*. London: SAGE.

Dunbar-Jacob, J. (2016). *Nurses and the Quest for Quality*. Pitt Nurse. University of Pittsburg School of Nursing Magazine, 1-32.

Ellwardt, L., Labianca, G. & Wittek, R. (2011). Who are the objects of positive and negative gossip at work? A social network perspective on workplace gossip. *Social Network*, doi:10.1016/j.socnet.2011.11.003.

Encyclopedia of Nursing & Allied Health, (2002). Gale Cengage.

Ennis, G., Happell, B. & Reid-Searl, K. (2015). Clinical Leadership in Mental Health Nursing: The importance of a Calm and Confident Approach. *Perspectives in Psychiatric Care*. 51, 57-62.

Erasmus, K. (2008). "To err is human"... where does negligence, malpractice and misconduct fit the puzzle? *Professional Nursing Today*, 12(5).

Esmaeli, M., Cheraghi, M.A., Salsali, M. & Ghiyasvandian, S. (2013). Learner nurses` expectations regarding effective clinical education. A qualitative study. *International Journal of Nursing Practice*, 1-8.

Esterhuizen, J. (2016). The professional nurse`s scope of practice: a historical South African perspective. *Professional Nursing Today*, 20(1), 12-14.

Eu-Saturn (2016). *The European Scholarship for South Africans*. The University of the Western Cape. Accessed 4 June 2016 from: http://www.eu-saturn.eu/universities/south-africa/university-of-the-western-cape-uwc-2.

Evetts, J. (1999). Professionalisation and Professionalism: issues for interprofessional care. *Journal of Interprofessional Care*, 13(2), 119-128.

Fagermoen, M.S. (1997). Values embedded in meaningful nursing practice. *Journal of Advanced Nursing*, 1997, 25, 434-441.

Fantahun, A., Demessie, A., Gebrekirstos, K., Zemene, A., & Yetayeh, G. (2014). A cross sectional study on factors influencing professionalism in nursing among nurses in Mekelle Public Hospitals, North Ethiopia, 2012. *BMC Nursing,* 13, 10.

Farenwald, N.L, Basset, S.D, Tschetter L., Carson, P. White, L., & Winterboer, V.J. (2005). Teaching core nursing values. *Journal of Professional Nursing*, 7(4), 239-245.

Felstead, I. (2013). Role modelling and students` professional development. *British Journal of Nursing*; 22(4), 223-227.

Flexner, A. (1915). Is social work a profession? *School and Society*, 1(26), 901-911.

Foster, I. & Stadler, C. (2013). *The importance of interpersonal style*. http://static1.1.sqspcdn.com/static/f/861003/22807151/1369960838953/The+importance+of+interpersonal+style.pdf?token=vO9M2PehGqgjEcFwpnxvFHBCJ80%3D.

Foundation Coalition (n.d.). Understanding Conflict and Conflict Management. Accessed 10 April 2017 from: http://fc.civil.tamu.edu/publications/brochures/conflict.pdf.

Francis, P. & Dugger, S.M. (2014). Professionalism, Ethics and Value-Based Conflicts in Counseling: An Introduction to the Special section. *Journal of Counseling and Development*, 92, 131-134.

Friedman, T.L. (2005). *The world is flat: a brief history of the 21st Century*. New York: Farrar, Strauss and Giroux.

Friedson, E. (1970). *Professional Dominance: the social structure of Medical Care*. New York, NY: Atherton Press.

Friedson, E. (1970). *Profession of Medicine: a study of the sociology of applied knowledge*. New York, NY: Harper & Row.

Friedson, E. (1986) *Professional powers: a study of the institutionalization of formal knowledge*. Chicago, IL: University of Chicago Press.

Frost, J. & Frost, K. (2014). *Values Based Leadership. Developing inspirational leaders*. Accessed 5 August 2016 from: http://www.valuesbasedleadership.co.uk /article/Values %20 Based%20Leadership.pdf.

Fry, S.T. (1989). Teaching Ethics in Nursing Curricula: Traditional and Contemporary Models. *Nursing Clinics of North America*, 24 (2), 485-497.

Fry, S.T. & Johnstone, M.J. (2006). *Ethics in Nursing practice. A guide to ethical decision making*. Oxford: International Council of Nurses.

Furtner, M.R., Sachse, P. & Exenberger, S. (2012). Learn to influence yourself: Full Range Self-leadership training. *Journal of the Indian Academy of Applied Psychology*, 38(2), 294-309.

Garman, A. N., Evans, R., Krause, M. K. & Anfossi, J. (2006). Professionalism-Healthcare Leadership Alliance. *Journal of Healthcare Management*, 51(4), 219-222.

Gaur, M. & Ebrahimi, N. (2013). Understanding Workplace Relationships-With Special Reference to Superior-Subordinate Relationship – An important Dimension Having Impact on the Success, Growth And Performance of the Employees And Organization. International *Journal of Research and Development*- A Management Review, 2(2), 2319-5479.

Gessner, G. (n.d.). Nursing Model: Jean Watson`s Caring Theory. Georgetown University. Accessed 4 April 2017 from: https://blogs.commons.georgetown.edu/gtg6/files/Nursing-Model.pdf

Geyer, N., Mogotlane, S. & Young, A.(2010). *Juta`s Manual of Nursing.Volume 1*. Cape Town: Juta.

Ghadirian, F., Salsali, M. & Cheraghi, M.A. (2014). Nursing professionalism: An evolutionary concept analysis. *Iran Journal of Nursing and Midwifery Researc*h, 19(1), 1-10.

Gibbs, G.R. (2007). *Analyzing qualitative data. The SAGE Qualitative Research Kit)*. Thousand Oaks, CA: SAGE.

Goastellec, G. (2010). *Understanding Inequalities in, through and by Higher Education*. University of Lausanne, Switzerland.

Goffman, E. (1959). *The presentation of self in everyday life.* NY: Doubleday.

Gokenbach, V. (2012). *What does Professionalism in Nursing really mean?* Accessed 19 March 2016 from: http://www.nursetogether.com/professionalism-in-nursing-what-does-it-re.

Goldie, J. (2013). Assessment of professionalism: A consolidation of current thinking. *Medical Teacher*, 35(2), 952-956.

Goodrich, J. & Cornwell, J. (2008). *Seeing the person in the patient: The point of care review paper: The Kings Fund*. Accessed July 2015 from: www.kingsfund.org.uk/publications/the_point_of_care.html.

Gordon, J. (2003). Fostering students` personal and professional development in medicine: a new framework for PPD. *Medical Education,* 37, 341-349.

Government Gazette (2011). Nursing Act, 2005 (ACT No. 33 of 2005). Regulations relating to the Approval of and the Minimum Requirements for the Education and Training of a Nurse leading to Registration as a Professional Nurse. Accessed 10 April 2017from: http://www.gov.za/sites/www.gov.za/files/ 34852rg9647_gon1046.pdf.

Green, J. & Thorogood, N. (2005). *Qualitative Methods for Health Research*. SAGE, *British Medical Journal*, 331,1234–1238.

Green, J. & Thorogood, N. (2009). *Qualitative Methods for Health Research*. SAGE.

Greiner, A.C. & Knebel, E. (Eds.) (2003). *Health Professions Education: A Bridge to Quality*. Institute of Medicine (US) Committee on the Health Professions Education Summit. Washington (DC): National Academies Press (US).

Grice, G.R., Monson, K., Pitlick, J., Chereson, R. & Duncan, W. (2013). Developing a Professional Plan. *Innovations in Pharmacy*. 4(1): Article 103. Accessed 4 August 2016 from: http://pubs.lib.umn.edu/cgi/viewcontent.cgi?article=1105&context=innovations.

Guion, L. A., Diehl, D.C. & McDonald, D. (2011). *Triangulation: Establishing the Validity of Qualitative Studies*. University of Florida. Extention. Institute of Food and Agricultural Sciences.

Original publication date 2002, Revised August 2011. Original written by Lisa A. Guion, former faculty member, revised by David C. Diehl and Debra McDonald. http://edis.ifas.ufl.edu.

Gupta, M. & Gupta, G. (2011). *Research Methodology*. PHI Private Learning Limited. New Dehli.

Hackett, R.D. & Wang, G. (2012). "Virtues and Leadership: An integrating conceptual framework founded in Aristotelian and Confucian perspectives on virtues. *Management Decision*, 50(5), 868-899.

Hafferty, F.W. (2006). Definitions of Professionalism: A Search for Meaning and Identity. *Clinical Orthopaedics & Related Research*, 449, 193-204.

Hafferty, W. & Levinson, D. (2008) Moving beyond nostalgia and towards a complexity science view of medical professionalism. *Perspectives in Biology and Medicine*, 51(4), 599-615.

Hall, L.E. (1963). A centre for nursing. *Nursing Outlook*, 11, 805-806.

Hall, R.H. (1967). *"Components of Professionalism".* A Paper presented at the 1967 Annual Meeting of the American Sociological Association. San Francisco, California.

Hall, R. (1968). "Professionalization and Bureaucratization." *American Sociological Review* 33, 92-104.

Halldorsdottir, A. & Karlsdottir, S. (2011). The primacy of the good midwife in midwifery services: an evolving theory of professionalism in midwifery. *Scandinavian Journal of Caring Science*, 25, 806-817.

Halliwell, E. (2010). *Mindfulness Report 2010*. Bit.ly/MHFMindful2010. In Brass, E. (2016). How mindfulness can benefit nursing practice. *Nursing Times*. 112(18), 21-23, *Pharmacy Education*, 71-91. Binghamton, NY: Pharmaceutical Products Press.

Hammer, D.P. (2000). Professional attitudes and behaviors: the "A's and B's" of professionalism. *American Journal of Pharmaceutical Education*, 64(4), 455–64.

Harding, J. (2013). *Qualitative Data Analysis from start to finish*. London: Sage.

Hassankani, H., Aghdam, A.M., Raghmani, A. & Mohammadpoorfard, Z. (2015). The relationship between learning motivation and self-efficacy among learner nurses. *Research and Development in Medical Education*, 4(1), 97-101.

Hayes, T.L. (2006). *An Exploration of Professional Values Held by Baccalaureate and Associate degree students*. Electronic Thesis. School of Nursing. Florida State University.

Health and Care Professions Council (HCPC). (2014). Standards of Education and Training. Accessed 10 April 2017 from: http://www.hpc-uk.org/assets/documents/ 10000BCF46345 Educ-Train-SOPA5_v2.pdf.

Hecht, B.H. (2014). Out of Hours: The image of general practice-the revolution begins. British *Journal of General Practice*, April 2014. Accessed 8 Augustus 2016 from: http://bjgp.org/content/bjgp/64/621/190.full.pdf.

Henderson, A., Briggs, J., Schoonbeek, S. & Paterson, K. (2011). A framework to develop a cliniacal learning culture in health facilities: ideas from the literature. *International Nursing Review*, 58, 196-202.

Henderson, A., Cook, M., Creedy, D.K. & Walker, R. (2012). Learner nurses` perceptions of learning in practice environments: a review. *Nurse Education Today*, 32(3), 290-302.

Henderson, A. & Eaton, E. (2012). Assisting nurses to facilitate student and new graduate learning in practice settings: What "support" do nurses at the bedside need? *Nurse Education in Practice*, 13, 197-201.

Henning, E. (2004). *Finding your way in qualitative research.* (1st ed.). Pretoria: Van Schaick.

Henning, E. (2011). *Finding your way in qualitative research.* (8th ed.). Pretoria: Van Schaick.

Hennink, M., Hutter, I. & Bailey, A. (2011). *Qualitative research methods*. London: Sage Publications Ltd. https://www.certiport.com/Portal/Common/DocumentLibrary/IEAB Whitepaper040808.pdf.

Health Reform Note 2 (2010). *Accreditation of Healthcare providers*. Econex:Trade, Competition and Applied Economics. Accessed 3 April 2017 from: http://econex.co.za/wp-content/uploads/2015/04/econex_health-reform-note_2.pdf.

Hershberger, P.J., Zryd, T.W., Rodes, M.B. & Stolfi, A. (2010). Professionalism: Self-control matters. *Medical Teacher*, 32:1, 36-41.

Holloway, I. (Ed.) (2005). *Qualitative research in health care.* Maidenhead: Open University Press.

Holstein, J.A. & Gubrium, J.F. (2003). *Active interviewing* (67-80). In Gubrium, J.F. & Holstein, J.A. (Eds.)., *Postmodern interviewing*. Thousand Oaks, Sage.

Houle, L.(2010). Language Barriers in Healthcare. Senior Honors Project. Accessed 29 September from: http://digitalcommons.uri.edu/srhonorsprog/175/.

Houser, J. (2012). *Nursing Research, (2nd ed.)*. Reading, Using and Creating Evidence. Jones and Bartlett Learning. Canada.

Hooper, M., Browne, G. & O` Brien, A. (2016). Graduate nurses` experience of mental health services in their first year of practice: An integrative review. *International Journal of Mental Health Nursing*, 25(4), 286-298.

Huang, H., Sun, F. & Lien, Y. (2015). Nurse practitioners, medical negligence and crime: A case study. *Clinical Nursing Studies*, 3(4), 21-28.

Huber, D. (2000). *Leadership and Nursing Care Management*, Philadelphia, Saunders. International Council of Nurses. (2006). *Code of Ethics for Nurses*. ICN: Geneva. (www.icn.ch/).

Iacobucci, T., Daly, B.J., Lindell, D. & Griffin, M.Q. (2012). Professional values, self-esteem and ethical confidence of baccalaureate learner nurses. *Nursing Ethics*, 20(4), 479-490.

International Council of Nurses. (2006). *Code of Ethics for Nurses*. ICN: Geneva. (www.icn.ch/).

International Council of Nurses (2012). The ICN code of ethics for nurses. Accessed 29 March 2017 from: http://www.icn.ch/images/stories/documents/about/ icncode_english.pdf.

International Council of Nurses (2015). Accessed 20 February 2016 from: http://www.icn.ch/who-we-are/the-icn-story-1899-1999/the-icn-story-1899-1999-1000.html.

Jack, K. & Wibberley, C. (2013). The meaning of emotion work to student nurses. A Heideggerian analysis. *International Journal of Nursing Studies*, 51(6), 1-8.

Jacob, S. & Furgerson, S. (2012). Writing interview protocols and conducting interviews: tips for students new to the field of qualitative research. *The Qualitative Report*, 17(6), 1–10.

Jamieson, J., Mitchell, R. & Le Fevre, J. & Perry, A. (2015). Bullying and Harassment of trainees. An unspoken emergency? Emergency Medicine Australia, 27, 464-467.

Jeffreys, M. (2008). *Dynamics of Diversity. Becoming better nurses through diversity awareness*. Imprint. 2008 Nov-Dec, 55(5):36-41. Accessed 29 March 2017 from: www.nsna.org.

John Hopkins University (n.d). *Nursing Skills and Emotional Competence.* Accessed 18 October 2015 from: http://nursing.jhu.edu/life-at-hopkins/career-center/documents/career-binder/nursing_skills_emotional_com.pdf.

Johnson, B.E. (2011). The speed and accuracy of voice recognitionsoftware-assisted transcription versus the listen-and-type method: a research note. *Qualitative Research,* 11(1), 91-97. Doi:10.1177/1468794110385966.

Jokelainen, M. (2013). *Systematic Review and Finnish and British Mentors`Conceptions. Dissertation in Health Sciences*. Faculty of Health Sciences. University of Eastern Finland.

Jomsri, P., Kunaviktikul, W., Ketefian, S. & Chaiwalit, A. (2005). Moral Competence in Nursing Practice. *Nursing Ethics*, 12(6).

Jones, K., Warren, A. & Davies, A. (2015). *Mind the gap. Exploring the needs of early career nurses and midwifes in the workplace*. Summary report from Birmingham and Solihull Local Education and Training Every Student Counts Project. https://www.hee.nhs.uk/sites/default/files/documents/Mind%20the%20Gap%20Report_0.pdf.

Jonker, J. & Pennink, B. W. (2010). *The essence of research methodology*. London: Springer.

Jooste, K. (2017). *The principles and practice of nursing and healthcare. Ethos and professional practice, management, staff development and research*. Pretoria: Van Schaik.

Kaddoura, M.A. (2011). Critical thinking skills of nursing students in Lecture-Based Teaching and Case-Based Learning. *International Journal for the Scholarship of Teaching and Learning* (online), 5(2):1-8. Accessed 25 March 2017 from http://www.georgiasouthern.edu/ijsoti.

Kadushin, A. & Kadushin, G. (2013). *The Social Work Interview*, (5th ed.). Columbia University Press.

Kangasniemi, M., Pakkanen, P. & Korhonen, A. (2015). Professional ethics in nursing: an integrative review. *Journal of Advanced Nursing,* 00(0). 000-000. doi: 10. 1111/jan.12619.

Kardos, S., (2012). *Knowledge workers and the new role of leaders and managers.* Essay for the 2012. Peter Drucker Challenge, 2992 words including quotations.

Kelly, L.(1981). *Dimensions of Professional Nursing*, (4th ed.). New York, MacMillan.

Khan, J. (2008). *Research methodology*. New Delhi: SB Nangiia.

Killam, L.A., Mossey, S., Montgomery, P., & Timmermans, K.E. (2013). First year learner nurses` viewpoints about compromised patient safety. *Nurse Education Today*, 33, 475-480.

Knafl, K., & Breitmayer, B.J. (1989). *Triangulation in qualitative research: Issues of conceptual clarity and purpose*. In J. Morse (Ed.). *Qualitative nursing research: A contemporary dialogue* (193-203). Rockville, MD: Aspen.

Knight, S. & Cross, D. (2012). Using Contextual Constructs Model to Frame Doctoral Research Methodology. *International Journal of Doctoral Studies*, 7, 39-62.

Kolb, A.Y. & Kolb, D.A. (2005). The Kolb Styles Inventory-Version 3.1(online). Accessed 25 March 2017 from: http://www.businessballs.com/kolblearningstyles.htm.

Krathwohl, D., Bloom, B., $ Masia, B. (1964). *Taxonomy of educational objectives, handbook II*, affective domain. New York: David McKay Co.

Krueger, R.A. (1998). *Developing Questions for Focus Groups*. London. Sage.

Krueger, R.A. & Casey, M.A.(2000). *Focus groups: a practical guide for applied research* (3rd ed.). Thousand Oaks, CA: SAGE.

Kubsch, S., Hansen, G. & Huyse-Eatwell, V. (2008). Professional Values: The Case for RN-BSN Completion Education. *The Journal of Continuing Education in Nursing*, 39(8), 375-384.

Kuhse, H. & Singer, P. (2001). *What is bioethics? A historical approach*. In Kuhse & Singer (Eds.), *A companion to bioethics* (3-11). Oxford; Blackwell.

Kupperschmidt, B.R. (2001). Understanding net generation employees. Journal of Nursing Administration, 31(12), 570-574.

Lachman, V., Murray, J.S., Iseminger, K. & Ganske, K.M. (2012). Doing the right thing: Pathways to moral courage. Learn how to prepare yourself for the ethical and moral dilemmas you`re likely to encounter in the workplace. *American Nurse Today*, 7, (5), 24-29.

LaDuke, S.(2000). The Effects of Professional Discipline on Nurses. *American Journal of Nursing*,100(6), 26-33.

Lai, P.K. & Lim, P.H. (2012). Concept of professional socialization in nursing. *IeJSME*: 6(1), 31-35.

Lamont, S., Brunero, B., Lyons, S., Foster, K. & Perry, L. (2014:2). Collaboration amongst clinical leadership team: a mixed-methods sequential explanatory study. *Journal of Nursing Management*, 1-11.

LaSala, K.B. & Nelson, J. (2005). What contributes to professionalism? *Medsurg Nurs*, 14(1), 63-7.

Lavoie-Tremblay, M., Marchionni, C. & Drevniok, U. (2010). The needs and expectations of Generation Y Nurses in the Workplace. *Journal for Nurses in Staff Developoment*, 26(1), 2-8.

Lawal, J., Weaver, S., Bryan, V., Lindo, J. (2015). Factors that influence the clinical learning experience of learner nurses at a Carribean school of nursing. *Journal of Nursing Education and Practice*, 6(4), 32-38.

Leape, L.L., Shore, M.F., Dienstag, J.l., Mayer, R., Edgman-Levitan, S., Meyer, G.S., & Healy, G.B. (2012). Perspective: A Culture of Respect, Part 1: The Nature and Causes of Disrespectful behaviour by Physicians. *Academic Medicine*; 87, 845-852.

LeDuc, K. & Kotzer, A.M. (2009). Bridging the Gap: A Comparison of the Professional Nursing Values of Students, New Graduates and Seasonal Professionals. *Nursing Education Research,* 30(5).

Lee, A., Steketee, C., Rogers, G., & Moran, M. (2013). Towards a theoretical framework for curriculum development in health professional education. *Focus on Health Professional Education: A Multi-disciplinary Journal*, *14*(3), 64–77.

Lehna, C., Peterson, T.G., Grubaugh, K., Mastropietro, S. & Scoettle, B. (1999). Nursing Attire: Indicators of Professionalism? *Journal of Professional Nursing*, 15(3), 192-199.

Leners, D.W., Roehrs, C. & Piccone, A. (2006). Tracking the development of professional values in undergraduate learner nurses. *Journal of Nursing Education,* 45, 504-511.

Lewis, A. (2009). *Nurses found guilty of misconduct*. *Independent*-On-Line News. August 24. Cape Town. South Africa. Accessed 24 February /2012 from: http://www.iol.co.za /news/south-africa/cape-nurses-found-guilty-of-misconduct-456107.

Lifchez, S.D. & Redett, R.J. (2014). A standardized patient model to teach and assess professionalism and communication skills: the effect of personality type on performance. *Journal of Surgical Education*, 71(3), 297-301.

Lin, Y., Wang, I., Yarborough, S., Alfred, D. & Martin, P. (2010). Changes in Taiwanese learner nurse values during the educational experience. *Nursing Ethics,* 30, 646-654.

Lincoln, Y.S., & Guba, E.G. (1985). Naturalistic inquiry. Newbury Park, CA: Sage Publications.

Lincoln, Y.S., & Guba E.G. (1985). Naturalistic inquiry. In Denzin, N.K. & Lincoln, Y.S. (Eds.), *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

Lincoln, Y.S., Lynham, G. & Guba, E.G. (2011). *Paradigmatic controversies, contradictions, and emerging confluences, revisited.* Sage.

List of Generations Chart (n.d.). Retrieved 11 September 2015 from: http://www.esds1.pt/site/images/stories/isacosta/secondary_pages/10%C2%BA_block1/Generations%20Chart.pdf.

Lorenzitti, J., Oro, J., Matos, E. & Gelbcke, F.L. (2014). Work organisation in hospital nursing: Literature review approach. *Text Context Nursing, Florianòpolis*, 23(4), 1104-12.

Lutz, E.M., Elfrink, V.L. & Eddy, D.M. (1991). Research on values and values education in nursing. In P. A. Baj & G. M. Clayton (Eds.), *Review of research in nursing education* (107 – 139). New York : National League for Nursing. http://scholar.google.com/ scholar _lookup ?publication_year=1991&pages=107-139&issue=7&author=E.+M.+Lutzauthor=V.+L.+ Elfrinkauthor=D.+M.+Eddyauthor=P.+A.+Bajauthor=G.+M.+Clayton&title=+Review+of+ research+in+nursing+education+&.

Maben, J. & Griffiths, P. (2008). *Nurses in Society, Starting the debat*e. National Research Unit. King`s College, London. University of London.

Maben, J., Latter, S. & Clark, J. (2006). The theory-practice gap; impact of professional-bureaucratic work conflict on newly-qualified nurses. *Journal of Advanced Nursing,* 55, 465-477.

Mannino, J. & Cotter, E. (2016). Educating learner nurses for nursing practice in the 21st Century. *International Archives of Nursing and Healthcare,* 2(1), 1-4.

Marcum, J.A. (2013). The Role of Empathy and Wisdom in Medical Practice and Pedagogy: Confronting the Hidden Curriculum. Review article. *Journal of Biomedical Education*, 13, 1-8.

Maree, K. (2007). *First steps in Research*, (1st ed.). Pretoria: Van Schaik.

Maree, K. (2011). *First steps in Research*, (9th ed.). Pretoria: Van Schaik.

Marshall, C. & Rossman, G.B. (1995). *Designing Qualitative Research*, (2nd ed.). London: Sage.

Martimianakis, M.A., Maniate, J.M. & Hodges, B.D. (2009). Sociological interpretations of professionalism**.** *Medical Education*, 43, 829-837.

Martin, P., Yarbrough, S. & Alfred, D. 2003. Professional Values Held by Baccalaureate and Associate Degree Learner nurses. *Journal of Nursing Scholarship*, 35(3), 291296.

Mathevula, F.R. & Khoza, L.B. (2013). Nurse educators and student nurse neophytes` perceptions of good interaction in the classroom. *Health SA Gesondheid*, 18(1), Article nr. 669, 9.

Mathibe-Neke, J.M. (2015). The Role of the South African Nursing Council in Promoting Ethical Practice in the Nursing Profession: A Normative Analysis. *Research Report*. MSC(Med) in Bioethics and Health Law. University of the Witwatersrand, Johannesburg.

Matua, G. A., Seshan, V., Akintola, A.A. & Thanka, A.N. (2014). Strategies for providing effective feedback during preceptorship: Perspectives from an Omani hospital. *Journal of Nursing Education and Practice*, 4(10), 24-31.

Maxwell, J.A. (2013). *Qualitative Research Design: An Integrative Approach* (3rd ed.). Volume 41. Sage Publications, Inc.

Mazurek Melnyk, B., Gallaghner-Ford, L. & Fineout-Overholt, E. (2014). The Establishment of Evidence-Based-Practice Competencies for Practicing Registered Nurses and Advanced Practice Nurses in Real-World Clinical Settings: Proficiencies to improve He…*Worldviews on Evidence Based Nursing*, 11(1), 5-15.

McNair, R.P. (2005). The case for educating healthcare students in professionalism as the core content of interprofessional education. *Medical Education*, (39), 456-464. Blackwell Publishing.

Mellish, J. M., Brink, H. I. L. & Paton, F. (2000). *Teaching and Learning the Practice of Nursing*, (4th ed.). Johannesburg: Heinemann.

Meretoja, R. & Koponen, L. (2011). A systematic model to compare nurses` optimal and actual competencies in the clinical setting. *Journal of Advanced Nursing*, 414-422. Blackwell Publishing Ltd.

Mergler, A. & Patton, W. (2007). Adolescents Talking about Personal Responsibility. *Journal of Student Wellbeing*. 1(1), 57-70.

Merriam-Webster Dictionary (1997). *Professionalism.* Accessed 11 April 2017 https://www.merriam-webster.com/dictionary/professionalism.

Meulenbergs, T., Verpeet, E., Schotsmans, P. & Gastmans, C. (2004). Professional codes in a changing nursing context: literature review. *Journal of Advanced Nursing*, (46), 331-336.

Middleton, J. (2011). Leadership Skills for Nurses. Nursing Times.Special Supplement. Accessed 10 April 2017 from: https://www.nursingtimes.net/journals/2011/08/24/j/n/i/ leadership-skills-for-nurses.pdf.

Miles, M.B., & Huberman, A.M.(1994). *Qualitative data analysis: An expanded source book* (2nd ed.). Thousand Oaks, CA:Sage.

Miller, B.K. (1988). A Model for professionalism in nursing. *Today`s OR Nurse*,19(9), 18-23.

Min, A. & Kim, I. S. (2013). Relationship of Perception of Clinical Ladder System with Professional Self-Concept and Empowerment based on Nurses' Clinical Career Stage. *Journal of Korean Academic Nursing Administration,* 19(2), 254-264.

Moll, S., Frolic, A. & Key, B. (2015). Investing in compassion: exploring mindfulness as a strategy to enhance interpersonal relationships in healthcare practice. *Journal of Hospital Administration.* 4(6), 36-45.

Morley, D. (2013). Supporting student nurses in practice with additional online communication tools. *Nurse Education in Practice,* 14, 69-75.

Morse, J.M., Solberg, S.M., Neander, W.L., Bottorff, J.L. & Johnson, J.L. (1990). Concepts of caring and caring as a concept. *Advanced Nursing Science,* 13 (1), 1- 14.

Morse, J.M., Bottorff, J., Neander, W., Solberg, S. (2007). Comparative analysis of conceptualizations and theories of caring. *Journal of Nursing Scholarship,* 23 (2), 119-26.

Morse, J.M. & Field, P.A. (1996). *Nursing Research: The Application of Qualitative Approaches*. Basingstoke, Macmillan.

Moscaritolo, L.M. (2009). Interventional strategies to decrease learner nurse anxiety in the clinical learning environment. *Journal of Nursing Education*, 48(1), 17-23.

Moses, J.M. & Knutsen, T.L. (2007). *Ways of Knowing: Completing Methodologies in Social and Political Research*. Basinstoke: Palgrave Macmillan.

Msiska, G., Smith, P., Fawcett. T & Munkhondya, T.M. (2015). Where does the grade come from? Problems and Challenges in Evaluating the Clinical Performance of Nursing Students. *Open Journal of Nursing*, 5, 470-481.

Mubarak, S. (2011). *The Effect of Punctuality*. Education Land. Accessed 15 October 2013 from: http://educationland.wordpress.com/2011/10/08/the-effectof-Punctuality/.

Mukumbang, F. & Adejumo, O. (2014). Patients` experiences of being nursed by student nurses at a teaching hospital. *Curationis* 37(1), Article 1230, 10.

Mulaudzi, F.M., Mokoena, J., & Troskie, R. (2001). *Basic nursing ethics in practice*. Heineman. South Africa.

Mulube, S.M. & Jooste, K. (2014). First year learner nurses` perceptions of learning motivation in self-directed learning in a simulated skills laboratory at a higher education institution. *South African Journal of Higher Education*, 28(6), 1776-1794.

Muller, M. (2009). *Nursing Dynamics*, (4th ed.). Heinemann: Sandton.

Murray, T.A., MacIntyre, R.C. & Teel, C.S. (2011). An analysis of the partnership performance: The St.Johns Mercy Medical Centre- Saint Louis University School of Nursing dedicated education unit project. *Journal of Profession al Nursing*, 27(6), 58-63.

Myers, M. (2013). *Qualitative research in business and management*, (2nd ed.). Thousand Oaks: Sage Publications Inc.

National Registry of Evidence-based Programs and Practices [NREPP]. (2016). *Behind the Term: Trauma.* Development Services Group, Inc., under contract no. HHSS 28320120 0037i/HHSS 2834 2002T, ref. no. 283- 12-3702. Accessed 20 August 2016 from: http://www.nrepp.samhsa.gov/Docs%5CLiteratures%5CBehind_the_Term_Trauma.pdf.

New South Wales Government (2012). Future arrangements for governance of New South Wales Health: Report of the Director-General. Sydney, NSW. Accessed 29 March 2017 from: http://www0.health.nsw.gov.au/resources/govreview/pdf/governance_report.pdf.

Neuman, W.L. (2006). *Social research methods: qualitative and quantitative approaches*, (6th ed.). Boston: Pearson Education Inc.

Nieswiadomy, R. M. (1998). *Foundations of Nursing Research*, (3rd ed.). Appleton and Lange. USA.

Nightingale, F. (1946). Notes on nursing: *what it is and what it is not, by Nightingale, Florence, 1820*-1910. Accessed 11 April 2017 from: https://archive.org/details/notesnursingwhat00nigh

Nilsson, K., Grankvist, K., Juthberg, C., Brulin, C. & Söderberg, J. (2014). Deviations from venous blood specimen collection guideline adherence among senior learner nurses. *Nurse Education Today*, 34(2), 159-284. http://dx.doi.org/10.1016/j.nedt.2013.06.018.

Norgaard, B., Ammentorp, J., Kyvik, K.O. & Kofoed, P. (2012). Communication skills training increases self-efficacy of health care professionals. *Journal of Continuing Education in the Health Professions*, 32(2), 90-97.

Ntakana, K.N. (2011). *The effectiveness of student support programmes at a tertiary institution: A case study of Walter Sisulu University*. Thesis: Master of Education. Department of Educational Psychology and Special Education. University of Zululand.

Nursing Act. (2005). Act No. 33 of 2005. Accessed 29 July 2015 from: http://www.sanc.co.za/pdf/NursingAct2005.PDF.

Nursing Council of Thailand (1997). *The Professional Nursing and Midwifery Act BE 2528 (revision 2540*). Bangkok: Nursing Council of Thailand.

Nursing Education Association (NEA). (2011). 2011 Nursing Summit. *NEA Newsflash* 1(1).1.

Nursing Education Stakeholders Group. (2012). A Proposed Model for Nursing Education and Training in South Africa. *Trends in Nursing*, 1(1).

Nursing and Midwifery Council (NMC). (2013). Maintaining Boundaries. Accessed 3 September 2014 from: http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/Maintaining-Boundaries-/.

Nursing and Midwifery Council (NMC). (2015). *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwifes*. Bit.ly/ PHSOC are Compassion.

Nursing Standards. (2010). *Nursing Management*. Accessed 10 April 2017 from: http://currentnursing.com/nursing_management /nursing_standards.html.

Oates, C. (2000). *"The use of focus groups in social science research"* In Burton, D. (ed.) Research Training for Social Scientists. London: Sage.

O`Brien, R. (2016). *Ethical Values and Moral Courage. Nurses in Collective Bargaining Activities. Health Progress*. Accessed 20 November 2016 from: www.chausa.org.

Ochsner, A.K. (1996). Development and Validation of a Self-Report Inventory For Professional Nursing Values. *Dissertation in Higher Education*. Texas Tech University. Texas.

Omolola, A.O. & Gray, P. (2014). *Communication barrier during clinical placement: Challenges and Experiences of international learner nurses*. Thesis. Arcada University of Applied Science.

O'Neill, M. (1973). A study of baccalaureate nursing students` values. *Nursing Research*, 22, 437-443.

Onwuegbuzie, A.J., Dickinsin, W.B., Leech, N.L. & Zoran, A.G. (2009). A Qualitative Framework for Collecting and Analyzing Data in Focus Group Research. *International Journal of Qualitative Methods*, 8(3).

Onwuegbuzie, A.J., Leech, N.L. & Collins, K.M.T. (2010). Innovative Data Collection Strategies in Qualitative Research. *The Qualitative Report*, 15(3), 696-726.

Oosthuizen, M.J. (2012). The portrayal of Nursing in South African Newspapers: A qualitative Content Analysis. *Africa Journal of Nursing and Midwifery*, 14(1), 49-62.

Osman, A., Wardle, A., & Caesar, R. (2012). Online professionalism and Facebook–Falling through the generation gap. *Medical teacher*, 34(8), 549-556.

O`Sullivan, H., Van Mook, W., Fewtrell, R. & Wass, V. (2012).Integrating professionalism into the curriculum: AMEE Guide No.61, *Medical Teacher*, 34(2), 64-77.

Özsoy, A. & Donmez, R.O. (2015) Nurses professional values scale revised: Psychometric properties of the Turkish version. *Nursing Practice Today*, 2(1), 16-24.

Panyapatipo, P.A.P. (n.d.). *Mindfulness and Self-Awareness*. Accessed 9 April 2017 from: http://www.dhammatalks.net/Books7/Acharn_Plien_Sati-Sampajanna_Mindfulness-Awareness.pdf.

Papastavrou, E., Dimitriadou, M., Tsangari, H. & Andeou, C. (2016). Learner nurses` satisfaction of the clinical learning environment: a research study. *BioMed Central*. 15(44).

Paragana, K.D. (2009). *Your professional Presence: Advice on Dress and Appearance*. NSNA Imprint. Accessed 5 September 2014 from: http://www.nsna.org /Portals /0/ Skins /NSNA/pdf/Imprint_FebMar09_Feat_Cardillo.pdf.

Parandeh, A., Khaghanizade, M., Mohammadi, E. & Mokhtari-Nouri, J. (2016). Nurses' human dignity in education and practice: An integrated literature review. *Iranian Journal of Nursing and Midwifery Research,* 21(1), 1-8.

Pattalitan, A.P. (2016). Implications of learning theories to assessment and instructional scaffolding Techniques. *American Journal of Educational Research,* 4(9), 695-700.

Patton M.Q. (2002). *Qualitative Research & Evaluation Methods*. London: Sage publications.

Peate, I. (2012). Kindness, Caring and Compassion. Guest Editorial. *Australian Nursing Journal*, 12(19), 7, 16. Accessed 16 July from: http://planetreegrove.com/wp-content/uploads/2013/08/ Kindness-caring-and-compassion.pdf.

Pera, S.A., & Van Tonder, S. (1996). *Etiek in die verpleegpraktyk.* Kenwyn. Juta.

Pesut, D. (2014). *The Scholarship of Reflective Practice*. Sigma Theta Tau International (2003-2005). Accessed 14 November from: https://www.nursingsociety.org /docs / default.../ resource_reflective.pdf.

Pledge. (n.d.). *Dictionary.com Unabridged*. Accessed 22 August 2016 from: Dictionary.com http://www.dictionary.com/browse/pledge.

Poindexter, K., Hagler, D. & Lindell, D. (2015). Designing authentic assessment: Strategies for nurse educators. *Nurse Education*, 40(1), 36-40

Polit, D.F & Hungler, B.P. (1987). *Nursing Research. Principles and Methods*. (3rd ed.). Lippincott. Philadelphia.

Polit, D. & Beck, C.T. (2008). *Nursing Research. Generating and Assessing Evidence for Nursing Practice*. (8th ed.). Wolters Kluwer. New York.

Polit, D. & Beck, C.T. (2012). *Nursing Research. Generating and Assessing Evidence for Nursing Practice.* (9th ed.). Wolters Kluwer. New York.

Porr, C., Dawe, D., Lewis, N., Meadus., Snow, N. & Didham, P. (2013). Patient Perception of contemporary nurse attire: A Pilot study. *International Journal of Nursing Practice*, 1-7.

Pornwattanakul, S., (1999). *Professional nurse ethical behaviours in hospitals in Nonthaburi Province indicated in the Professional Nursing and Midwifery Act BE 2528*[Thesis]. Bangkik: Mahidol University.

Practice Review. (2010). Dignity in care: meanings, myths and the reality of making it work in practice. *Nursing Times*, 106(40).

Price, S.L. (2008). Becoming a nurse: a meta-study of early professional socialization and career choice in nursing. *Journal of Advanced Nursing*, 65(1), 11-19.

Project Management Institute. (2016). *Code of Ethics and Professional Conduct.* Accessed 23

November 2016 from: http://pmi-dhc.ca/images/downloads/WebsiteDownloads/appmicodeofethics.ashx.pdf.

Rassin, M. (2008). Nurses Professional and Personal Values. *Nursing Ethics*, 15, 614.

Ray, M. (2010). *A study of caring within an institutional culture: The discovery of the theory of bureaucratic caring*. Saabrücken, Germany: LAP Lambert Academic Publishing.

Ray, M. & Turkell, M. (2010). The theory of bureaucratic caring. In M. Parker & M. Smith(Eds.), *Nursing theories and nursing practice* (3rd ed.). Philadelphia F.A. Davis.

Rees, C.E. & Knight, L.V. (2007). The trouble with assessing students' professionalism: theoretical insights from socio-cognitive psychology. *Academic Medicine*, 2007; 82(1), 46–50.
Regan, P. (2012). Reflections of specialists community public health nursing practice development: transformative learning through Mezirow`s reflective discourse. *International Practice Development Journal, 2(2) [9*].

Registered Nurses Association of Ontario. (2007). *Professionalism in Nursing. Nursing Best Practice Programme. Healthy Work Environments Best Practice Guidelines*. Accessed 4 December 2015 from: http://rnao.ca/sites/rnao-ca/files/Professionalism_in_Nursing.pdf.

Reid, J. (2012). Respect, compassion and dignity: the foundations of ethical and professional caring. *Association for Perioperative Practice.* ISSN 1467-1026.

Richardson, L. (2000). "Writing: A Method of Inquiry." In Handbook of Qualitative Research (2nd ed.), edited by Norman K. Denzin and Yvonna S. Lincoln, 923-948. Thousand Oaks, CA: Sage.

Richmond, V.P., Wrench, J.S. & Gorham, J. (2009). *Communication, Affect and learning in the Classroom*. (3rd ed.). New York.

Riegel, E.M. (2013). Orienting a new generation of nurses: Expectations of the millennial new graduate. *Open Journal of Nursing*, 3, 461-466.

Robinson, O.C. (2014). Sampling in Interview-Based Qualitative Research: A theoretical and Practical guide. *Qualitative Research in Psychology*, 11(1), 25-41.

Roos, E. (2014). Attrition of undergraduate nursing students at South African Universities. Thesis: Magister Societatis Scientiae. Department of Nursing. University of the Free State.

Rouse, R. & Al-Magbali, M. (2014) Identifying nurse managers` essential communication skills: an analysis of nurses` perceptions in Oman. *Journal of Nursing Management*, 1-9.

Roussel. L., Swansburg, R.C. & Swansberg, R.J. (2006). *Management and leadership for nurse administrators*, 4th ed.). Boston: Jones and Bartlett.

Royal Institute of British Architects. (2005) *Code of professional conduct*. Accessed 8 September 2014 from: http://www.architecture.com/ Files/RIBAProfessionalServices/ ProfessionalConduct/ Constitution/CodeOfConduct/2005RIBACodeOfProfessionalConduct.pdf.

Rubin, A. & Babbie, E. (2011). *Research methods for social work*. New York: Brooks/Cole Cengage Learning.

Russel, C., Gregory, D., Ploeg, J., DiCenso, A. & Guyatt, G. (2005). Qualitative research. In A. DiCenso, G. Guatt, & D. Ciliska (Eds.), *Evidence-based nursing: A guide to clinical practice*, 120-135. St Louis: Elsevier Mosby.

Rutherford, M. (2014). The Value of Trust to Nursing. CNE Series. *Nursing Economic$*, 32(6), 283-289. Accessed 30 June from: https://www.nursingeconomics.net/ce/ 2016/ article3206283327.pdf.

Salyers, V., Carter, L., Cairns, & Durrer, L. (2014). The use of Scaffolding and interactive learning strategies in online courses for working nurses: Implications for adult and online education. *Canadian Journal of University Continuing Education*, 40(1).

Sandal, G.M., Bye, H.H. & Van de Vijver, F.J.R. (2011). Personal values and crew compatibility: Results from a 105 days simulated space mission. *Acta Astronautica*, 69, 141-149.

Schwandt, T.A. (2001). *Dictionary of Qualitative Inquiry*. Thousand Oaks, California: Sage.

Scott, P. A., Matthews, A. & Kirwan, M. (2013). *What is nursing in the 21st century and what does the 21st century health system require of nursing*? John Wiley & Sons Ltd.

Scottish Government. (2012). *Professionalism in nursing, midwifery and the allied health Professionals in Scotland: a report to the Coordinating Council for the NMAHP Contribution to the HealthCare Quality Strategy for NHS Scotland*. Edinburgh. ISBN: 978-1-78045-925-7.

Searle, C. (1978). The Criteria for Professionalism in Nursing in South Africa. *Curationis*; 1, (1), pp. 4-8. doi: 10.4102/curationis.v1i1.196.

Searle, C., Human, S. & Mogotlane, S.M. (2009). *Professional Practice. A South African Perspective*. Fifth Edition. Heinemann. Sandton.

Searle, C. & Pera, S.A. (1997). *Professional Practice. A South African Perspective*. Durban. Butterworths.

Shahriari, M., Mohammadi, E., Abbaszadeh, A. & Bahrami, M. (2013). Nursing ethical values and definitions: A literature review. *Iran Journal of Nursing and Midwifery Research*, 18(1), pp. 1–8.

Shaw, H.K. & Degazen, D. (2008). Integrating the Core Professional Values of Nursing: A Profession, Not Just a Career. *Journal of Cultural Diversity*, 15(1).

Shephard, P. (2016). *Transforming the mind*. Accessed 4 April 2017 from: http://www.tran4mind.com/transfromation.

Shibaev, V.P. & Shibaeva, L.M. (2014). Characteristics of an effective professor in a world`s educational practice. *Life Science Journal*, 11(8), 459-464.

Schmidt, B. (2014). Core professional nursing values as experienced by baccalaureate nursing students who are men. *Doctoral Dissertation*. Nova Southeastern University, Retrieved from NSUWorks, College of Nursing, (12). http://nsuworks.nova.edu/hpd_con_stued.

Singh, I. (2015). Training and Professional Development and Healthcare Support Workers: Supporting Foundation for Quality and Good Practice for Care of the Acutely Ill Older Person. International Archive of Nursing and Health Care, 1,007.

Smith, S.A. (2012). Nurse Competence: A Concept Analysis. *International Journal of Nursing Knowledge*, 23(3), 172-182.

Sounart, A. (2007). *Mishaps & Malpractice: How New Nurses Can Protect Themselves*. AMN Healthcare, Inc [Online]. Retrieved from Internet 13 March 2012. http://www.nursezone.com/recent-graduates/recent-graduates-featured-articles/Mishaps-amp-Malpractice-How-New-Nurses-Can-Protect-Themselves_20104.aspx.

South Africa. (2005). *Nursing Act No. 33 of 2005*. Retrieved from *http://www.sanc.co.za/pdf/Nursing%20Act%202005.PDF. 10/09/2012*.

South African Nursing Council. (2009). *Charter for Nursing Practice*. SANC: Pretoria (www.sanc.org.za).

South African Nursing Council. (2004-2012). *Regulation 425 as amended*. Retrieved from http://www.sanc.co.za/regulat/Reg-4yr.htm, 10 August 2012.

South African Nursing Council. (2013). Code of Ethics for Nursing Practitioners in South Africa. Excellence in Professionalism and Advocacy for Healthcare Users. http://www.sanc.co.za/pdf/SANC%20Code%20of%20Ethics%20for%20Nursing%20in%20South%20Africa.pdf.

South African Nursing Council. (2004-2016). *Nursing Education and Training Standards*. Accessed 7 July 2015 from: http://www.sanc.co.za/pdf/Nursing%20Education%20and%20Training%20 Standards.pdf.

South African Nursing Council. (2004-2016). *Regulations Concerning the minimum requirements for registration of the Additional Qualification in Nursing Education*. Accessed 10 April 2017 from: http://www.sanc.co.za/regulat/Reg-ned.htm

South African Nursing Council. (2004-2015). *Education and Training of Nursing and Midwifery Students*. Accessed 29 October 2015 from: http://www.sanc.co.za/education_and_training.htm.

South African Nursing Council. (n.d). *The Relationship between the Scope of Practice, Practice Standards and Competencies*. Accessed 1 June 2016 from: http://www.sanc.co.za/pdf/Competencies/SANC%20Relationship%20between%20SOPs,%20Practice%20Standards%20and%20Competencies.pdf.

Stake, R. (1995). *The art of case study research*. Thousand Oaks, CA:Sage.

Stake, R. (2000). *Case studies*. Chapter 16 of Denzin and Lincoln(ed). *Handbook of Qualitative Research,* 2nd (ed.). Sage.

Stagg, S.J., Sheridan, D.J., Jones, R.A., & Speroni, K.G. (2013). Workplace bullying: The effectiveness of a workplace program. *Workplace Health and Safety* 61(8), 333-338.

State of Cape Town. (2014).*Celebrating 20 years of Democracy*. Accessed 28 October 2015 from: https://www.capetown.gov.za/en/stats/CityReports/Documents/SOCT%2014%20report %20complete.pdf.

Stapleton, P., Henderson, A., Creedy, D.K. Cooke, M., Patterson, E., Alexander, H., Haywood, A. & Dalton, M. (2015). *Boosting Morale and improving performance in the Nursing Setting*. Accessed 29 March 2017 from: http://www98.griffith.edu.au/dspace /bitstream/handle/ 10072/17025/47631_1.pdf..?sequence=1.

Statistics South Africa (2016). *Census (2011)*. Accessed 4 June 2016 from: http://www.statssa.gov.za/.

Steketee, C., Lee, A., Rogers, G. & Moran, M. (2013). Towards a theoretical framework for curriculum development in health professional education. *Focus on Health Professional Education*, 14(3), 64-77.

Steward, R.D. (2015). Nursing Professionalism: A View from the starting line. Thesis submitted to the Faculty of Graduate Studies in Partial Fulfilment of the requirements for the Degree of Masters of Nursing. Graduate Programme in Nursing. Calgary. Alberta. Accessed March 2016 from: http://theses.ucalgary.ca/bitstream/11023/2445/2/ucalgary_2015_ stewart_robyn.pdf.

Streubert, H.J. & Carpentor, D.R. (2011). *Qualitative research in nursing 5th Edition*. China: Lippencott Williams and Wilkins.

Suar, D. & Khuntia, R. (2010). Influence of Personal Value and Value Congruence on Unethical Practices and Work Behaviour. *Journal of Business Ethics,* 97(3), 443-460.

Subhan, M. S. (2014). *Current pedagogical teaching strategies being used by educators at the Kwazulu Natal College of Nursing Campuses across varied subjects and their views regarding*

innovative methodologies. Dissertation: Masters of Technology: Nursing. Faculty of Health Sciences. Department of Nursing. Durban University of Technology.

Subedar, H. (2008). *The professional regulatory environment, in Nurse educator`s guide to management*, Pretoria: Van Schaik,

Strong, J., Ashton, R., Chant, D. & Cramond, T. (1994). An investigation of the dimensions of chronic low back pain: the patient`s perspectives. *British Journal of Occupational Therapy 57*, 204-208.

Tanaka, M., Yonemitsu, Y., Kawamoto, R. (2014). Nursing professionalism: A national survey of professionalism among Japanese nurses. *International Journal of Nursing Practice*; 20, 579-587.

Tappen, R.M. (2011). Advanced nursing research: From theory to practice. Sudbury, MA: Jones & Bartlett.

Task Force on Professionalism. (2000). White Paper on pharmacy student professionalism, *Journal of American Pharmacy Association*, 40(1), 96-100.

Tay, L.H., Ang, E. & Hegney, D. (2012). Nurses`s perceptions of the barriers in effective communication with inpatient cancer adults in Singapore. *Journal of Clinical Nursing, online*, 1-12.

Teacher Registration Board. (2015). Managing Professional Boundaries. Australian teacher regulatory authorities, Accessed 18 November 2016 from: https://crnns.ca/wp-content/uploads/2015/02/ProfessionalBoundaries2012.pdf.

Teixeira, A. & Barbieri-Figueiredo, M. (2015). Nursing empowerment and job satisfaction: an integrative review according the Structural Theory. *Journal of Nursing Referência*, 4(6), 151-158.

Tenza, I.S. (2015). Clinical facilitation: Undergraduate nurses` perceptions of best practice in an academic hospital in Johannesburg. *Research Report.* Masters of Science in Nursing. University of the Witwatersrand, Johannesburg.

Ter Halle, Y. (2016). *Influence of leader and follower behaviour on employee voice, team task responsibility and team effectiveness*. Dissertation. University of Twente. Netherlands

*Thai Nurses`Association code of ethics*. (1985). Bangkok: Thai Nurses`Association, (in Thai).

The Local Government Handbook. (2012-2016). A complete guide to municipalities in South Africa. Accessed 3 June 2016 from: http://www.municipalities.co.za/metropolitans/view/6/city-of-cape-town-metropolitan-municipality#map.

Thomas, J. Robert, M. & Arnold, R. (2011). Giving Feedback. *Journal of Palliative Medicine*, 14(2), 233-239.

Thomas, T.P. (2013). *The Effect of Personal Values, Organisational Values, and Person-Organisation Fit on Ethical Behaviours and Organisational Commitment Outcomes among Substance Abuse Counselors: A Preliminary Investigation*. PhD (Doctor of Philosophy) Thesis, University of Iowa.

Twentyman, M. & Eaton, E. (2007). Enhancing support for nursing students in the clinical setting. Accessed 9 November 2015 from: https://www.nursingtimes.net/enhancing-support-for-nursing-students-in-the-clinical-setting/203296.article.

Ulin, P.R., Robinson, E. T. & Tolley, E.E. (2005). *Qualitative measures in public health: A Field guide for Applied Research*. San Francisco: Jossey-Bass.

United Nations Educational, Scientific and Cultural Organisation (UNESCO). (1995). Legal Instruments. Declaration of principles of Tolerance. 16 November 1995.Retrieved from: http://portal.unesco.org/en/ev.php-URL_ID=13175&URL_DO=DO_TOPIC&URL_SECTION=201.html.

University of Brighton. (2014-2015). Evaluating your teaching(online). Accessed 25 March 2017 from: http://blogs.brighton.ac.uk/cltresources/files/2014/08/Evaluating_your_teaching _2014-1z1g4fe.pdf.

University of the Western Cape. (2016). Accessed 4 June 2016 from: https://www.uwc.ac.za/Faculties/CHS/Pages/Home.aspx#Schools.

Unrau, Y.A., Gabor, P.A. & Grinnell, R.M. (2007). *Evaluation in social work: art and science in practice*. London: Oxford University.

Uys, L.R. (1999). *Fundamental Nursing*. Maskew Miller. Longman.

Van den Bergh, L. (2013). *Teacher feedback: the development and evaluation of a professional development programme*. Eindhoven. Techniche Universiteit Eindhoven. DOI:10.6100 /IR754854.

Van der Elst, E., Dierckx de Casterle, B. & Gastmans, C. (2012). Elderly patients' and residents' perceptions of the good nurse: a literature review. *Journal of Medical Ethics,* 38 93-7.

Van der Merwe, A. (2010). Ethos of nursing and professional practice. In Jooste, K (Ed.). *The principles and practice of nursing and health care*. Pretoria. Van Schaick.

Van Wyk, S., Heyns, T. & Coetzee, I. (2015). The value of the pre-hospital learning environment as part of the emergency nursing programme. *Health SA Gesondheid*, 20(91-99).

Wall, P., Andrus, P.M. & Morrison, P. (2014). Bridging the Theory Practice Gab through clinical Simulations in a nursing undergraduate programme in Australia. *International Journal of Learning, Teaching and Educational Research,* 8(1), 127-135.

Watson, J. (2008). Nursing: The philosophy and science of caring(2nd ed.). Boulder, Colorado: University Press of Colorado.

Watson, J. (2009). Caring as the essence and science of Nursing and healthcare. *O Mundu Da Saude, Sao Paulo*. 33(2), 143-149.

Watt, B. (2013). *It` s Time to view leadership as a profession. Leadership. Recruitment extra*. Accessed 30 March 2016 from http://www.ddiworld.com/DDIWorldAU/media/Articles/view leadership_mar13_ar_re.pdf.

Wear, D. & Kuczweski, M.G. (2004). The professionalism movement: can we pause? *American Journal of Bioethics,* 4(2), 1-10.

Webb, C. & Kevern, J. (2001). Focus groups as a research method: a critique of some aspects of their use in nursing research. *Journal of Advanced Nursing*, 33(6), pp.798-805.

Weinman, J., Ebrecht, M., Scott, S., Walburn, J. & Dyson, J. (2008). 'Enhanced wound healing after emotional disclosure intervention'. *British Journal of Health Psychology*, 13(1), 95–102.

Weis, D. & Schank, M. J. (2000). Toward building an international consensus in professional values. *Nurse Education Today,* 17, 366-369.

Western Cape Government of Health (Images). (2016). Accessed 22 April 2016 from : https://www.google.co.za/search?q=socio+economic+and+cultural+issues+in+cape+town+pdf&biw=1366&bih=643&source=lnms&tbm=isch&sa=X&sqi=2&ved=0CAcQ_AUoAmoVChMI_7KO3JHxxwIVMlrbCh0YXAPB#tbm=isch&q=city+of+cape+town+health+pdf&imgdii=uk8d-fySPGVmQM%3A%3Buk8d-fySPGVmQM%3A%3Big9_LW55XOvGsM%3A&imgrc=uk8d-fySPGVmQM%3A.

Western Cape Department of Health. (2013). *Annual Report* 2013/2014. Accessed 22 April 2016 from: http://www.wcpp.gov.za/sites/default/files/Dept%20Health%20AR%202013-14.pdf.

Western Cape Government. (2011). Accessed 11 April 2017 from: http://www.energyboardroom .com/oilandgasdirectory/the-government-of-the-western-cape/.

Western Cape Government. (2016). *City of Cape Town*. Accessed 4 June 2016 from: www.capetown.gov.za.

Wilson, K. & Devereux, L. (2014). Scaffolding Theory: High challenge, high support in Academic Language and Learning (ALL) contexts. *Journal of Academic Language and Learning*, 8,(3).

Winlow, H.,Simm, D., Marvell, A. & Schaaf, R. (2013). Using Focus group Research to Support Teaching and Learning. *Journal of Geography in Higher Education*, 37(2), 292-303.

Wloszczak-Szubzda, A. & Jarosz, M.J. (2013). Professional communication competences of nurses - a review of current practice and educational problems. *Ann Agricultural and Environmental Medicine*, 20(1), 183-188.

Wood, J.T. (2007). *Interpersonal Communication. Everyday encounters*, 5th edition. Belmont, CA: Thomson Wadsworth.

Wright, S.M. & Carrese, J.A. (2002). Excellence in role modelling: insight and perspectives from pros. *Canadian Medical Association Journal*, 167(6), pp. 638-643. In Felstead, I. (2013). Role modelling and students` professional development. *British Journal of Nursing*; 22(4), 223-227.

Wynd, C.A. (2003).Current factors contributing to professionalism in nursing. *Journal of Professional Nursing*, 19(5), 251–261.

Yaniv, D. (2012). Dynamics of creativity and Empathy in Role reversal: Contributions from Neuroscience. *Review of General Psychology*, 16(1), 70-77.

Yeo, M. (1989). Integration of nursing theory and nursing ethics. *Advances in nursing science*, 11(3), 33-42.

Yin, R.K. (2003). *Case study Research: Design and Method*, (3rd ed.). Sage. London

Yin, R.K. (2009). *Case Study Research: Design and Methods,* (4th ed.). Thousand Oaks, CA: SAGE.

Yin, R.K. (2014). *Case Study Research: Design and Methods.* (5th ed.). New York: SAGE.

Zakaria, R., Musta`amal, A.H., Mohd Amin, N.F. & Saleh, H.M. (2015). *Transcribing with ATLAS.ti*. Institutional Repository of Technische Universität, Berlin. DOI 10.14279/ depositonce-5157

Zare, Z.G., Purfarzad, Z. & Adib-Hajbaghery, M. (2013). Medication Management Skills of Nursing Students: Comparing the Students and their Instructors` Evaluation in two Universities. *Nursing and Midwifery Studies*, 1(3), 139-145.

Zhao, N. (2008). Analyzing the Meaning in Interaction in Politeness Strategies in *Scent of a Woman. The Journal of International Social Research, 1(4).*

Zlatic, T.D. 2005. *Re-visioning Professional Education: An Orientation to Teaching.* 1st Edition. Kansas City, MO: American College of Clinical Pharmacy.

Zhu, W., Sosik, J.J., Riggio, R.E. & Yang, B. (2012). *Relationships between Transformational and Active Transactional Leadership and Followers`Organizational identification: The Role of Psychological Empowerment*. London: Institute of Behavioral and Applied Management.

ANNEXURES

ANNEXURE A: ETHICAL CLEARANCE LETTER 1

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

28 November 2012

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:
Ms P Bimray (School of Nursing)

Research Project:	A conceptual framework for nurse educationalists and professional nurses to facilitate professionalism amongst undergraduate learner nurses for nursing practice in the Western Cape.
Registration no:	12/10/18

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

A place of quality,
a place to grow, from hope
to action through knowledge

ANNEXURE B: **P**ERMISSION LETTER FROM A SCHOOL OF NURSING

UNIVERSITY OF THE WESTERN CAPE
SCHOOL OF NURSING
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592274, Fax: 27 21-9592271
E-mail: kjooste@uwc.ac.za

November 2012

Mrs P. Bimray

Title of Research Project: 'A *conceptual framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape".*

You are granted permission to conduct your study at the School of Nursing.

You have to arrange the data collection with the appropriate level coordinator(s) for a convenient time. During this phase you have to adhere to the ethical principles outlined in your study.

I wish you success with your studies.

K Jooste

Prof K Jooste
Director
School of Nursing

ANNEXURE C: INFORMATION SHEET FOCUS GROUPS LEARNER NURSES

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592274, Fax: 27 21-9592271
E-mail: pbimray@gmail.com

INFORMATION SHEET: LEARNER NURSES

Project Title: A framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape

What is this study about?

I am Portia Bimray, registered for a PhD in Nursing Science at the University of the Western Cape with Prof K. Jooste as my supervisor. I invite you to participate in this research project because it involves professionalism in nursing practice. The purpose of this study is to develop a framework for nurse educationalists and professional nurses to facilitate professionalism in learner nurses for nursing practice in the Western Cape.

What will I be asked to do if I agree to participate?

Focus groups will be conducted at a school of nursing at a university of the Western Cape, in a suitable room, that ensures privacy and comfort for participants. Each focus group will consist of 6-10 participants who will be learner nurses from first to fourth year, registered for the undergraduate nursing programme at a university in the Western Cape.

The focus groups will each last around 60 minutes. The questions that would be asked are: "What are your experiences of being part of a professional nursing course?"; "What do you think the School of Nursing should do to support undergraduate learner nurses to enhance professionalism after four years of training (Probe)?" Written consent for the interviews to be voice recorded will also be needed. Voice recordings of the interviews will be stored under lock and key for five years after the results of the project has been published before it will be destroyed. Only my supervisors, an independent coder and the researcher (me) will have access to these recordings. The researcher will take written field notes during the interviews. However, the participants' names will not be recorded in these notes.

Would my participation in this study be kept confidential?

We will do everything within our power to keep your personal information confidential. Participants in the focus group will be encouraged to keep information obtained confidential. To help protect your confidentiality, a number in the form of a code will be assigned on the field notes instead of your real name. It would prevent any other person from linking specific data to you. All information obtained by means of voice recording will be stored under lock and key for five years after publication of the results. As the researcher cannot ensure confidentiality, you **should undertake to keep all discussions in the group confidential and not to divulge the content of the focus group to anyone outside of this group**. The publication of the results of the project, will not mention any names of participants.

What are the risks of this research?

There are no known risks associated with participating in this research project.

What are the benefits of this research?

The results may assist the researcher to explore and describe to what extent undergraduate learner nurses have developed professionally during the four year nursing programme at UWC. Information acquired during this research project will be shared with all participants prior to public dissemination. Results of the study will be published in an accredited journal. The nursing profession and other nursing institutions might benefit from this study by using the framework to enhance professionalism amongst all categories of nurses.

Am I obliged to take part in this research project and can I stop participating at any time?

Your participation in this research project is completely free and voluntary. You may choose not to take part at all. If you decide to participate in this research, you may withdraw at any time during the study. If you decide to withdraw from the study, you will not be penalised in any way, neither will you forfeit any benefits to which you otherwise qualify.

How do I get my questions answered?

This research is being conducted by Portia Bimray, registered at the South African Nursing Council as a Nurse Educator and permanently employed by the University of the Western Cape. If you have any questions about the research study itself, please contact:

Portia Bimray
School of Nursing
Community of Health Sciences
University of the Western Cape
Modderdam Road
Private Bag X17
Bellville
7353
Cell Phone: 0823360516
Office: 0219592601
Email: pbimray@uwc.ac.za

Should you have any questions with regard to this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:
Head of Department: Prof Karien Jooste 021 9592274
Email: - kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences
Prof Hester Klopper 021 9592631
Email: hklopper@uwc.ac.za
University of the Western Cape
Private Bag X17
Bellville 7535
Head of Department
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

ANNEXURE D: INFORMATION SHEET FOCUS GROUPS: EDUCATIONALISTS AND PROFESSIONAL NURSES

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592274, Fax: 27 21-9592271
E-mail: pbimray@gmail.com

INFORMATION SHEET: EDUCATIONALISTS AND PROFESSIONAL NURSES

Project Title: A framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape

What is this study about?

I am Portia Bimray, registered for a PhD in Nursing Science at the University of the Western Cape with Prof K. Jooste as my supervisor. I invite you to participate in this research project because it involves professionalism in nursing practice. The purpose of this study is to develop a framework for nurse educationalists and professional nurses to enhance professionalism in learner nurses for nursing practice in the Western Cape.

What will I be asked to do if I agree to participate?

Focus groups will be conducted at the School of Nursing at the University of the Western Cape and at the identified health facility, in a suitable room, that ensures privacy and comfort for participants. Each focus group will consist of 6-10 participants that will be nurses from the same category as yourself (professional nurses, nurse educators and clinical supervisors).

The focus groups will each last around 60 minutes. The questions that would be asked are: "What are your experiences of being part of a professional nursing course?"; "What do you think the School of Nursing should do to support undergraduate learner nurses to enhance professionalism after four years of training (Probe)?". Written consent for the interviews to be voice recorded will also be needed. Voice recordings of the interviews will be stored under lock and key for five years after the results of the project has been published before it will be destroyed. Only my supervisors, an independent coder and the researcher (me) will have access

to these recordings. The researcher will take written field notes during the interviews. However, the participants' names will not be recorded in these notes.

Would my participation in this study be kept confidential?

We will do everything within our power to keep your personal information confidential. Participants in the focus group will be encouraged to keep information obtained confidential. To help protect your confidentiality, a number in the form of a code will be assigned on the field notes instead of your real name. It would prevent any other person from linking specific data to you. All information obtained by means of voice recording will be stored under lock and key for five years after publication of the results. As the researcher cannot ensure confidentiality, you **should undertake to keep all discussions in the group confidential and not to divulge the content of the focus group to anyone outside of this group**. The publication of the results of the project, will not mention any names of participants.

What are the risks of this research?

There are no known risks associated with participating in this research project.

What are the benefits of this research?

The results may assist the researcher to explore and describe to what extent undergraduate learner nurses have developed professionally during the four year nursing programme at UWC. Information acquired during this research project will be shared with all participants prior to public dissemination. Results of the study will be published in an accredited journal. The nursing profession and other nursing institutions might benefit from this study by using the framework to facilitate professionalism amongst all categories of nurses.

Am I obliged to take part in this research project and can I stop participating at any time?

Your participation in this research project is completely free and voluntary. You may choose not to take part at all. If you decide to participate in this research, you may withdraw at any time during the study. If you decide to withdraw from the study, you will not be penalised in any way, neither will you forfeit any benefits to which you otherwise qualify.

How do I get my questions answered?

This research is being conducted by Portia Bimray, registered at the South African Nursing Council as a Nurse Educator and permanently employed by the University of the Western Cape. If you have any questions about the research study itself, please contact:

Portia Bimray
School of Nursing
Community of Health Sciences
University of the Western Cape
Modderdam Road
Private Bag X17
Bellville
7353
Cell Phone: 0823360516
Office: 0219592601
Email: pbimray@uwc.ac.za

Should you have any questions with regard to this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Prof Karien Jooste 021 9592274
Email: - kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences
Prof Hester Klopper 021 9592631
Email: hklopper@uwc.ac.za
University of the Western Cape
Private Bag X17
Bellville 7535
Head of Department
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

ANNEXURE E: INFORMATION SHEET INDIVIDUAL INTERVIEWS

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592274, Fax: 27 21-9592271
E-mail: pbimray@gmail.com

INFORMATION SHEET: INDIVIDUAL INTERVIEWS

Project Title: A framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape

What is this study about?

I am Portia Bimray, registered for a PhD in Nursing Science at the University of the Western Cape with Prof K. Jooste as my supervisor. I invite you to participate in this research project because it involves professionalism in nursing practice. The purpose of this study is to develop a framework for nurse educationalists and professional nurses to facilitate professionalism in learner nurses for nursing practice in the Western Cape.

What will I be asked to do if I agree to participate?

Focus groups/individual interviews will be conducted at the Healthcare facility where you are working, in a suitable room that ensures privacy and comfort for participants. Each interview will consist of participants that will be nurses from the same category as yourself (professional nurses, nurse educators and clinical supervisors).

The focus groups/ individual interviews will each last around 60 minutes. The questions that would be asked are: "What are your experiences of professionalism among undergraduate nurses?"; "What do you think the School of Nursing should do to support undergraduate learner nurses to become professional nurses after four years of training (Probe)?" How can professional nurses support undergraduate learner nurses to improve professionalism? Written consent for the interviews to be voice recorded will also be needed. Voice recordings of the interviews will be stored under lock and key for five years after the results of the project has been published before it will be destroyed. Only my supervisors, an independent coder and the researcher (me) will have access to these recordings. The researcher will take written field notes during the interviews. However, the participants' names will not be recorded in these notes.

Would my participation in this study be kept confidential?

We will do everything within our power to keep your personal information confidential. To help protect your confidentiality, a number in the form of a code will be assigned on the field notes instead of your real name. It would prevent any other person from linking specific data to you. All information obtained by means of voice recording will be stored under lock and key for five years after publication of the results. The publication of the results of the project, will not mention any names of participants.

What are the risks of this research?

There are no known risks associated with participating in this research project.

What are the benefits of this research?

The results may assist the researcher to explore and describe to what extent undergraduate learner nurses have developed professionally during the four year nursing programme at UWC. Information acquired during this research project will be shared with all participants prior to public dissemination. Results of the study will be published in an accredited journal. The nursing profession and other nursing institutions might benefit from this study by using the framework to facilitate professionalism amongst all categories of nurses.

Am I obliged to take part in this research project and can I stop participating at any time?

Your participation in this research project is completely free and voluntary. You may choose not to take part at all. If you decide to participate in this research, you may withdraw at any time during the study. If you decide to withdraw from the study, you will not be penalised in any way, neither will you forfeit any benefits to which you otherwise qualify.

How do I get my questions answered?

This research is being conducted by Portia Bimray, registered at the South African Nursing Council as a Nurse Educator and permanently employed by the University of the Western Cape. If you have any questions about the research study itself, please contact:

Portia Bimray
School of Nursing
Community of Health Sciences

University of the Western Cape
Modderdam Road
Private Bag X17
Bellville
7353
Cell Phone: 0823360516
Office: 0219592601
Email: pbimray@uwc.ac.za

Should you have any questions with regard to this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:
Head of Department: Prof Karien Jooste 021 9592274
Email: - kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences
Prof Hester Klopper 021 9592631
Email: hklopper@uwc.ac.za
University of the Western Cape
Private Bag X17
Bellville 7535
Head of Department
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

ANNEXURE F: WRITTEN INFORMED CONSENT FOCUS GROUP: UNDERGRADUATE LEARNER NURSES

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

E-mail: pbimray@uwc.ac.za

Letter of request to participate in the study

Title of Research Project: A framework for nurse educationalists and professional nurses to develop professionalism of undergraduate learner nurses for nursing practice in the Western Cape.

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I undertake to keep all discussions in the focus group confidential and not to divulge the content of the focus group to anyone outside of this group.

Participant's name……
Participant's signature……

I further agree that the interview be voice recorded.

Participant's signature…….

I further agree that the researcher takes field notes.

Participant's signature…….
Witness…….
Date……

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Prof Karien Jooste

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)959-2274

Cell: 0828972228

Fax: (021)959-2271

Email: kjooste@uwc.ac.za

ANNEXURE G: WRITTEN INFORMED CONSENT FOCUS GROUP: NURSE EDUCATIONALISTS AND PROFESSIONAL NURSES

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

E-mail: pbimray@uwc.ac.za

Letter of request to participate in the study

Title of Research Project: A framework for nurse educationalists and professional nurses to develop professionalism of undergraduate learner nurses for nursing practice in the Western Cape.

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I undertake to keep all discussions in the focus group confidential and not to divulge the content of the focus group to anyone outside of this group.

Participant's name……..
Participant's signature…….
I further agree that the interview be voice recorded.

Participant's signature…….
I further agree that the researcher takes field notes.

Participant's signature…….
Witness…….
Date……

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Prof Karien Jooste

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)959-2274

Cell: 0828972228

Fax: (021)959-2271

Email: kjooste@uwc.ac.za

ANNEXURE H: WRITTEN INFORMED CONSENT: INDIVIDUAL INTERVIEWS

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

E-mail: pbimray@uwc.ac.za

WRITTEN INFORMED CONSENT: HOSPITAL 4

Letter of request to participate in the study

Title of Research Project: A framework for nurse educationalists and professional nurses to develop professionalism of undergraduate learner nurses for nursing practice in the Western Cape.

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I understand that all the information disclosed in the interview will be kept confidential and that I may request access to information anytime .

Participant's name……..
Participant's signature……..

I further agree that the interview be voice recorded.

Participant's signature…….

I further agree that the researcher takes field notes.

Participant's signature…….
Witness…….
Date……

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Prof Karien Jooste

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)959-2274

Cell: 0828972228

Fax: (021)959-2271

Email: kjooste@uwc.ac.za

ANNEXURE I: PERMISSION LETTER TO ACADEMIC/TERTIARY HOSPITAL 1

UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592274, Fax: 27 21-9592271
E-mail: pbimray@uwc.ac.za

The Nursing Services Manager
Tygerberg Hospital

Parow

REQUESTING PERMISSION TO CONDUCT A RESEARCH STUDY IN YOUR HOSPITAL

I hereby request to conduct a research study in your hospital. The study is entitled: A framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape.
This study is part of the requirements for acquiring a PhD Degree in Nursing Science. The study will be done under the supervision and guidance of Professor K. Jooste of the School of Nursing, University of The Western Cape.

The research aims to develop a framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice. Data collection will be obtained in two phases:

- Focus group interviews will be held at the School of Nursing, University of the Western Cape as well as at your Health Institution where you are currently employed as a professional nurse. Focus groups will be held in a private room as arranged, and it will take about 60 minutes to conduct an interview.

The researcher will adhere to the rights of participants to privacy and confidentiality. The identity of all respondents will be protected; a code number will be used during focus groups and field notes instead of their real name. The name of the hospital will not appear on the research report. All records will be kept for 5 years after publication of the results after which it will be destroyed. Only the supervisor, researcher, independent coder and statistician will have access to the data. The participants will not be coerced into participation and should they wish to withdraw

at any time during the study, their wish will be respected. The researcher will ensure adherence to the highest standards of research planning, implementation and reporting.

If you have any questions about the research study itself, please contact:

Portia Bimray

School of Nursing

Community of Health Sciences

University of the Western Cape

Modderdam Road

Private Bag X17

Bellville

7353

Cell Phone: 0823360516/ Office: 0219592601

Email: pbimray@uwc.ac.za

Should you have any questions with regard to this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Prof Yinka Adejumo 021 9593024

Email :- oadejumo@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Prof Hester Klopper 021 9592631Email: hklopper@uwc.ac.za

University of the Western Cape

Private Bag X17

Bellville 7535

Head of Department

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

ANNEXURE J: PERMISSION LETTER FROM ACADEMIC /TERTIARY HOSPITAL 1 FOR INDIVIDUAL INTERVIEWS

Western Cape Government
Health

Tygerberg Hospital

REFERENCE: Research Projects
ENQUIRIES: Dr M A Mukosi

REGISTRATION NO.: 12/10/18 (UWC)

A conceptual framework for nurse educationalists and professional nurses to facilitate professionalism amongst undergraduate learner nurses for nursing practice in the Western Cape.

Dear Ms P Bimray

PERMISSION TO CONDUCT YOUR RESEARCH AT TYGERBERG HOSPITAL

In accordance with the Provincial Research Policy and Tygerberg Hospital Notice No. 40/2009, permission is hereby granted for you to conduct the above-mentioned research at Tygerberg Hospital.

Yours faithfully

CHIEF EXECUTIVE OFFICER: TYGERBERG HOSPITAL

Date: 22 August 2013

Administration Building, Francie van Zijl Avenue, Parow, 7500
tel: +27 21 938-5966 fax: +27 21 938-6698

Private Bag X3, Tygerberg, 7505
www.capegateway.gov.za

ANNEXURE K: PERMISSION LETTER TO ACADEMIC/TERTIARY HOSPITAL 2

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592274, Fax: 27 21-9592271
E-mail: pbimray@uwc.ac.za

The Nursing Service Manager
Grootte Schuur Hospital
Observatory

REQUESTING PERMISSION TO CONDUCT A RESEARCH STUDY IN YOUR HOSPITAL

I hereby request to conduct a research study in your hospital. The study is entitled: A framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape. This study is part of the requirements for acquiring a PhD Degree in Nursing Science. The study will be done under the supervision and guidance of Professor K. Jooste of the School of Nursing, University of The Western Cape.

The research aims to develop a framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice. Data collection will be obtained in two phases:

- Focus group interviews will be held at the School of Nursing, University of the Western Cape as well as at your Health Institution where you are currently employed as a professional nurse. Focus groups will be held in a private room as arranged, and it will take about 60 minutes to conduct an interview.

The researcher will adhere to the rights of participants to privacy and confidentiality. The identity of all respondents will be protected; a code number will be used during focus groups and field notes instead of their real name. The name of the hospital will not appear on the research report. All records will be kept for 5 years after publication of the results after which it will be destroyed. Only the supervisor, researcher, independent coder and statistician will have access to the data. The participants will not be coerced into participation and should they wish to withdraw

at any time during the study, their wish will be respected. The researcher will ensure adherence to the highest standards of research planning, implementation and reporting.

If you have any questions about the research study itself, please contact:

Portia Bimray

School of Nursing

Community of Health Sciences

University of the Western Cape

Modderdam Road

Private Bag X17

Bellville

7353

Cell Phone: 0823360516

Office: 0219592601

Email: pbimray@uwc.ac.za

Should you have any questions with regard to this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Prof Yinka Adejumo
Tel: 021 9593024
Email: - oadejumo@uwc.ac.za
Dean of the Faculty of Community and Health Sciences
Prof Hester Klopper 021 9592631Email: hklopper@uwc.ac.za
University of the Western Cape
Private Bag X17
Bellville 7535
Head of Department
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

ANNEXURE L: PERMISSION RECEIVED FROM ACADEMIC/TERTIARY HOSPITAL 2

Western Cape Government
Health

GROOTE SCHUUR HOSPITAL
Enquiries: Dr Bhavna Patel
E-mail : Bhavna.Patel@westerncape.gov.za

Ms Portia Brimray
Doctoral Student
University of the Western Cape
Private Bag X17
BELLVILLE
7535

E-mail: pbimray@uwc.ac.za or pbimray@gmail.com

Dear Ms Bimray

RESEARCH: PhD RESEARCH PROFESSIONALISM OF UNDERGRADUATE STUDENTS IN THE WESTERN CAPE

Your recent letter to the hospital refers.
You are hereby granted permission to proceed with your research.
Please note the following:

a) Your research may not interfere with normal patient care
b) Hospital staff may not be asked to assist with the research.
c) No hospital consumables and stationary may be used.
d) **No patient folders may be removed from the premises or be inaccessible.**
e) Please introduce yourself to the person in charge of an area before commencing.
f) Confidentiality must be maintained at all times.

I would like to wish you every success with the project.

Yours sincerely

DR BHAVNA PATEL
SENIOR MANAGER: MEDICAL SERVICES
Date: 26th March 2013

C.C. Mrs M. Ross

G46 Management Suite, Old Main Building,
Observatory 7925

Tel: +27 21 404 6288 fax: +27 21 404 6125

Private Bag X,
Observatory, 7935

www.capegateway.go.v.za

ANNEXURE M: ETHICAL CLEARANCE LETTER 2

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences
Faculty of Health Sciences Human Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone (021) 406 6338 • Facsimile (021) 406 6411
e-mail: sumayah.ariefdien@uct.ac.za
www.health.uct.ac.za/research/humanethics/forms

29 August 2013

HREC REF: 455/2013

Ms P Bimray
c/o Prof K Jooste
Nursing Department
University of the Western Cape

Dear Ms Bimray

PROJECT TITLE: A CONCEPTUAL FRAMEWORK FOR NURSE EDUCATIONALISTS AND PROFESSIONAL NURSES TO FACILITATE PROFESSIONALISM AMONGST UNDERGRADUATE LEARNER NURSES FOR NURSING PRACTICE IN THE WESTERN CAPE.

Thank you for your email dated 28 August 2013, addressing the issues raised by the Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has formally approved the above mentioned study.

Approval is granted for one year till the 30 August 2014.

Please submit a progress form, using the standardised Annual Report Form, if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

Please add the HREC contact details (Prof M Blockman 0214066497/0214066338) to the I/C document.

Please note that the on-going ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

Yours sincerely

pp TJB Urges

PROFESSOR M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

sAriefdien

ANNEXURE N: PERMISSION LETTER TO PSYCHIATRIC HOSPITAL

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592274, Fax: 27 21-9592271
E-mail: pbimray@uwc.ac.za

The Nursing Service Manager
Lentegeur Hospital
Mitchell`s Plain

REQUESTING PERMISSION TO CONDUCT A RESEARCH STUDY IN YOUR HOSPITAL

I hereby request to conduct a research study in your hospital. The study is entitled: A framework for nurse educationalists and professional nurses to facilitate professionalism among undergraduate learner nurses for nursing practice in the Western Cape. This study is part of the requirements for acquiring a PhD Degree in Nursing Science. The study will be done under the supervision and guidance of Professor K. Jooste of the School of Nursing, University of The Western Cape.

The research aims to develop a framework for nurse educationalists and professional nurses to enhance professionalism among undergraduate learner nurses for nursing practice. Data collection will be obtained in two phases:

- Focus group interviews will be held at the School of Nursing, University of the Western Cape as well as at your Health Institution where you are currently employed as a professional nurse. Focus groups will be held in a private room as arranged, and it will take about 60 minutes to conduct an interview.

The researcher will adhere to the rights of participants to privacy and confidentiality. The identity of all respondents will be protected; a code number will be used during focus groups and field notes instead of their real name. The name of the hospital will not appear on the research report. All records will be kept for 5 years after publication of the results after which it will be destroyed. Only the supervisor, researcher, independent coder and statistician will have access to the data. The participants will not be coerced into participation and should they wish to withdraw at any time during the study, their wish will be respected. The researcher will ensure adherence to the highest standards of research planning, implementation and reporting.

If you have any questions about the research study itself, please contact:

Portia Bimray

School of Nursing

Community of Health Sciences

University of the Western Cape

Modderdam Road

Private Bag X17

Bellville

7353

Cell Phone: 0823360516

Office: 0219592601

Email: pbimray@uwc.ac.za

Should you have any questions with regard to this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department Prof Yinka Adejumo 021 9593024
Email :- oadejumo@uwc.ac.za
Dean of the Faculty of Community and Health Sciences
Prof Hester Klopper 021 9592631Email: hklopper@uwc.ac.za
University of the Western Cape
Private Bag X17
Bellville 7535
Head of Department
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

ANNEXURE O: PERMISSION RECEIVED FROM PSYCHIATRIC HOSPITAL

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857 fax: +27 21 483 9529
5th Floor Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP 025/2013
ENQUIRIES: Ms Charlene Roderick

UNIVERSITY OF THE WESTERN CAPE
MODDERDAM ROAD
BELLVILLE

For attention: **Portia Bimbray**

Re: A CONCEPTUAL FRAMEWORK FOR NURSE EDUCATIONALISTS AND PROFESSIONAL NURSES TO DEVELOP PROFESSIONALISM IN UNDERGRADUATE LEARNER NURSES FOR NURSING PRACTICE IN THE WESTERN CAPE

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries in accessing the following sites:

Lentegeur Hospital **Nadine Jacobs** **Contact No. 021- 402 6434**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR NT Naledi
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE:

ANNEXURE P: INTERVIEW GUIDE FOR FOCUS GROUP INTERVIEWS AND INDIVIDUAL INTERVIEWS

Main Question
Students

What are your experiences with regards to professionalism in the undergraduate programme that you are registered for?

Clarifying/ probing question

What are your experiences concerning professionalism at this institution or the facility where you are placed for clinical practice?

INTERVIEW GUIDE EDUCATIONALISTS (nurse educators, clinical facilitators) and **PROFESSIONAL NURSES**

Main Question

What are your experiences of undergraduate learner nurses concerning professionalism during their training at this institution?

Probing/ clarifying questions

Educators

Tell me about your experiences in facilitating learner nurses towards professionalism.

What do you think you should do /can do to support or assist undergraduate learner nurses towards professionalism during their four years of training (Probe)?

Clinical Facilitators

Tell me about your experiences in being involved in the accompaniment of undergraduate learner nurses at this institution (Clarify and probe).

What do you think…how can undergraduate learner nurses be assisted or supported towards professionalism during their four years of professional training (Probe)?

Professional nurses

Tell me about your experiences and involvement in the professional training of undergraduate learner nurses concerning professionalism in this facility/ institution.

What do you think…how can undergraduate learner nurses be assisted or supported towards professionalism in the during their four years of professional training (Probe)?

ANNEXURE Q: DATA ANALYSIS PROCESS OF THE WITHIN CASE ANALYSIS AND BETWEEN CASE (CROSS-CASE) ANALYSIS)

Learner nurses	**Nurse educationalists**	**Professional nurses**	**Common/General/ Similar themes in the cross-case analysis**
1. First and second year participants experienced role modelling of non-professional behaviour of specific nurse practitioners in specific setting	1.NE and CS expectations of prof behaviour	1. PN perceptions/experiences of non-professional behaviour of –university degree students	1.Nurses should demonstrate professional values during interaction with authorities, fellow colleagues, and patients
2.First and second year participants` perceptions and experiences of language barriers to development of professional behaviour	2.Suggestions to improve/ professionalism in nursing	2.Expectations and experiences of realising of expectations of professional behaviour in practice	2. Interpersonal communication style of nurses with all stakeholders
3. Practitioners prejudiced towards university degree students		3. Professional nurses' roles in enhancing/strengthening students' professional behaviour	3. Realisation of essential role modelling in different settings
4.Participants` understanding/perception of professional behaviour		4. Obstacles in mentoring and monitor students professional behaviour	4. Support mechanisms to Develop/Promote professionalism in learner nurses

5. Participants experience students` professional/unprofessional behaviour as contributing to the image of the university		5. Suggestions to support/enhance students professional behaviour	5 Nurses to be mindful in practice
6. Reasons for students and practitioners unprofessional behaviour and implications and suggestions for improvement			6. Recognition of teaching and learning needs in theory and practice, for professional development of new generation and historical heritage of the profession

ANNEXURE R CONCLUSIONS FROM CASE 1: LEARNER NURSES

Theme	Category	Sub-category	Concluding statements
Theme 1: First and second year participants experienced role modelling of unprofessional behaviour of specific nurse practitioners in specific settings	Category 1:Humiliating and demoralising style of communication and non- tolerant behaviour with learner nurses by professional nurse practitioners in specific settings		•Professional nurses as nurse leaders (secondary agent) should encourage learner nurses to take the lead and remind seniors of teaching moments in the clinical facilities. •Professional nurses of character acknowledge that learner nurses are part of the healthcare team and worthy to be taught and not judged in the hospital settings. •Professional nurses as leaders should show humility (humbleness) by serving the learner nurses in fulfilling their learning objectives in practice. •Professional nurses should create a welcoming atmosphere in the healthcare settings and make learner nurses (recipient) feel part of the professional team. •Professional nurses as secondary agent should act as leaders by talking to learner nurses (recipient) with respect and dignity during e.g. orientation or if they make a mistake. •When learner nurses (recipient) are reprimanded by professional nurses, it should be done while taking into account the uniqueness of the person, to encourage improvement in tasks. The correction of mistakes should be an empowering experience for students towards personal and professional growth and self-leadership. Therefore, verbal communication should be respectful in the correct context. •Nurse leaders (educationalists/ agent) are professional role-models who should inspire learner nurses (followers), to build/develop professional behaviour. •The character of the professional nurses should demonstrate respect for others, treating learner nurses with dignity and entrusting them with the care of a patient. •When dealing with matters of reprimand (discipline) or conflict, nurse professionals) should do so fairly and in the context of privacy. •The interaction between learner nurses and professional nurses in the clinical learning environment should demonstrate a positive professional relationship. •In nursing, the context of an atmosphere of trust (reliability) is needed between the learner nurse (recipient) and the patient where the (learner) nurse has confidence in what she is doing. •In nursing practice, professional nurses should build the confidence of the learner nurse (recipient), by acknowledging their work done and taking their feelings into account. •Nursing should be promoted as a caring profession in which a friendly environment should be created by the professional nurse (secondary agent) for the learner nurses as followers. •The learning environment should be created in such a way that it is a positive experience for learner nurses, where exchange of knowledge and information take place without fear of judgement or being labelled. •Professional nurses should act as leaders who inspire and motivate followers (learner nurses) and thereby create a positive work atmosphere that enables followers to serve others. •The morale of learner nurses (recipient) is lifted when professional nurses encourage good interpersonal relationships in the work environment.

			•Tolerance should be shown in kind, respectful demeanour of professional nurses being role models, who create a welcoming atmosphere for learner nurse who is new to the ward. •Reward and appreciation are strategies that should be used by professional nurses to motivate learner nurses (recipient) •In the clinical practice environment, mistakes by learner nurses are inevitable and honest feedback by professional nurses (secondary agent) should focus on corrective measures which build confidence and personal character and ensure professional development instead of being degrading learner nurses in front of patients and other colleagues. •Professional nurses should encourage positive ways of communication that contribute to the emotional and psychological wellbeing of learner nurses and refrain from gossiping which is degrading. •Professional nurses should show humility (personal reliability) by having regard for the feelings (emotions) of learner nurses when they e.g. give feedback about nursing tasks performed by learner nurses. •Professional nurses should exercise self-control (self-discipline) to convey a caring attitude. •Professional nurses should at all times stay calm and content, even when under stress. •Power and authority should be used by professional nurse leaders to influence (connection) learner nurses (recipient) to achieve the vision of the healthcare facility as well as the healthcare goals and objectives of the patient care ward or unit. •It is expected from professional nurses to motivate and inspire undergraduate learner nurses. •Professional nurses should use their influence and power in a positive way to meet the goals and objectives of the healthcare facility. •Self-confidence and assertiveness are skills that need to be acquired by learner nurses (recipient) to enable them to speak up for themselves without feeling intimidated by seniors. Professional nurses should inspire learner nurses to bring across their point of view by listening to them. •During their training in the respective year levels, learner nurses (recipient) should apply their theoretical knowledge with the practical skills when they are in the clinical learning environment. •At the respective year levels of training, learner nurses(recipient) are expected to meet the learning objectives and should be found competent before they can progress to a higher level of learning and be proficient in carrying out nursing care competencies at a lower level of thinking. •Experiential learning was needed in the clinical setting to enable learner nurses to identify with what they have been taught in theory at the university (professional development). •Professional nurses (agent) will instil confidence in learner nurses (recipient) when they trust them with performing nursing care duties in accordance with the learning objectives at the appropriate year level of learning in their programme. •There should be correlation between the patient care outcomes indicated in the nursing education institution (theory) and those in nursing practice to meet both learning and patient care outcomes through integrating applied skills. •Practical demonstration of professionalism by the professional nurses in clinical practice is an educational strategy that could be employed to show learner nurses how to act professionally and assisting learner nurses towards their professional development in clinical practice. Role-modelling professional behaviour by professional staff (agent) is needed so that learner nurses (recipient) can observe what is expected of them with regards to their professional behaviour in clinical practice. •An effective interpersonal relationship between a senior and junior nurse is needed to demonstrate their

			connection in being part of a greater team.
	Category 2: Lack of respect for time		•Professional nurses (secondary agent) have a responsibility (personal reliability) to respect their working time as it could demonstrate to learner nurses that they are reliable and can be depended upon. •Professional nurses and learner nurses have certain responsibilities and should deliver their duties within their legal scope of practice. •Professional nurses (agent) remain accountable for tasks delegated to students (recipient) in practice. •Professional nurses should create a friendly environment(context) by welcoming learner nurses with a positive approach of orientating new learner nurses into a new patient care unit so that the learner nurse could familiarise themselves with the expectations in the patient care wards. •Learner nurses (recipient) acquire skills in a less intimidating learning environment when they know what is expected of them. •Learner nurses should be aware (mindful) of embedded learning outcomes in the nursing curriculum which is a requirement for the clinical practice environment. •Professional nurses (agent) should be able to share and communicate their knowledge (competence) with others. •Professional nurses should encourage learner nurses (recipient) to apply their theoretical knowledge and practical skills in the clinical learning environment.
	Category 3: Incidences of misconduct and non-commitment to patient care		•Agent (nurse educationalists and professional nurses in practice) have a responsibility to inspire a work ethics in learner nurses (recipient) by conducting themselves appropriately in a professional manner. •The care of the patient should be the first consideration of a professional nurse and therefor personal matters should not interfere with patient care duties. •Professional nurses (agent) should be responsible and accountable for their acts and omissions concerning the care needs of patients and should not blame others when things go wrong. •Professional nurses should take responsibility for taking the lead in quieter times e.g. weekend, and demonstrate positive behaviour in the workplace. •Professional nurses (agent) should be role models and show commitment to serve the needs of others (character domain) by being at the bedside of the patients and ensure that attention is given to what needs to be done. •Desired professional behaviour of learner nurses (recipient) seems to be learned in the clinical learning environment by adopting the behaviour of nurse educationalists and professional nurses (primary and secondary agent). Agents are therefore expected to be an example by performing nursing care duties the right way so that learner nurses (recipient) can follow their example. •All nurses should do what is right and not neglect their patient care responsibilities because of the context of the burden of increased patient numbers. •Learner nurses should have patience (tolerance) to maintain professionalism under difficult circumstances in the face of workload pressure and lack of support mechanisms that include resources e.g. teaching/learning material (procedure). •Workload relief by means of human resources and adequate learning resources are needed to support learner nurses in the application of theoretical knowledge in the practice environment. Adequate and appropriate clinical teaching and learning material and equipment are needed for simulation to prepare learner nurses for "real thing" in the clinical practice environment.
	Category 4: Inconsistent		•Consistency among clinical supervisors in teaching and assessing nursing theory and practice enable learner

	expectations of and or ignoring of procedural guidelines / performances		nurses to perform their nursing tasks in the correct manner, thus influencing (interpersonal compatibility) learner nurses to achieve the desired behaviour during clinical skills demonstrations in the skills laboratory. Consistency is important so that all learner nurses are subjected to fair and equal treatment during clinical assessments. •Guidance from clinical supervisors could ensure that learner nurses perform their nursing tasks correctly within their legal framework by adhering to their scope of practice which prevents them from unsafe practices. •Nurse educationalists (primary agent) and professional nurses (secondary agent) are expected to bridge the gap between theory and practice in the clinical placement facilities to ensure professional capabilities (competence) of learner nurses. •Nurse educationalists should be fair (social justice) and apply consistent assessment and evaluation strategies (procedures) in their assessment/judgement of others/learner nurses. •In nursing, collaboration between different nursing education institutions and nursing practice is needed to ensure consistency in the professional learning outcomes for all learners because it creates uniformity and belonging among the learner nurses. •There should be team work amongst nurse leaders in order to act in the best interest of learner nurses.
Theme 2: First and second year participants` perceptions and experiences of language barriers in the development of professional behaviour	Category 1: Language barriers are experienced as detrimental to professional development		•Professionalism of nurses takes place between professional nurses, clinical supervisors and learner nurses, and patients in a multicultural environment (context). •In nursing practice, communication should take place with respect for socio-cultural diversity. Professional nurses in the clinical practice environment should be considerate and understand the feelings of others (learner nurses) that are unable to express themselves because of the language they speak. •A common or universal language enables diverse individuals to understand each other and prevent distortion of meaning. Interpersonal compatibility in communication is needed between the agent and the learner nurse. •In the healthcare environment, all nurses (agent and recipient) interact and build relationships with people from diverse backgrounds. •Nurses convey a professional message by using themselves as channels of communication. Body language of nurses should not offend others. •Congruency in the verbal and non-verbal communication shows that the leader is fully attentive. •Language in the healthcare environment is essential for the professional development of learner nurses (recipient). •Underlying in verbal and non-verbal communication is to be attentive or mindful of others. •Mindfulness is needed to demonstrate that the professional nurse as leader has the followers' (learner nurses`) best interest at heart.
Theme 3: Practitioners prejudiced towards degree students			•Equality and non-judgemental treatment of training nurses from different nurse training institutions at healthcare facilities are essential for achieving learning outcomes and gain competence in theory and practice. •In nursing, everybody should be treated equally and therefore nursing education and training standards should be equal for all nurses. •Primary agents from various educational institutions, develop their own curriculum under the directive of the South African Nursing Council. •Professional nurses should not judge or discriminate (social justice) against any institution of learning (context) for nurses.

			•In nursing, there should reciprocity (collegiality) in services rendered between nursing practice and nursing education. HEIs provide a service to HCIs by training undergraduate learner nurses to become professional nurses. In the same way, HCI render a service to HEI to provide placement opportunities for undergraduate learner nurses.
	Category 1: Higher Education Institution B/ College diploma students advantaged in professional development because of more exposure to practice		•Exposure to clinical nursing practice is essential to gain self confidence in providing nursing care in the practice environment. •All nurses on different levels should apply their knowledge to practical skills (competence) to deliver effective and safe patient-centred nursing care. •All nurses should possess attributes which include affective, psychomotor and cognitive processes to be a competent nurse. •The professional curriculum for learner nurses registered for the programme leading to the qualification as professional nurse should be consistently implemented in all healthcare settings. •Fear amongst learner nurses (recipient) on having a lack of skills when completing their qualification, should be combatted by role models (agent) in practice.
Theme 4: Participants understanding of professional behaviour	Category 1: Respect in communication and behaviour to all concerned	Sub- Category 1: Politeness and communication skills	•Professional nurses should demonstrate politeness in their professional communication with fellow colleagues during the delivery or rendering of patient care. •Professional nurses should be mindful to have compassion for others and treat them with respect and dignity. •The professional nurse should be tolerant and create a friendly environment with the learner nurse in a private space when for example shortcomings are addressed in the execution of clinical procedures. •Mutual respect is needed for the effective interaction between nurse educator and learner nurse. •Nurse educationalists (primary agent) should place value on respect and communication skills as well as being a role model and having managerial skills such as organising as a component of professionalism as part of the training programme. •Assertiveness is a communication skill that all learner nurses (recipient) should possess. Assertiveness allows nurses to bring their point of view across without being aggressive. •Agents should focus on the professional capability of learner nurses that should be enhanced by knowledge and self-directed learning. •Learner nurses (recipient) should be able to integrate and apply their theoretical and practical knowledge in professional clinical practice. For effective communication and to improve the interpersonal professional relationship in the clinical practice environment, learner nurses should be confident about their learning needs by being self-directed and motivated to learn. •Learner nurses should respectfully and confidently communicate their learning needs as a token of their interpersonal compatibility, to the professional nurses in the patient care wards. •Professional nurses (secondary agent) should respect the right of others (learner nurses/recipient) to learn or to know more to develop professionally.
		Sub-category 2: Displaying empathy and caring	•Professional nurses (secondary agent) should have empathy with learner nurses from different cultural backgrounds. When professional nurses demonstrate empathy towards cultural differences, learner nurses would feel that they are understood in the clinical placement facilities for their differences.

		relationships	•In nursing, mindfulness in cultural differences and backgrounds is important to understand and respect others because it influences one`s view and philosophy in life. •Learner nurses (recipient) could feel valued when they are understood for their differences in culture and treated with fairness by the professional nurse. •Having knowledge about another person`s culture creates a feeling of self-worth because the person feel understood. •Learner nurses from different cultural backgrounds should be confident in what they do rather than having anxiety or being fearful of behaving unprofessionally because of cultural differences. They should be aware of their responsibility (personal reliability) of trained professional nurses "to care" regardless of their cultural background or nationality. •Professional nurses (secondary agent) from different cultural backgrounds and ethnicity have a duty or responsibility to care for others, including learner nurses (recipient) who also come from different cultural backgrounds. •In the clinical learning environment, professional nurses (secondary agent) should show that they care (caring) as an important dynamic, by being sensitive (empathy) and understand the cultural diversity of learner nurses (recipient) and that they have individual and unique needs. •Nurses (agent and recipient) should be aware of the underlying dynamic of being mindful of the cultural differences of others as it builds teamwork and collegial relationships with others. •Followers/ learner nurses (recipient) should be in control of their emotions (self-control) even when upset or disrespectful behaviour shown to them by leaders. •Respectful behaviour by the leaders towards followers therefore enables followers to be receptive and give their cooperation to staff in the healthcare facilities instead of retaliating when are not treated well. •Respect is reciprocated and cooperation should be given by followers (recipient) instead of showing retaliation or resistance towards disrespectful professional nurses in the clinical placement facilities. •Professional nurses should respect the religious (spiritual) needs of others (patients/ learner nurses) as a basic human right. •The spiritual needs are part of the holistic care nurses (agent and recipient) render to patients and should be respected by showing consideration for patients to have this need fulfilled whilst receiving care. •Nurses (agent and recipient) should respect human rights (e.g. the right to practice own religion). •Equal treatment and fairness is applied when nurses (recipient) are allowed to practice their religion without infringement on this basic human right in the clinical learning environment. •Professional nurses should treat everyone equally and with fairness (social justice) without any discrimination against religion. •By showing fairness (social justice) in the care of others, professional nurses use their own intrinsic dignity to accept that each person is unique with the shortcomings and imperfections, especially coming from different backgrounds, speaking different languages and not being understood. •Learner nurses (recipient) should be in control of their emotions when they are upset (self- control).
		Sub- Category 3: Approachability, tolerance in attitude, within professional boundaries	•Approachability and openness in communication enables learner nurses to feel less intimidated when they are comfortable to interact with professional nurses who have a friendly attitude and conducts him or herself consistent with the dress code that is a reflection of a professional. •Professional nurses (secondary agent) should demonstrate kindness (friendliness) in attitude. •Professional nurses are professional persons (body) who represent the nursing profession by physically

			wearing a prescribed uniform or dress code that is a reflection of a professional. •When interacting with others (recipient), there should be congruency in the professional conduct or attitude and the physical appearance of a professional (agent). •The professional relationship between clinical supervisors and learner nurses should be friendly on a professional level that fosters learning and transfer of knowledge based on proper conduct. •It is perceived that friendliness is a professional capability that nurse educators or leaders possess within their framework of being a professional. •Both nurse educators (lecturers) and professional staff is expected to treat learner nurses (recipient) with a kind and warm attitude (caring) in both the classroom and clinical learning environment, hence demonstrating their connectedness and interpersonal compatibility with learner nurses. •Professional nurses should make learner nurses (recipient) feel comfortable and welcome in the clinical learning environment (context) by giving guidance and support when learner nurses are new to the ward or patient care unit. •Professional nurses should be patient and tolerant with learner nurses when they carry out nursing actions as part of their clinical learning. •Learner nurses should receive warm and kind treatment in both the academic learning and clinical practice environment. •Learner nurses expect to learn the proper professional conduct from clinical supervisors who transfer learning within the respectful boundaries of a professional relationship between agent and recipient. •The clinical practice environment should effectively be used as a resource for learning. Professional nurses are influencing learner nurses positively when they are creating an opportunity for learning (procedure) in the ward/patient care unit. •Leadership is essential for professional nurses in the facilitation of learning whereby educational opportunities (procedure) are created in the clinical learning environment •Professional nurses who are self-confident to delegate nursing responsibilities influence learner nurses (recipient) positively. •Professional nurses should inspire confidence in learner nurses (recipient) by being open and transparent. •Professional nurses should be assertive by delegating responsibility (educational opportunity) to learner nurses.
		Sub- Category 4: Displaying verbal and non-verbal communication skills	•Communication is an important aspect of the practical component in the clinical learning environment. •Patient care in the practice environment depends on the effective communication of patient care needs. Professional nurses (secondary agent) should display a caring attitude amongst followers or learner nurses (recipient) through encouraging effective communication and thus ensuring that patient needs are attended to. •Respectful communication is essential for tolerance and to avoid conflict situations between seniors and followers. •Professional nurses in practice are expected to convey or communicate the delegation of tasks in a controlled manner to learner nurses, as self-control is an essential value of interpersonal compatibility. Professional nurses should apply mechanisms of self-control by having a caring attitude. •In nursing, for effective interaction between seniors and members of staff, professional nurses connect with learner nurses by showing respect to avoid conflict of interest. •The academic learning environment and the clinical nursing practice environment are both environments for

			the professional development of the learner nurse. Communication and collaboration between HEI and NP is essential to facilitate the professional development of learner nurses •It therefore seemed that there should be collaboration/cooperation and a commitment to excellence between Higher Education Institutions and NP. •Higher Education Institutions and nursing practice (context) have the authority to impose disciplinary measures in the case of misconduct of learner nurses. Nursing education and NP should have a shared responsibility to assist learner nurses towards improving professionalism. •Clinical supervisors as leaders, should be able to influence learner nurses if they want to effect change in the learner nurse`s behaviour, especially when strategies such as demonstration in the skills laboratory is employed for integration of knowledge and skills. Clear messages between clinical supervisors (primary agent) and learner nurses (recipient) should be inspiring and motivating so that they are able to influence t;he learner nurses towards a clear focus (interpersonal compatibility). •Professional nurses as leaders, are needed to influence and motivate followers such as learner nurses to obtain clear outcomes. •Clear learning outcomes are needed to avoid conflicting messages as it did not motivate and inspire learner nurses.
	Category 2: Interaction of personal and basic human values, norms and professional values	Sub-Category 1: Modification of personal values to fit with professional values	•Learner nurses coming from different backgrounds, bring their own set of values into the profession. •Having basic values such as respect, kindness, politeness or good manners as part of a person`s background, could direct one`s actions and conduct. These values demonstrate the nurse`s interpersonal compatibility with others as well as showing personal reliability with regards to punctuality. •In nursing, conflict might occur when a nurse`s personal values is different from the professional values of nursing. •All nurses should be mindful of their own cultural values as this might influence (interpersonal compatibility) the values of the profession. •Learner nurses should have the courage (personal reliability) to do what is right or ought to be done when there is conflict between the personal values and the profession values. All nurses should be aware (mindful) of their own values from the different cultural backgrounds where they come from. When personal and professional values differ the nurse need to modify his/her behaviour to bring about positive change in respect of positive nursing care outcomes. • When people are mindful of who they are and where they come from behaviour can be modified in practice.
	Category 3: Student role reversals- from school learner to adult learner	Sub-category 1: Personal responsibility for learning and behaviour	•Young (novice) learners enter university straight from school to take on adult responsibilities e.g handing over of patient progress reports to other staff. They should therefore be prepared to take on nursing responsibilities to serve patients. •There should be an awareness of the change in role learners take on when they transit from school level to university where they are expected to be responsible for their own learning (self-directedness). •Learner nurses should be able to apply the value of judgement (professional capability) and take up their self-leadership roles at times when they occupy a specific learning environment, i.e. clinical practice environment. •Learner nurses should be able to exercise influence themselves as a value of interpersonal compatibility to behave appropriately whilst assuming different roles of leadership, when necessary, in the undergraduate programme:

			•Learner nurses should be able to use their own initiative and be proactive (having professional capability) where they move from follower to being a self-leader. •Reflection as a form of experiential learning is an important part of learning and self-development as it enables the learner nurse to improve on own his or her own practice by integrating theory and practice. Reflection on theory and practice is important to integrate learning in delivering nursing care. •The learner nurse should adapt depending on the academic and practice environment in which they find themselves at a particular point in time. Role changes (reversals) take place when a learner nurse enter the formal higher education learning environment, being a high school learner and becoming an adult learner. •For this role change to take place within the learner nurse, a certain level of wisdom is required to differentiate between the two learning environments and to make a judgment in the professional behaviour they exert when fulfilling the respective roles. •Learner nurses should be allowed to exercise freedom of choice (e.g. autonomy in decision-making). •All nurses are responsible for their own behaviour depending on the role they (student or professional) exercise at a given time in their life. •All nurses should use their knowledge and skills and take initiative (be proactive) in order to improve patient care outcomes. •Learner nurses should take ownership and become responsible for their own learning needs (self-directedness). •Nurses should reflect on their nursing practice as an important skill of integrating learning and developing competence through the ability to make clinical judgements. •Learner nurses could be self-directed by influencing themselves positively to positively adjust undesired behaviour.
	Category 4: Dress code and professional image of a nurse		•Professional nurses (secondary agent) in practice should role-model professionalism in practice so that the public recognises nursing as a profession. •The uniform reflects the image of the profession and is worn as a symbol of pride. •First year learner nurses should be professionally groomed and inspired (interpersonal compatibility) by the senior learner nurses in second and third year who provide a structure (scaffold) for professional development through being role-models that can be seen as examples to look up to. •Novice learner nurses in their first year are inspired by their senior peer learner nurses. •Professional behaviour is learned from the examples of peers (scaffolding) as role models to the novice learner nurse. •Role modelling by peers is essential for collaboration (scaffolding) and working towards improving the profession. •Unity is formed amongst all members of the profession when role-models adhere to the prescribed dress code. •There should be an awareness of the congruency between one`s professional conduct and appearance. •It seems that the required dress code will bring about a change in behaviour when worn in both academic and clinical practice learning environments. •Adhering to the formal dress code builds character and creates a sense of self-respect and pride because the uniform increases awareness of the choices made nurses make in terms of their behaviour when wearing a uniform. •All nurses should use their discretion and exercise judgement regarding their conduct when appearing in

			public with a nurses` uniform (examples were given about smoking and drinking). •Learner nurses upon entering the nursing profession, subscribe to a professional dress code and develops a common professional identity of the nursing profession. All members (learner nurses, nurse educationalists and professional nurses have a responsibility to uphold the efforts of the profession to maintain the professional image by deciding how to behave in public
Theme 5: Participants experience students` professional/unprofessional behaviour as contributing to the image of the university degree students	Category 1: Some students do not reflect respect in behaviour and do not take professional responsibility in practice seriously		•Learner nurses are expected to apply a different mind-set or attitude by conducting themselves appropriately in the different learning environments. When they go as ordinary students to the workplace environment, learner nurses should be aware of the professional standards that exist in the hospitals. •Learner nurses should have an awareness (mindfulness) of the professional standards (ethical guidelines) in the hospitals that exist and should be adhered to when they transit from the academic learning environment as normal university students who want to have fun (free to be), to the clinical practice learning environment. • Learner nurses should have knowledge about how (wisdom) to conduct themselves professionally in the clinical learning environment. Their communication with senior professional nurses (agent) in the clinical placement settings should be respectful. •Learner nurses should have the professional capability to create a learning environment in which they take ownership of being competent in initiating their own learning (self-directed) and are self-motivated while carrying out a positive image of the nursing profession (terminus).
Theme 6: Reasons for students and practitioners unprofessional behaviour and implications and suggestions for improvement	Category 1: Specifics of professionalism not clear, practical guidelines needed		•Clear guidance and direction about what professionalism means is an essential part of the undergraduate nursing programme to enable learner nurses to understand why and how they should conduct themselves professionally. •Professional standards give direction and enables nurses (recipient) to understand and conduct themselves appropriately. •Different generations of nurses should have the same understanding of what professionalism means and how professionals should apply themselves in practice. •HEIs should be responsible for the training of the new generation of nurses in e.g. the application of responsible usage of innovative practices and technology such as cell-phones in practice •HEIs should be up to date with the latest innovative learning strategies and developments to train a new generation of learner nurses. •Nurses should practice nursing care within the context of nursing practice standards and professional guidelines of the profession, for delivering of safe patient care. •Learner nurses gain new knowledge through innovative ways that suit their generation.
	Category 2: Professional values taught but not internalised		•Self-directedness as a value for professional capability is required in learner nurses, and includes self-motivation and a commitment to take responsibility for own learning and applying knowledge in practice. •Nurses should be able to apply what they have learned throughout their training and career in practice that will lead to delivering quality care (terminus). •Learner nurses should be taught how to apply the professional values in practice •Teaching strategies to promote deep learning for internalization of values, instead of just focusing on theory, are needed to assist learner nurses with their learning needs as it is essential for the professional development of the learner nurse. •Professional values should be taught and internalised over time by learner nurses.
	Category 3: Formal pledge in first year for		•Learner nurses should from their first year, pledge (commit) to taking care of human life, as the pledge should be viewed as a life changing experience to those who enter the nursing profession.

	commitment		
	Category 4: Lack of motivation for nursing		•Committed and motivated young leaders that are inspired by studying nursing to influence the community (interpersonal compatibility referring to the connection domain), should be selected by higher educational institutions. •Nurses` training schools at higher education institutions should recruit and select motivated learner nurses who are committed to the profession. •All institutions place a greater emphasis on the nursing pledge of learner students.
	Category 5: Students need platform for grievances		•A supportive platform (support mechanism) is needed for learners to voice their discontent, unhappiness, concerns and complaints. •Professional nurses (secondary agent) as influential leaders in the clinical placement setting should facilitate change in learner nurses by inspiring and motivating them. •Support structures such as mentors and nurse leaders should create grievance platforms for learner nurses to freely verbalise their grievances. •Feedback by professional nurses should be used as a strategy for professional development (procedure) of followers to improve nursing competencies in clinical practice. •Learner nurses as followers should be able to evaluate and give feedback to professional nurses on shortcomings in their leadership styles in nursing practice, in order to improve the profession.
	Category 6: Traumatic experiences in personal life and practice influence professional behaviour		•Learner nurses are persons with personal, social and academic challenges that lead to the need for emotional support. Support is needed to cope with the academic demands of an integrated theory and practice programme whilst dealing with personal challenges. •Personalised support structures such as counselling services unique to the emotional needs of learner nurses, are needed to support learner nurses with the academic pressure, being exposed to sensitive and stressful situations (diseases, death), and managing their family responsibilities. •The need for a nurse councillor (nurse educator) who is available on campus who cares for learner nurses enables vulnerable learner nurses to deal with their mental and emotional trauma during their academic programme. •Nurse educators (primary agent) as mentors should be available for academic consultation as well as for personal matters to support learner nurses in their academic programme, workload and time management. •Coping strategies such as humour should be exercised in the learning environment. •Humour is regarded as a strategy (support mechanism) for learner nurses to relieve stress while undertaking the nursing programme. •Nurse leaders (educationalists) should create an environment for learner nurses to feel encourages and inspired to learn despite various challenges. •The higher education institution should acknowledge the importance of training learner nurses to become professional nurses, and therefore should provide adequate learning opportunities.
	Category 7: Learner nurses need more academic help and mentoring and supportive monitoring in the clinical practice settings		•Learner nurses should be inspired by committed professional nurses (role models) who are responsible for overseeing the professional academic and clinical development aspect for learner nurses in the hospitals. •Nurse educators (primary agent) should monitor and assist the learner nurses (recipient) to reach the desired learning outcomes and use appropriate learning material for successful academic performance. •Learner nurses (recipient) depend (rely) on leaders, such as clinical supervisors (primary agent) to advocate on their behalf in the clinical placement facilities. •Clinical supervisors (primary agent) should have courage (character) to intervene and do what they know is

			right when mistakes are made by learner nurses in the clinical practice environment. •Support e.g. using more clinical supervisors is needed in the patient care wards to ease the workload pressure of learner nurses (recipient). •Clinical supervisors as mentors should be available in the hospital, e.g. have an office, to be in reach of learner nurses for personal and academic support in the clinical practice environment. The availability of clinical supervisors will enable learner nurses to lean and carry out their practical skills correctly. •More practical exposure seems to provide the required support for learner nurses in the undergraduate programme.

ANNEXURE S CONCLUSIONS FROM CASE 2: NURSE EDCATIONALISTS

Theme	Category	Sub-category	Concluding statements
Theme 1: Nurse educators and clinical supervisors` expectations of professional behaviour	Category 1: Adhering to prescribed dress code		•In nursing, a white uniform is the preferred colour of choice that all categories of nurses should wear. •Professional appearance is important and seen as a responsibility by the nurses from the "old school more so than the (younger) new generation. This responsibility is a demonstration of the value regarding the personal reliability of the old generation towards the profession. •Nurse educators as role models, should professionally groom and prepare learner nurses (recipient) for nursing practice, by giving guidance and direction (leadership) in the classroom and clinical placement environments of wearing the appropriate dress code. •In nursing, identification of all nurses (agent and recipient) is important because the patient has the right to be cared for by an identified healthcare professional to ensure safe nursing practice. •All nurses should be identifiable according to their name, category and or rank in the nursing profession (context). •Learner nurses (recipient) should communicate respectfully to the nurse educators (primary agent) in practice.
	Category 2: Behaviour that reflects internalisation of professional values and norms	Sub-category 1: Internalising means internal locus of control	•Nurse educators (primary agent) expect learner nurses to turn the values inward and have personal integrity so that they can be trusted and counted on (personal reliability) when no one is looking. This could demonstrate a commitment to excellence on the part of the learner nurse who should have a sense of responsibility when they perform the necessary nursing care tasks and responsibilities. •Learner nurses (recipient) should serve others with values of humility (personal reliability character) and compassion (interpersonal compatibility or connectedness) which are important elements of self-development. •Learner nurses should always do their best in the interest of building their character (personal reliability) which includes being of service to others, sense of responsibility, truthfulness, honesty, integrity, passion, showing humility and having courage as this was important for personal and professional development. •Nurse educationalists (primary agent) should understand, care (underlying dynamic) and have empathy (interpersonal compatibility) for the status the learner nurse as a "student" occupy at a particular point in time and be aware that professional behaviour (professionalism) will be internalised and developed over time within the learner nurse. •Nurse educationalists should have empathy and understand the professional behaviour of learner nurses as context specific where learner nurses behave differently when they are in either the academic environment or the clinical practice environment.
		Sub-category 2: Internalisation and practising professional behaviour also needs consistent reinforcement	•Nurse educators (primary agent) expect behavioural changes towards positive professional outcomes or excellence when learner nurses are taught elements of professionalism in theory. •Nurse educators should be proactive as an essential element of their professional capabilities by applying their knowledge and exercise sound judgement (wisdom) in applying strategies of reward and punishment to encourage positive professional outcomes (proactive) in the behaviour of learner nurses and ensure excellence in nursing care (terminus). •Nurse educationalists as leaders should use strategies such as reinforcement, complimenting and rewarding

		strategies in practical and theory teaching	(procedure) students for positive outcomes in behaviour to encourage (motivate) learner nurses in the academic environment. •Nurse educators should be non-judgemental and fair in their assessments of learner nurses (recipient). •Learner nurses have the right to fair disciplinary processes when (punished/ disciplined). •Learner nurses should be held accountable for their nursing actions by imposing disciplinary measures for not living up to the required professional expectations.
	Category 3: Practice examples of expected professional behaviour	Sub- category 1: Total image and respectful social behaviour reflected in practice and class	•Nursing subscribe to a code of conduct. Professional dress code and rules of behaviour are embedded in the nurses code of conduct (ethics) and standards of the profession. •Professionalism forms part of the undergraduate learner nurses` theoretical and clinical (integrated) training programme as stipulated in the South African Nurses Council regulations (SANC under the provisions of the Nursing Act, No 33 of 2005). •Learner nurses should adhere to rules of conduct such as being on time for class. •Nurse educators expect learner nurses to display the appropriate professional conduct in class required for professional practice.
		Sub-category 2:Professional boundaries in relationship between student and supervisor and patient	•Nurse educationalists (primary agent) should always maintain a friendly but professional relationship with learner nurses (recipient). •Nurse educationalists could use social networks to connect with learner nurses in a responsible way, and use their discretion appropriately when interacting or engaging with learner nurses on social media networks such as BBM (Black Berry Messaging) or Facebook. •Nurse educationalists should apply judgement in their decision-making by using common sense when interacting with learner nurses on social media networks. Learner nurses need to understand how to respect the private space of others
		Sub-category 3: Appropriate clinical competence	•The context of professionalism should take account that learner nurses should be competent on one level before being promoted to the next year level in the programme. •Learner nurses should be taught to have the lacked the necessary confidence to perform in the practice environment, to be competent in knowledge, skills and attitude.
		Sub-category 4: Respectfulness and confidence in interaction with patients and professionals	•Learner nurses (recipient) should be respectful and considerate towards colleagues in authority positions and nurses in leadership roles (agent). •Learner nurses should always act in the best interest of the patient by making them feel safe which will promote wellbeing of the patients during their interaction. •Learner nurses should have a caring (underlying dynamic) and compassionate (interpersonal compatibility) attitude towards patients so that they feel comfortable to approach the learner nurse to attend to their basic needs. •All nurses (agent and recipient) communicate and connect with others by building relationships with each other as these are important aspects for professionalism •Learner nurses should at all times treat the vulnerable patients with compassion, human dignity and respect. Learner nurses (recipient) should be self-confident in their interaction with patients even though the learner nurse lacks knowledge. Having confidence in communication contribute towards making the patient feel at ease and building relationships of trust between the patient and the nurse.
		Sub-category 5: Motivation and taking responsibility	•Learner nurses are expected to be professionally capable. When they are in the clinical wards learner nurses should be professional by showing interest to learn what needs to be learned and take responsibility for their own learning(being self-directed) as an essential value of their professional capability.

			•Learner nurses should have motivation (self-influence) as a value of their interpersonal compatibility and be eager to learn what needs to be learned. •Learner nurses should take responsibility for their own learning by approaching the sisters (professional nurses) in the wards with their learning needs.
Theme 2: Suggestions to improve professionalism in nursing	Category 1: Educators and clinical supervisors to work towards bridging the gap between theory and practice		•Nursing professionals (professional nurses and nurse educationalists) should assist the learner nurse to bridge the gap between theory and practice.
		Sub-Category 1: Specific, differentiated and scaffolding in skills training at different levels	•Scaffolding learning is part of educational opportunities that includes continuity and reinforcement of the professional values throughout the undergraduate nursing programme. •Agents should be specific about the expectations around professionalism in the respective year levels, when they attend the skills laboratory before placement in clinical practice. •Clinical supervisors should make known to first year learner nurses what is expected from them in terms of professionalism right from the beginning of their training. •Learner nurses should already from first year start modelling (shaping) the expected professional values of the nursing profession. are instilled in the first year of the undergraduate nursing programme: •Learner nurses who were more experienced, have a responsibility to share their knowledge with their fellow learner nurses who are younger, and mentor them during their undergraduate programme. •Sharing of knowledge should be seen as a professional capability of all agents in nursing practice.
		Sub-Category 2: Empowering students to resist poor practice examples/role modelling and adapt to different policies and practices of facilities (empowering for no-excuse-of-own behaviour)	•Learner nurses should be guided in an empowering environment (context) with clear professional policies and guidelines, in which professional nurses act as (role models) by their example (professional behaviour).

	Category 2: Finding the fine balance between considering exceptions to the rules of professional behaviour and reinforcing them		• Nurse educators (primary agent) should show empathy (interpersonal compatibility) and demonstrate that they understand the socio-economic circumstances of learner nurses as it forms part of their holistic needs which impact on health (professionalism). • Nurse educators should use their discretion (critical judgement) as part of their professional capabilities in making decisions of granting exceptions to the rules or imposing discipline, but only after careful analysis of a situation. • All nurses have a responsibility towards their employer, their colleagues and their patients to do what is right in spite of economic circumstances. • Nurse educators (primary agent) should have the courage to do what is right and demonstrate their personal reliability by being honest in their assessment of learner nurses, especially those with physical disabilities/impairment which might influence how prepared they are for nursing practice. • Nurse educators should not discriminate (social justice) against learner nurses with physical (e.g. sight) or mental (e.g. stress and depression) disabilities/impairment, but should rather be honest and truthful to the learner nurse of how their nursing performance will affect patient care delivery.
	Category 3: Reward system with accolades for professional behaviour		•Educationalists (primary agent) use teaching strategies such as rewards for proof of evidence of professional behaviour, to assist learner nurses to develop professionalism. •Nurse educators should reward (praise) learner nurses in their fourth year of the undergraduate nurses training programme when they can show proof of evidence of their professional development throughout the undergraduate nurses training programme. •First and second year learner nurses should be informed about the expectations of professionalism through entering into a contract for professional development over the four years of nurse training programme. •Nurse educators use evaluation as strategy to monitor whether their guidance led to the desired professional development of learner nurses.
	Category 4: Platform for students to voice grievances relating to professional behaviour		•Nurses should have the ability to act and be proactive in order to ensure desired (patient care) professional outcomes. • Nurse educators (primary agent) should be proactive in creating a supportive platform for learner nurses to voice their grievances.
	Category 5: Role-modelling respectful behaviour, dress code, punctuality		•Nurse educationalists (clinical supervisors) inspire followers (learner nurses) by being a role model of respectful behaviour who upholds the efforts of the profession. •Nurse educators (primary agent) should take responsibility to advocate nursing professionalism by having the courage (personal reliability) to change or modify unwanted personal behaviour when it is in their nature to be loud, and do what is right in the interest of the profession by role-modelling respectful behaviour towards learner nurses. •Professional nurses (secondary agent) should lead as role-models of professional behaviour so that learner nurses can follow their example.
	Category 6: Assessing relevance of some professional conduct rules in a changing era		•Professionalism is not an easy concept to instil in human beings. It however develops over time and the profession has the potential to be restored to an acceptable status by the public whilst being dynamic and changing with the generation. •Nursing practice happens in different societies, communities and environments with its own unique challenges. Nurses (agent and recipient) should be able to maintain professionalism in spite of the challenges faced by societies, communities and the different environments nurses come from.

			•Human values come from societies in which nurses live. •Nurse educators should take into consideration that all nurses (including learner nurses) are part of different communities and the society at large and therefore be more empathetic and mindful of the socio-political influences when they teach professionalism to the learner nurses. •In nursing, nurses should be skilled to use information technology in the best interest of the patient. Patient records and information should be kept safe and confidential. •Professional nurses (primary agent) should be flexible when it comes to the use of information technology. With times changing, nursing becomes aware (mindful) of the use of information technology for patient recordkeeping purposes.
		Sub-Category 1: Times for students/ nursing dress code/use of technology	•Nursing is not static, but happens in an ever changing and dynamic environment/context. •Nursing is diverse in nature and acknowledge the socio-economic and cultural differences of society on which nursing practice is based. •Nurse educators (primary agent) should take action and be proactive in the changing environment which prepares learner nurses for the 21st Century. •The use of technology in the 21st century, as the method of communication for the learner nurse should be considered to be inclusive in the criteria of the profession, •What it means to be professional should be redefined in the 21st century without losing sight of the foundations of nursing where both worlds: the "old" meets the "new".

ANNEXURE T

CONCLUSIONS FROM CASE 3: PROFESSIONAL NURSES

Theme	Category	Sub-category	Concluding statements
Theme 1: Professional nurses` perceptions/ experiences of non-professional behaviour of university students	Category 1: Variation in perceptions of the incidence of unprofessional behaviour/lack of motivation according to wards		•Professional nurses (secondary agent) from various clinical placement institutions deal with learner nurses (recipient) who possess various interpersonal compatibility skills (politeness, respectfulness) and professional capabilities such as being self-directed and motivated to know more (gaining knowledge). •Learner nurses should demonstrate that they are trustworthy (personal reliability) so that professional nurses can rely (depend) on them to perform allocated tasks in practice. •Professional nurses expect learner nurses (recipient) to behave in a self-controlled manner by being well-disciplined and thus demonstrating their connectedness or interpersonal compatibility towards learner nurses. •Learner nurses should be passionate to do nursing when they entering the profession and behave in a respectful manner (interpersonal compatibility) towards patients. •Learner nurses develop professional capability when they display a hunger for learning (desire) and wanting to know more in the clinical placement facilities. •Professional nurses should be aware of the vulnerability of learner nurses (recipient) when they enter the clinical placement environment for the first time.
Theme 2: Expectations and experiences of professional behaviour in practice	Category 1: Respectful behaviour towards and acknowledgement of professionals and their commands		•In the clinical nursing practice environment, the organisational structure follows a hierarchy of nursing positions due to authority of professional nurses as leaders (secondary agent). Learner nurses (recipient) and all their nursing colleagues should uphold the efforts of the profession to respect (interpersonal compatibility) nurse leaders who are experts in the clinical practice environment. •Professional nurses in authoritarian positions set the example to lead and influence (interpersonal compatibility) learner nurses as they work towards the set goal/s of the healthcare facility or the patient care unit (agent). •Sub-ordinates, including learner nurses, should respect the nurse leaders for their expertise and obey their commands. •Learner nurses have a responsibility towards their patients, employer, colleagues and themselves. They should be committed (procedure), dependable and reliable (personal reliability) and show kindness (respect and dignity) and compassion (interpersonal compatibility) to all concerned. •Learner nurses should demonstrate that they are trustworthy (personal reliability) when patients can depend on them to be on time for duty. •Learner nurses who are compassionate (interpersonal compatibility) towards patients should be rewarded (procedure) for rendering a quality patient care service. •Learner nurses should display a caring attitude (underlying dynamic) and humility (personal reliability) towards patients when they carry out their basic nursing care responsibilities. •Learner nurses should listen to professional nurses who are their seniors, and obey their commands.
	Category 2: Adherence to professional dress		•All nurses (agent and recipient) portrait a professional image by wearing a unified dress code. •All nurses should be trusted (personal reliability) when they are identifiable in the workplace environment

	code, demeanour (entire image) and neatness/non-adherence in some cases		(context). •All nurses should be trusted because of their professional image and identity. •All nurses should portrait a professional and positive attitude when dressed in the appropriate dress code.
	Category 3: Skills level entering practice (not complying with expectations)		•Clinical preparation of learner nurses (recipient) should focus on the essential patient care needs in healthcare facilities to minimize placing additional responsibilities of teaching on the professional nurses. •Learner nurses should be competent in the basic clinical skills and be able to apply critical judgement (wisdom) as a professional capability when performing nursing care duties. •Professional development should take place throughout the four year training programme. Therefore, knowledge integration and application (professional capabilities) is expected to transpire in the senior (years) of learner nurses. •Learner nurses should acquire essential skills needed for nursing practice. •Nurse educators (primary agent as academic) at the higher education institution (context) should use strategies for learning such as reinforcement (procedure) of essential skills needed for patient care in nursing practice. •Learner nurses should be prepared and have the professional capabilities (knowledge) to practice as professional nurses. Learner nurses should have personal reliability in being service-oriented and develop a desire to help others. •Professional nurses (agent) should demonstrate their professional capabilities by having critical and analytical thinking skills (wisdom) which is required for management and leadership roles in nursing. •Learner nurses demonstrate critical judgement when they bridge theory and practice by applying knowledge and practical skills (wisdom), thus developing professional capabilities.
	Category 4: Personal motivation for nursing (positive in selective cases)	Sub-Category 1: Motivation affects general attitude and commitment to duties	•Professionalism is life-long. Learner nurses should develop an attitude of being service-oriented (altruism) when they are in the placement facilities instead of being concerned over their personal needs (selflessness) i.e. having their books signed or having a job and the use of cell-phones when carrying out nursing duties. •Learner nurses (recipient) should be motivated (intrinsic motivation) and inspired to be self-directed to develop professional capability. •Learner nurses should be passionate (humility) or have the desire to carry out the patient care duties of what nursing entails. •Learner nurses should have the attitude to be of service (personal reliability) to others and carry out patient care duties in the clinical placement facilities. •All nurses (recipient and agent) should have a commitment (procedure) and desire (humility) to serve (personal reliability) the needs of the patient instead of acting in his or her own self-interest where personal physical needs take precedence over important nursing duties and responsibilities. •Learner nurses should make the patient feel that they are worthy of their service in rendering nursing care and not feel that basic nursing tasks e.g offering of a bedpan to a patient, are beneath them . •Learner nurses(recipient) should show responsibility (personal reliability) to do what needs to be done •Learner nurses should demonstrate humility (humbleness) (personal reliability) to ensure positive patient outcomes above personal recognition. •Learner nurses should take responsibility(personal reliability) by exercising sound judgement(wisdom) and apply their critical thinking skills(professional capabilities) to solve patient care problems in clinical practice •Learner nurses should integrate their knowledge and skills and have wisdom to apply analytical thought

			from abstract reasoning to basic applications of common sense.
		Sub-category 2: Motivation or lack thereof and attitude affect behaviour and non-adherence to rules, punctuality, cell phone etiquette	•Learner nurses (recipient) should be compassionate and have the patient`s best interest at heart, thus displaying interpersonal compatibility. •Learner nurses should demonstrate personal reliability by taking responsibility and accountability for their actions. •Learner nurses should demonstrate that they are reliable and committed to serve the needs of the patient by being punctual for duty and showing courtesy and respect towards professional nurses. •Learner nurses should take responsibility to do things right whilst learning in clinical practice for they will be held accountable for instead of blaming others for when things go wrong and do not blame others. •Learner nurses should obey the rules and protocols of the profession and the healthcare institution. Professional nurses (secondary agent) are required to reinforce (procedure) the professional and organisational rules to learner nurses. •Learner nurses should not act in their own self-interest when in the clinical learning environment, but rather obtain skills by utilizing teachable moments for professional development in practice (procedure) to serve the needs of patients. •Learner nurses should be service-minded and have a desire to be altruistic as an important part of personal reliability. •Learner nurses are regarded as adults and expected to be responsible for patient care duties.
		Sub-Category 3: Ethical behaviour	•In nursing honesty and integrity are important aspects of personal reliability in order to build trust relationships with others. Learner nurses should be honest and not engage in unlawful practice of misconduct such as forging of signatures.
Theme 3: Professional nurses' roles in enhancing/strengthening students' professional behaviour	Category 1: Role modelling of professional behaviour in hospitals	Sub-category 1: Issues of attitude, behaviour and commitment	•Professional nurses (secondary agent) as leaders have a commitment (procedure) to influence (interpersonal compatibility) learner nurses (recipient) to effect positive change in the behaviour of learner nurse who copy the professional behaviour of professional nurse in practice. •Professional nurses should be role model and leaders so that learner nurses (recipient) can follow good examples in practice. •Professional nurse leaders are required to positively influence learner nurses by ensuring harmony in the workplace environment. •Professional nurses should lead by example (role modelling) and demonstrate interpersonal compatibility through self-control by maintaining a stable affect under work pressure. •Professional nurses should be able to manage workplace stressors by applying conflict management skills in the workplace environment. •Professional nurses should be aware (mindfulness) (underlying dynamic) about their behaviour towards patients and the professional treatment which they demonstrate to learner nurses. •Professional nurse became conscious of the fact that there should be a change in the way learner nurses are treated. They should treat learner nurses with respect.
		Sub-category 2: Issues of dress code and punctuality	•Professional nurses (secondary agent) should be examples to learner nurses (recipient) by dressing professionally as it influences them to behave professionally during interaction in practice (context). Professional nurses should be an example (role model) by honouring the rules of the workplace and be punctual for duty. A commitment (professional capability) to service (personal reliability) is demonstrated by adhering to the work ethic of the healthcare facility
	Category 2: Mentoring		•Professional nurses (secondary agent) should be aware or mindful (acknowledge) (underlying dynamic) of

	and monitoring students' professional behaviour		their role and function as nurse educators in a culturally diverse nation when they are in practice. •Professional nurses in practice should reinforce (procedure) the desired ground rules and expected professional behaviour to novice nurses at the start of their training in practice. •Professional nurses should have courage (personal reliability) to use their knowledge and skill (professional capabilities) to guide and direct learner nurses to adhere and conform to the rules (context) of the profession in order to achieve the desired behaviour in learner nurses (recipient) of what is acceptable and unacceptable behaviour in clinical practice. •Continuous reinforcement (procedure) of what professionalism entails is essential for the professional development of learner nurses. Professional nurses should guide learner nurses with their professional development by being assertive to address and having the courage to correct learner nurses in their wrongdoing whilst in clinical practice to achieve the desired professional behaviour. •Teaching strategies (procedure) such as lecturing at the clinical placement facilities (context) should be employed of the expectations of professionalism to support learner nurses to develop professionally. •Learner nurses should practise (procedure or support mechanism) professionalism as emphasised and expected by senior professional nurses. •Professional nurses should be welcoming and demonstrate tolerance in behaviour towards the learner nurses who are new in the wards. Learner nurses should be committed and self-directed (professional capability) to learn what is necessary in terms of their learning outcomes.
Theme 4: Obstacles in mentoring and monitoring students' professional behaviour	Category 1: Approachability and attitude of professional nurses		•Professional nurses (secondary agent) should be approachable and demonstrate personal reliability in their availability to serve the needs of the learner nurse in the clinical placement facilities. •Professional nurses should have a caring attitude so that learner nurses (recipient) feel free to approach them in clinical practice. •Learner nurses should be treated well by the professional nurses by being friendly and more caring towards the learner nurses. •Professional nurses should be mindful of the learner nurses who are new in the wards by acknowledging them as part of the team and making them feel welcome in the ward. •Professional nurses should make learner nurses feel welcome as part of the team by orientating (support structure) them about the expectations in the ward. •Learner nurses (recipient) are expected to be mindful of their responsibility as self-directed learners who take responsibility for their own learning. •Professional nurses should have empathy with the learner nurses by making time to orientate the learner nurses even though they are under pressure and suffer stress in the workplace because the wards are full. •Professional nurse should be mindful and show personal reliability in their humility to serve the (learning) needs of learner nurses. Nurse leaders should be humble in attitude.
	Category 2: Work pressure and shortage of staff (no time to orientate learner nurses)		•Professional nurses as leaders (secondary agent) should be mindful of their responsibility (personal reliability) to orientate learner nurses as well as their interpersonal compatibility to stay calm (self-control) under workload pressure, especially when the patient care wards are full and busy. They should demonstrate patience (interpersonal compatibility) towards learner nurses and make time to orientate (procedure) students who are new in the wards. •Professional nurses experience emotional and physical challenges (internal environment) when they are under pressure because of shortage of staff (support structure) in the workplace environment (context). •Professional nurses should demonstrate personal reliability in their humility to apologise for their

			shortcomings in serving the needs of learner nurses. •Professional nurses should show compassion and empathy (interpersonal compatibility) towards learner nurses (recipient) by having a caring attitude even though they are under stress (self-control). •Professional nurse should maintain grace under pressure even when there is chaos in the wards. •Increase in human resources (support mechanisms) positively influences the teaching function of professional nurses in that it contributes to the professional development (procedure) of learner nurses. •Professional nurses should show kindness (interpersonal compatibility) and interest (mindfulness) towards learner nurses in the patient care wards. •Professional nurses should show interest and be motivated to assist (orientate) the learner nurses on their first day in the wards by telling them what is expected of them to avoid misunderstandings.
Theme 5: Suggestions to support/enhance students` professional behaviour	Category 1: Students should monitor their own progress by means of reports		•Professional nurses (secondary agent) should give feedback to higher education institutions in the form of reports to monitor the progress of learner nurses in the clinical placement wards as part of being proactive in the professional development of the learner nurse.
	Category 2: Students should take responsibility for own behaviour and learning		•Learner nurses (recipient) should voice their learning needs by being self-directed (professional capability) and taking responsibility (personal reliability) to recognise what needs to be learned.
	Category 3: Professional nurses should orientate, welcome students in the team and clarify expectations		•Professional nurses (leaders/ secondary agent) create a warm and friendly environment (context) in which learner nurses feel welcome as part of the professional team through orientation (procedure) in a new patient care unit. •Orientation of learner nurses (recipient) who are new to the patient care units by professional nurses in the hospital environment is essential to prevent misunderstandings and ensures that learner nurses know what is expected of them in the wards. •Professional nurses (secondary agent) should be role models who should inspire (interpersonal compatibility) and motivate the learner nurses to be part of the team.
	Category 4: Mentorship and monitoring should be put into practice		•Monitoring of learner nurses (recipient) by their mentors to strengthen collaboration with professional nurses in terms of feedback and improvement of positive behavioural change in learner nurses. •Nurse leaders (primary and secondary agent) in the different learning environments collaborate (procedure) and use reports as feedback to improve positive professional outcomes in learner nurses •Clinical supervisors(primary agent) should be available to act as mentors to monitor learner nurses in the clinical learning environment •Professional nurses (secondary agent) should be role models who take the lead in directing (guiding) learner nurses to become professionals. •Professional nurses should be influential at the highest level of interpersonal compatibility, by showing learner nurses what is the right thing to do. They should take the lead and be role models to direct the learner nurses to become professional. •Professional nurses should have the courage and not be afraid of imposing disciplinary actions (context) against the wrongdoing of learner nurses. •Rigorously enforcement of rules assists learner nurses (recipient) with their professional development and achieving the desired level of professionalism.
		Sub-Category 1:	•Learner nurses (recipient) have the right to communicate their grievances in a safe environment which allow

		Platform for students to voice their concerns and needs and opportunity for emotional support	for a platform (procedure)where they are free to express themselves.
	Category 5: More exposure to learning in practice to improve professional competence and behaviour		•Learner nurses (recipient) could improve professional competence by more exposure to practice. •Learner nurses could benefit by receiving bedside (on the spot) or in-service training in the healthcare facility. •More practical exposure for learner nurses could improve the integration of theory and practice. •Learner nurses from higher education institutions could positively contribute to the professional image of nursing and would develop professionally, provided that they get more practical exposure (procedure). •Increasing the students` practical exposure could be achieved through a block system (procedure) with separate times when students are in the classroom and wards (context).

ANNEXURE U

Portia Bimray- RE: Re Research
From:
To:
Date:
Subject:
HI
Rochelle Bailey <Rochelle.Bailey@westerncape.gov.za>
Portia Bimray <pbimray@uwc.ac.za>
2013/09/06 10:03 AM
RE: Re Research
THAT'S OK WITH ME I WILL LET YOU KNOW IF THERE'S ANY CHANGES
From: Portia Bimray [mailto:pbimray@uwc.ac.za]
Sent: 06 September 2013 09:56 AM
To: Rochelle Bailey
Subject: Re: Re Research
Good Morning Sr. Bailey
Thank you for your assistance with the arrangements of focus group interviews for my research.
Page 1 of 2
Friday 13 and Monday 16 September seems to be in order to cover both shifts. As discussed, I will use the last hour of your training session as to not interrupt your presentation. This is much appreciated.
Kind regards and blessings
Portia Bimray
Lecturer
School of Nursing
UWC
0219592601 / 0823360516
pbimray@uwc.ac.za / pbimray@qmail.com
>>> Rochelle Bailey 09/06/13 8:33 AM >>>
Morning Portia
Hope you well? I spoke to Mrs Lauw and the Operational Managers this morning and explained your process and that it won?t affect and interfere with the work capacity in the wards and they all agreed, therefore you can decide and inform me which dates you will come? .. the following dates are scheduled for PN: 9,13,16,20, 23 and 27 SEPTEMBER 2013. Have a blessed day?
Kindly regards
Rochelle Bailey
HRD Training and Development
Department Health
Karl Bremer Hospital
Western Cape Government
Private Bag xxl, Bellville.
Tel : 021 918 1280/1311
Fax: 021918 1409
E-mail : **rochelle.bailey@pgwc.gov.za**
Website : **www.westerncape.gov.za**
file://C:\Users\Admin\AppData\Local\Temp\XPgrpwise\5229A857UWCACADEMI...
2013/09/10

ANNEXURE V
LETTER FROM EDITOR

LINGUAFIX

EDITING AND TRANSLATION
REDIGERING EN VERTALING
☎ 0826816232
vnhelene@gmail.com
www.linguafix.net

09/04/2017

This letter is to record that I have completed a language and technical edit of "**A CONCEPTUAL FRAMEWORK FOR NURSE EDUCATIONALISTS AND PROFESSIONAL NURSES TO FACILITATE PROFESSIONALISM AMONG UNDERGRADUATE LEARNER NURSES FOR NURSING PRACTICE IN THE WESTERN CAPE".**

Helene van Niekerk
M.Diac.
PGD (Editing and Translation)