UNIVERSITY OF THE WESTERN CAPE

FACULTY OF COMMUNITY AND HEALTH SCIENCE

RESEARCH REPORT

Title: Development of a Clinical Nursing Education model for Nigerian Universities

Student name: Rafiat Ajoke Anokwuru

Student number: 3280992

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Supervisor: Professor FM Daniels

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Model Development

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ABSTRACT

Globally, nursing education has moved from a hospital-based education to a university-based education. Though this change resulted in the improvement of the quality of nurses it has also presented its own challenges. Clinical education, one of the major components of nursing education, was adversely affected by the reduction in the amount of time and the quality of clinical placements. In order to combat these challenges, innovative models on clinical education were developed with the objective to produce nurses that can deliver quality care to patients in an evolving health sector.

It has been established that a uniform clinical model guides clinical education in the universities offering the Bachelor of Nursing Science degree in Nigeria. Consequently, this research study purposed to develop a model that guides clinical nursing education at these universities. The Cognitive Apprenticeship Theory and the Context Input Process Product (CIPP) model serve as a framework in this regard. The CIPP model is used to explore the effectiveness of clinical nursing education, while concepts relevant to the Cognitive Apprenticeship Model are used in structuring the components in the interview guide and the development of the model.

This study employed a qualitative, descriptive and theory-generating research design in phase one. Document reviews, focus group discussions and semi-structured interviews were used to collect data. A total of 104 students, 29 educators, 64 professional nurses and 29 alumni were purposively sampled. The participants were drawn from four universities and the teaching hospitals of three states in the south-western region of Nigeria. Ethics approval to conduct the study was duly obtained from all relevant authorities. Protocol relating to ethics was observed throughout the study. The data was analysed using the Atlas ti7 software.

Phase two of the study, the development of the model, was guided by concept synthesis, statement synthesis and theory synthesis, according to theory development by Avant and

Walker (2014). A total of 15 concepts were identified from concluding statements but were synthesised to the following five concepts: positive learning experience; effective clinical education process; capacity building; supportive learning environment and government support. The model is presented in graphic form and it is hoped that the successful implementation of this model will improve clinical nursing education offered by universities in Nigeria.

DECLARATION

I, Rafiat Ajoke Anokwuru declare that the dissertation entitled: “Development of a Clinical Nursing Education model at Nigerian Universities” is my own work and has not been submitted for any other degree or examination at any other university other than the University of the Western Cape. All the sources I have used or quoted have been indicated and acknowledged by complete references.

Name: Rafiat Ajoke Anokwuru

Date: August, 2017

Signed: *Anokwuru Rafiat*

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DEDICATION

This work is unreservedly dedicated to the covenant keeping, immortal and only wise one, God. To whom is all the glory honour and adoration forevermore. Amen.

Table of Contents

LIST OF ABBREVIATION

AACN	American Association of Colleges of Nursing
BNSc	Bachelor of Nursing Sciences
CDC	Center for Disease Control and Prevention
CIPP	Context, Input, Process and Product
FGD	Focus Group Discussions
FUNDISA	Forums for Nursing Deans in South Africa
HoD	Head of Department
IoM	Institute of Medicine
NCSBN	National Council of State Boards of Nursing
NLN	National League for Nursing
NLNAC	National League for Nursing Accrediting Commission
NMCN	Nursing and Midwifery council Of Nigeria
NUC	National Universities Commission
RM	Registered Midwife
RN	Registered Nurse
RPHN	Registered Public Health Nurse
RWJF	Robert Wood Johnson Foundation
WHO	World Health Organization

LIST OF FIGURES

LIST OF TABLES

LIST OF APPENDICES

CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Nursing, according to Henderson, Twentyman, Heel and Lloyd (2006:564) is a "practice-based discipline", and it has been established that clinical education is an important factor in ensuring quality care for patients since skills and competencies are developed through clinical education (Chuan & Barnett, 2012).

Clinical education, according to Shulman (2005), is one of the signatures of nursing education. It is a fundamental part of nursing education because it provides an opportunity for student nurses to put into practice and perfect the skills they have acquired in the classroom and the nursing skills laboratory. It also brings them in contact with patients and real life situations. In addition, the worth of education a nurse receives is largely dependent on how excellent their clinical experience was (Khan, Shafi,& Akhtar,2015; Kaphagawani & Useh, 2013). The quality of clinical education is therefore one of the key determinants used to measure and evaluate the success of a nursing programme and the performance of newly qualified nurses in practice (Nyangena, Mutema & Karani, 2011).

Nursing education therefore provides the platforms in which the future of the nursing profession is sustained and quality, competent and critical thinking nurses are sharpened (Kelly & Ahen, 2009; Maclyntyre, Murray, Teel & Karshmer, 2009). This is in line with the main aim of nursing education, which is to produce quality nurses that are able to respond positively to challenges in healthcare and are also able to deliver quality care to patients. The nursing education that a nurse receives goes a long way in determining the quality of care that a patient will eventually receive from the nurse (Ironside & McNelis, 2011; Institute of Medicine, 2010; McHugh & Lake, 2010).

Attempts at improvement led to major transformation in nursing education; from the era of practical nursing, the simplest form, to that of doctorate level. In addition, training shifted from hospital-based training to university-based training (Mannix, Wilkes & Luck, 2009; Mannix, Faga, Beale & Jackson, 2005). The latter shift resulted in some dramatic changes to clinical education.

In the past, clinical education in the nursing curricula was not a challenge because it was based on the assumption that since student nurses were being trained in the hospital setting with patients and professionals present, learning would take place naturally. This was further strengthened by the presence of experienced nurses at their disposal to mentor these students and deal with any challenge they face since they lived and trained within the hospital complex (Mannix, Faga, Beale & Jackson, 2005).

But the advent of university-based nursing education, and the training of nurses moving from the hospital to the university, presented several challenges in clinical education. One such challenge was the fact that nursing students were no longer regarded as part of the hospital staff but as visitors to the clinical settings and their training needs were viewed as an extra burden on the staff (Stokowski, 2011; Pollard, Ellis, Stringer & Cockayne, 2007). Issues such as whether students are regarded as supernumerary or part of the workforce are still being debated today. Another challenge is that of the compressed or limited number of hours allocated to clinical practice in order to accommodate the theoretical component of the university curriculum, and the number of weeks in the university semester (Mannix, Faga, Beale & Jackson, 2005).

The problem of clinical education in a university-based nursing education has been further compounded by various challenges and developments facing the health sector in the, 21st century, such as increasing patient acuity. Patient acuity, according to Hughes (2008), is the classification of patients according to the nursing care that they need. Patient acuity also

influences the number and qualification of nurses needed in a particular unit at a particular time. This affects, and most often, reduces the time that experienced and qualified nurses have available between patient care to attend to the students, thereby putting a strain on the student's clinical learning (Sir, Dundar, Steege & Pasuspathy, 2015; Kamau, 2015). Furthermore, reduction in the patient's length of hospital stay due to the high cost of medical insurance; shortage of nursing staff in relation to the competition for clinical learning opportunities for the myriad of healthcare workers placed at clinical facilities for clinical practice and advancement in medical knowledge and technologies becomes a challenge (Maclyntyre, Murray, Teel & Karshmer, 2009; Australian Institute of Health and Welfare, 2003). The National Advisory Council on Nurse Education and Practice (2010) confirms that these challenges dramatically reduce the space for clinical placement and opportunities for clinical learning without overcrowding the clinical facilities. This lack of or limited clinical learning affects the quality of nurses that are being produced.

Another challenge facing clinical education in nursing education has been a shortage of nursing educators available to teach nursing students. Reasons for this require investigation and action. In addition, despite dramatic and rapid changes in the health sector over the years, the methods of clinical nursing training have not changed equivalently (Nielsen, Noone, Voss & Matthew, 2013; Niederhauser, Schoessler,Gubrud-Howe, Magnussen & Codier, 2012; Frenk et al., 2010). In fact, Tanner (2006) identified that the present clinical education model used in most schools of nursing was developed more than eighty years ago and the courses referred to as fundamentals of nursing may not necessarily be fundamental to nursing in today's changing world of technology, and may not be as relevant to the present-day training of nurses (Ironside & McNelis, 2011).

Several other authors have also alluded to challenges with nursing curricula. Nibert (2013) suggests that the nursing curriculum should be based on the current healthcare environment

and technologies. In this way, the issues highlighted by Ironside and McNelis (2011) would be overcome. Another challenge was raised by Agbedia (2012) who argues that the nursing curriculum is overloaded and does not leave enough room for clinical education, which is the bedrock of any good nursing education programme.

In the United States of America, Europe and other parts of the world similar healthcare challenges as those highlighted above led to the development of innovative models for clinical education (NCSBN, 2005; IOM, 2009; NLN, 2010), towards producing nurses that can deliver quality care to patients in an evolving health sector (Nielsen et al., 2013; Niederhauser et al., 2012; Diefenbeck, Flowfield & Herman, 2006).

Although Africa also faces similar challenges, little research has been done towards the development of any relevant models that can be used in clinical nursing education in the African context. However, in the South African context, the government, through the Department of Health, published an article "The National Strategic Plan for Nurse Education, Training and Practice (2011)", which highlights important issues such as standardisation of the nursing programme. The issue of developing new models for clinical teaching is also raised. In response to this publication, the Forum for Nursing Deans in South Africa (FUNDISA), a platform for nursing scholars in South Africa, has developed a model for clinical education in nursing in South Africa (www.fundisaforum.org, 2012). Nigeria, on the other hand, uses a model, according to Adejumo and Ehlers (2001), that is geared towards a diploma in nursing education and which tilts more towards hospital-based training. Otherwise in Nigeria, each nursing school seems to have their own clinical education model or framework which they follow.

1.1.1 Nursing education in Nigeria

Nursing education in Nigeria can be traced back to the 1800s with the arrival of the missionaries in Nigeria. It was significantly influenced by religion, colonial administration and the world wars (Adebanjo & Olubiyi, 2008). Informal nursing education began in the 1800 with the missionaries recruiting young men and women with primary school education for training as nurses to take care of the health and spiritual needs of the community which they wanted to evangelise. There was no formal education or curriculum during this time and the training of these nurses was largely based on the experience of the missionary nursing sisters.

According to Ajibade (2012), formal training of nurses and midwives began in 1930 in most mission schools. The Midwives Board of Nigeria was also established in the same year. In 1946, the Nursing Council of Nigeria was established and was responsible for developing the curriculum and entry requirements for the training of nurses towards becoming registered nurses in the schools of nursing (Adebanjo & Olubiyi, 2008). In 1949, four schools of nursing were established in each region of the country, then divided by the Richards Constitution, and used the formal syllabus as established by the then Nursing Council of Nigeria. In 1960, nurses were sent abroad for further training at universities. By 1962 a few returned to Nigeria which resulted in the establishment of the Department of Nursing at the University of Ibadan with assistance from the World Health Organisation and the Nigerian Federal Government (Ajibade, 2012).

According to the Ayandiran, Irinoye, Faronbi and Mtshali (2013), the mandate of the department at the time was to produce nursing leaders in nursing education and nursing administration which greatly influenced the type of clinical education that was being offered in the programme, as well as the entry level professional qualifications for registered nurses and registered midwives.

However, in 1973, the then University of Ife, currently known as Obafemi Awolowo University, started a generic nursing programme that targeted fresh secondary school graduates. The focus of this programme was to train nurses at university level that would be highly qualified to work in any area of the health system. That is why, after successful completion of this programme, a nurse is awarded a Bachelor of Nursing Science certificate with qualifications as a registered nurse, a registered midwife and as a registered public health nurse. In 1979 the Nursing and Midwifery Council was established, under Decree No. 89 (Registration Act Cap. N143). Their function was to regulate and maintain standards of the nursing profession.

1.1.2 Current trend in nursing education in Nigeria

The history of nursing education in Nigeria has resulted in many nurses not being university trained. According to Adebanjo and Olubiyi (2008), "75% of the practicing nurses in Nigeria are certificate and diploma holders". Nursing in Nigeria has gone through major transformation to give nursing in Nigeria a facelift. One such reformation is the standardisation of entry requirements for nursing by the Nursing and Midwifery Council of Nigeria in 2010. A student seeking admission into the school of nursing must have a credit in Physics, Chemistry, Biology, Mathematics and English. Another reformation has been the upgrading of schools of nursing into mono-technics in order to quantify the certificates of the nurses to decide between an ordinary diploma degree or a higher national degree (Adebanjo & Olubiyi, 2008; Ayandiran, Irinoye, Faronbi and Mtshali, 2013).

Yet another development occurred when the Nigeria University Commission made the generic programme of the Obafemi Awolowo University the benchmark for nursing education in Nigerian universities in 2010.

However, with all these changes and reformation in nursing education in Nigeria, little or nothing is being done to improve clinical education in university programmes. Despite adjustments to the university-based nursing curriculum, no real model has been put in place to ensure the delivery of a quality clinical nursing education programme which is the core of nursing education and nursing care.

1.2 STATEMENT OF PROBLEM

There seems to be a worldwide outcry over moving the training of nurses from hospital-based education to university-based education (Ayandiran, Irinoye, Faronbi & Mtshali, 2013) in the belief that university education will better prepare nurses to meet the health sector challenges in the 21st century (Dolamo & Olubiyi, 2013). Such transformation has occurred in Nigeria, including the standardisation of graduate nursing education through the introduction of a generic graduate programme. It has, however, intensified the need to not only streamline the theoretical component of the curriculum, but to ensure that clinical learning is well catered for in the graduate nursing programme.

However, despite transformation and innovation in nursing education in Nigeria there is no evidence of a uniformed clinical model being used in nursing education programmes at universities that addresses clinical nursing education challenges resulting from this transformation and the changing healthcare sector needs (Agbedia, 2012; Dolamo & Olubiyi, 2013).

Hence there is a need to develop a clinical education model that will guide the training of nurses at universities in Nigeria.

1.3 PURPOSE OF STUDY

The purpose of this study is to explore clinical nursing education in Bachelor of Nursing Science programmes in Nigeria and to develop a clinical nursing education model for Nigerian universities.

1.4 RESEARCH OBJECTIVES

1.4.1 To explore the effectiveness of clinical nursing education in Bachelor of Nursing Science programmes at universities in Nigeria in producing clinical competent nurses by:

1.4.1.1 Explore and describe the context for clinical nursing education offered at universities in Nigeria.

1.4.1.2 Explore and describe the resource allocation for clinical nursing education offered at universities in Nigeria.

1.4.1.3 Explore and describe the process of delivery of clinical nursing education offered at universities in Nigeria.

1.4.1.4 Explore and describe whether the clinical nursing education offered at universities in Nigeria is effective.

1.4.2 To develop a clinical nursing education model for Nigeria.

The sub-objectives stated above 1.4.1.1 – 1.4.1.4 were aligned to the CIPP model but were achieved through exploring the experiences of the students and graduates; and the perceptions of the nurse educators and professional nurses on the effectiveness of clinical nursing education in Bachelor of Nursing Science programmes at universities in Nigeria.

1.5 SIGNIFICANCE OF STUDY

The aim of nursing education is to produce nurses that will deliver sound nursing care to patients by utilising all the skills that they have acquired during their education and training (Grealish & Smale, 2011; Lindahl, Dagborn & Nilsson, 2009). However, this aim cannot be achieved through unplanned clinical education. This research will therefore contribute to nursing profession and especially nursing education as follows:

- Provide a clinical model to guide clinical education in the Bachelor of Nursing Science programme.
- Standardize and streamline clinical nursing education in Nigeria, and possibly improve graduates' clinical competence and patient outcomes.
- Enhance the integration of theoretical knowledge and clinical skills.
- Improve the quality of healthcare given to patients in hospitals.

1.6 CLARIFICATION OF CONCEPTS

The following terms are defined or clarified for use in this study:

i. Bachelor of Nursing Science

Bachelor of Nursing Science is a five-year undergraduate programme that prepares the nursing professionals as polyvalent nurses for nursing, midwifery and public health practice. At the completion of the programme a successful student is awarded the
B NSc degree and a student is only certified as a registered nurse, registered midwife and registered public health nurse after successful completion of the professional examinations from the regulatory body, that is the Nursing and Midwifery Council of Nigeria.
In this study, all the participating universities offer the B NSc programme.

ii. Clinical nursing education

Clinical education can be defined as supervised learning opportunities made available to student nurses through clinical experiences at clinical facilities that reflects current best practice in the country (NLNAC, 2008).

iii. Graduate

According to the Cambridge online dictionary, “a graduate is a person who has finished the university or college degree”. For this study, a graduate will be a student who has completed the university nursing degree and has worked for a minimum of two years and is currently employed in a clinical setting. They are also referred to as alumni.

iv. Nurse educator

According to the Nursing and Midwifery Council of Nigeria (NMCN), a nurse educator is a nurse who is registered with the NMCN as a nurse educator. For the purpose of this research, a nurse educator includes educators and clinical instructors who teach both in the classroom and the demonstration lab, and accompany the students for clinical practice during their clinical placement.

v. Nursing education

According to the Medical Dictionary for Health Professions and Nursing, (2012), nursing education is “a planned curriculum usually with clinical practice experience to prepare nurses”.

For this study, nursing education refers to the education offered in the nursing departments in Nigerian universities following an accredited/structures curriculum.

vi. Professional nurse

According to the Nursing and Midwifery Council of Nigeria, a professional nurse is a person who has received authorised education, acquired specialised knowledge, skills and attitudes, and is registered and licensed with the Nursing and Midwifery Council of Nigeria to provide promotive, preventive, supportive and restorative care to individuals, families and

communities, independently, and in collaboration with other members of the health team (NMCN, 2014 www.nmcn.gov.ng). For this study, the definition of a professional nurse will be used as defined by the Nursing and Midwifery Council of Nigeria and refer to those working with the students in the wards during clinical placement.

vii. Educational Level

In Nigerian institutions, the level or part a student is, in the university is indicated using 100-400 or 500 level depending on the number of years of the programme of study. That is to say a five -year course as it is in nursing programme will have students from 100- 500 level.

In the study, 300-500 level students' points to students in the third year to students in the fifth year which is the final year of the nursing programme.

viii. Effectiveness

According to the Cambridge online dictionary, effectiveness is defined as "the ability to be successful and produce the intended results". For this study, effectiveness refers to the success of clinical nursing education as experienced by the students and graduates of the nursing programme and as perceived by the nurse educators and professional nurses involved in clinical nursing education at Nigerian Universities.

1.7 PARADIGMATIC PERSPECTIVES

Paradigm, according to McGregor and Murnane (2010), is a set of assumptions, concepts, values and practices that constitutes a way of viewing reality. There are two main philosophical assumptions, namely, the ontological and epistemological assumptions.

1.7.1 Paradigm

According to Scotland (2012:9), "every paradigm is based upon its own ontological and epistemological assumptions" and this can be seen in the methodology and methods that

underpin a particular research. In view of this, he further states that any methodology a researcher decides to use is determined by the reason for the data, where the data will come from and when the data will come, and how the data is collected and analysed. (Ritchie, Lewis, Nicholls & Ormston, 2013). Grix (2010) states that two researchers working on the same phenomenon can have a different research approach because they have differing epistemological and ontological positions.

This research employs the principles of the interpretive paradigm. Interpretive paradigm according to Willis (2007) is understanding a phenomenon from the perspectives of the individuals or group of persons living in the world of the phenomenon being studied. In the interpretive paradigm there is no right or wrong way of viewing any subject of knowledge (Denzin & Lincoln, 2008). According to Thanh and Thanh (2015) interpretive paradigm supports the qualitative approach to research because it seeks to understand a phenomenon from the society's point of view. Qualitative research according to Creswell (2013) is research that seeks to explore the meaning the society gives to a phenomenon. Furthermore Thanh and Thanh (2015) stated that the best research approach to study an educational phenomenon is the qualitative research as it seeks to capture the in-depth experiences of both the educators and the student on a particular research interest. Hence the researcher's choice of interpretative paradigm, as the research seeks to understand the effectiveness of clinical nursing education offered in the Nigerian Universities. In order to develop a model that will improve the quality and standard of clinical nursing education in the Nigerian universities nursing programs. The interpretive paradigm is characterised by the purpose of the research, the nature of reality (ontology), the nature of knowledge and the relationship between the researcher and what is being researched.

1.7.1.1 Purpose of research

Understanding and interpreting the students', nurse's educators', professional nurses' and graduates' perspectives of clinical education in Nigeria and developing a model that will guide clinical education in nursing programmes at universities in Nigeria

1.7.1.2 Ontological assumption

The ontological assumption is concerned with what needs to be known about the nature of the world. In ontological assumptions we have two main positions, realism and idealism. Realism proposes that our belief or understanding does not have anything to do with external reality whereas idealism advances that our understanding and belief have everything to do with the external reality (Ritchie, Lewis, Nicholls & Ormston, 2013).

The ontological position of this study is that of relativism. There are multiple realities in this study as it is dependent on how an individual perceives his/her environment and uses his/her language to describe it. The following assumptions predicate the ontological position of this study:

- The reality of what the student expects during clinical practice and the ward environment differs and it affects their perception about professional nurses and their behaviour towards professional nurses and the clinical practice.
- The interpretation of professional nurses in the ward of what the attitude of the students should be during clinical practice informs the behaviour of professional nurses towards the students.
- The clinical instructors' interpretation of what clinical education should be and how it should be delivered to the students affects the quality of the clinical experience of a student.

- The perceptions of a graduate of a nursing programme of how clinical education should be would be influenced by their experiences in the labour market.

1.7.1.3 Epistemological assumption

The epistemological assumption is concerned with what an individual knows and is subjective in nature. Epistemological assumptions have two main positions, namely, inductive logic and deductive logic.

The epistemological position of this research is based on inductive reasoning and subjectivism (Grix, 2010). There are different levels and types of information based on the individual experiences and knowledge of what clinical education entails for participants in the study. This fact informs the reason why the researcher included individuals that are directly involved in clinical education, as well as those setting the standards for clinical education in nursing programmes at universities. The following assumptions underpin the epistemological position of this study:

- The educational level of the student involved in clinical education affects their perception about what to expect from the clinical experience.
- The perspectives of a professional nurse will be influenced by her experiences of the ward based on the availability of resources, their knowledge of the nursing world, and how they interact with the students, as well as the clinical experience in the ward.

1.7.1.4 The role of theory and interpretivism

The Cognitive Apprenticeship Model was used to guide this study, supported by the following assumptions:

- Community of practice refers to an environment that enhances learning based on the assumption that learning, though individualistic, occurs among likeminded people,

who have similar behaviour, work towards a common goal - usually bound by knowledge in a contextualised setting (Lave & Wenger, 1991; Wenger, 1998; Andrew, Tolson & Ferguson, 2008). The community of practice in the context of clinical education of a student is the hospital where the student is placed for clinical practice. According to Edward et al. (2004), a supportive clinical environment will enhance positive learning outcomes in students.

- Purposeful supervision of clinical practice play a major role in shaping future nurses and guarantees the professionalism of the graduate nurse (Häggman-Laitila et al. 2007). Supervision of nursing students in situated cognition theory is carried out using the cognitive apprenticeship style and the "role of the educator is that of a facilitator" (NCSBN, 2005). This is described in more detail in Chapter Twos. The educator uses different methods to stimulate thinking and reflection in the student. The latter encourages the student to go through the following four phases, as proposed in Kolb's,(1984) cycle of learning: concrete experience, reflective observation, abstract conceptualisation and active experimentation, so as to bring about transformation of the experience for the student.
- In as much as a student must pass through the four phases in the cycle of learning, before learning can take place, each student has a preferred method of learning which results in different learning styles. Clinical teaching must therefore be structured in such a way that encourages the learning styles of individual students while they pass through the four phases (Kolb's, 1984; Sharlanova, 2004).
- In Kolb's Learning Cycle model highlighted above, reflection is listed as one of the main activities that must take place in an individual before learning can occur. In nursing, according to Wilkinson (1999), reflective practice does not just happen. It has to be developed through innovative ways. It is therefore important for both

educators and students in nursing to develop reflective practice. For the student it is important in order to bring about transformative experience which is followed by learning, while for the educator it is important to reflect on ways and innovations in order to enhance teaching and learning.

- Learning must be structured according to the level of the students since learning improves and deepens as exposure continues.

1.8 RESEARCH METHODS

A qualitative approach and an exploratory descriptive design were used in this research study. Model development was guided by the theory generating design proposed by Walker and Avant (2014). The findings in phase one was used in the development of the model for phase two of the research. The research methods used in this study are described in detail in Chapter 3.

1.9 DATA ANALYSIS

The inductive thematic approach was used in identifying the themes from the data that was collected in phase one of the research. The analysis of data from the semi-structured interviews and focus group discussions and document analysis followed the general inductive approach using the steps as outlined by Vos, Strydom, Fouche and Delport (2011). The data analysis process is described in detail in Chapter 3.

1.10 OUTLINE OF THE THESIS

The arrangements of the chapters are as follows:

Chapter One: Provides the introduction and the background to the study. It highlights the purpose and objectives of the study, the study's significance and the paradigmatic perspectives of the study.

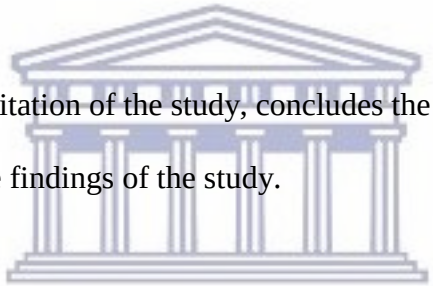
Chapter Two: Presents the literature review and theoretical framework that guide the study.

Chapter Three: Describes in detail the research methods employed in the study.

Chapter Four: Provides a detailed presentation and discussion of findings from interviews and focus groups. A literature control was used to place the findings in context with other studies.

Chapter Five: Presents a detailed description of the process of development of the clinical education model.

Chapter Six: Describes the limitation of the study, concludes the study and presents recommendations based on the findings of the study.



1.11 SUMMARY

Chapter One provided an orientation to the study by means of an introduction and background to the research topic. The purpose, objectives and rationale for embarking on the study were also presented. The chapter further clarified key concepts used in the study. In addition, the research design and methodology were briefly described. Chapter Two presents the literature review and theoretical framework that guided the study.

CHAPTER TWO

CONCEPTUAL FRAMEWORK

2.1 INTRODUCTION

This chapter describes how concepts in the Cognitive Apprenticeship Model and the CIPP Model serve as a conceptual framework for the study, as well as its relevance for research in the area of clinical nursing education. CIPP is an acronym that stands for *Context* evaluation, *Input* Evaluation, *Process* Evaluation and *Product* evaluation.

According to Mgbekem and Samson-Akpan (2013), scientific principles and technical skill are prerequisites for providing quality care to patients in nursing, and both these skills can be achieved through a good nursing education programme. Clinical nursing education is the bedrock of any good nursing programme, as it provides the avenue for student nurses to put into practice in the hospital or community setting what has been learnt in the classroom (Ironside, 2013; Green, 2013, NLN, 2008).

2.2 CONCEPTUAL FRAMEWORK

A conceptual framework, according to Polit and Beck (2006), refers to the concepts within a conceptual model which gives meaning to a study. The combination of these concepts obtained from the literature guides the whole research process. True to this study, a conceptual framework influences every part of the study by giving direction and organization −from the research questions to data collection, presentation of findings, as well as providing a context for interpreting the study findings (Regoniel, 2015; Miles & Hubernan, 2014; Jabreen, 2008).

2.3 COGNITIVE APPRENTICESHIP MODEL

Apprenticeship in teaching and learning has always been a key issue in teaching and learning. It involves the "expert" in a field helping the novice in the process of becoming an expert of a profession (Nielsen, 2010). It often happens in a far less formal setting and it is used more in the area of psychomotor domain rather than the "cognitive and metacognitive domain" (Jonassen, 2014:813).

The Cognitive Apprenticeship Model is the educational approach to Situated Cognitive Theory. According to Brown, Collins and Duguid (1989:32), the model serves as a strategy that "supports learning in a domain by enabling students to acquire, develop and use cognitive tools in authentic domain activity".

The table below compares traditional apprenticeship and cognitive apprenticeship by applying four distinct criteria:

Table 2.1 Difference between traditional apprenticeship and cognitive apprenticeship

	Traditional apprenticeship	**Cognitive apprenticeship**
Setting	It does not occur in a formal setting	It occurs in a formal setting
Domain	It involves more of the psychomotor domain	It involves more of the cognitive and metacognitive domain
Context	Knowledge gained is specific to a particular setting	Knowledge gained can be applied in different settings
Task	Learning is dependent on workload	Learning is dependent on pedagogical concerns

Adapted from: The Cambridge Handbook of the Learning Sciences, 2006

2.3.1 Framework for Cognitive Apprenticeship Model

This model consists of four main dimensions that embrace any learning environment viz. content, method, sequence and sociology. Each of these dimensions is further divided into comprehensive parts as illustrated in the figure below.

Cognitive Apprenticeship Model (Collins, Brown & Newman, 1989)

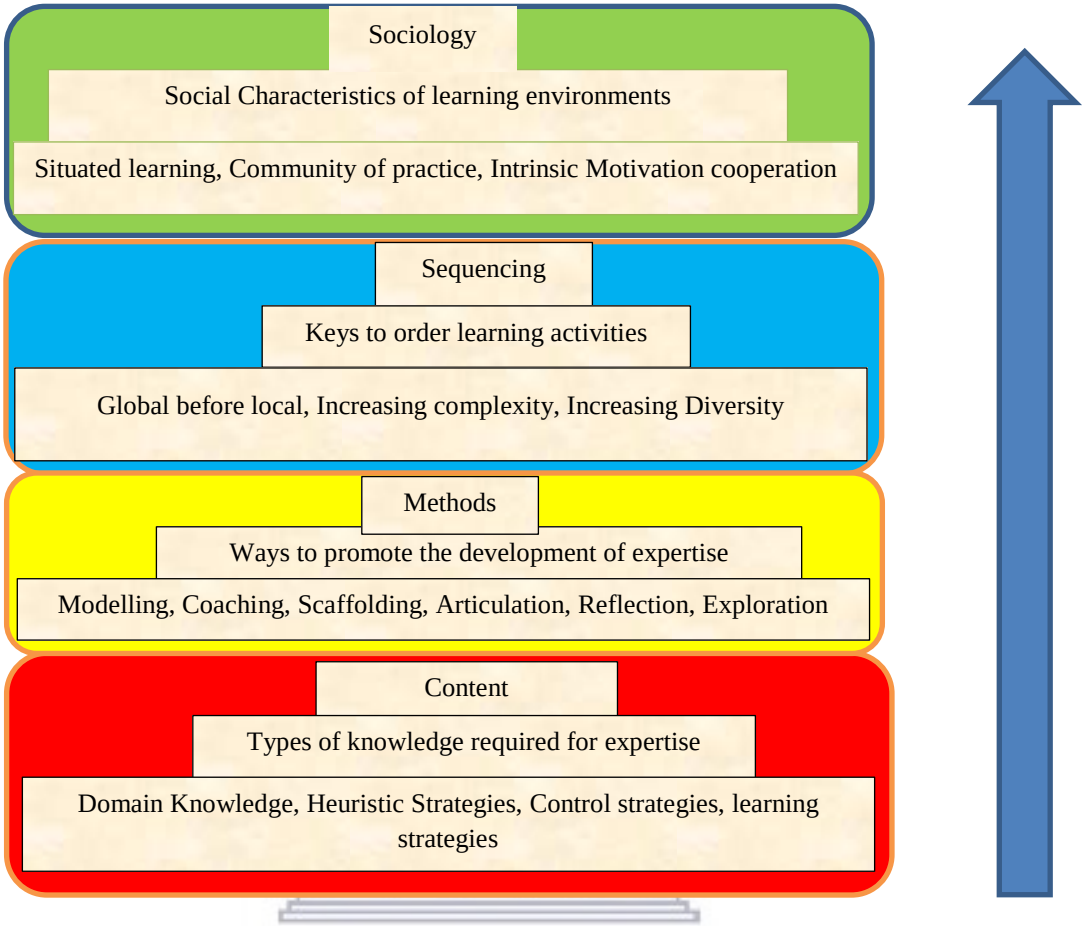


Figure 2.1 Cognitive Apprenticeship Model (Collins, Brown & Newman, 1989)

The following provides a more detailed description of the four dimensions of the Cognitive Apprentice Model:

2.3.1.1 Content

Content is the first dimension of the Cognitive Apprenticeship Model. According to Collins (1989), *content* refers to the type of knowledge required by the expert in a particular field of specialisation. It is divided into two main types of knowledge: the domain knowledge and the strategic knowledge.

i) Domain knowledge

Domain knowledge refers to the main knowledge passed down to a novice by an expert in the form of "textbooks, classroom lectures and practical demonstrations" (Sawyer, 2006:49). In terms of a clinical profession, it is not sufficient to have this type of knowledge alone as it requires the transfer of this knowledge into everyday life of the practice of the profession. For example, in nursing, an individual may know all about the nursing theories and the signs and symptoms and pathophysiology of a disease, but being able to know what is the right thing to do at the right time when attending to a patient is what differentiates domain knowledge from strategic knowledge.

ii) Strategic knowledge

There are three kinds of strategic knowledge strategies:

- Heuristic strategies: These are "effective problem-solving" methods often generated from methods picked up from experts and are not found in textbooks. They are usually called "tricks of the trade" because they are not taught formally (Bieniek, 2008 & Sawyer, 2006). They are very useful in decision- making in Nursing. The Heuristics knowledge a student nurse possesses goes a long way in helping the students in clinical reasoning (Hafenbradl, Waeger, Marewski & Gigerenzer, 2016).
- Control strategies: Also known as metacognition, control strategies are used in the process of problem solving. It involves the monitoring of the progress of the task, diagnosis of any problem that may arise in the task and the provision of solutions to the problems that may arise.
- Learning strategies*:* These are strategies of learning that are used to acquire knowledge in the domain and strategic knowledge.

2.3.1.2 Methods

This is the second dimension of the Cognitive Apprenticeship Model. Collins, as cited in Sawyer (2014), identified six teaching methods that provide an opportunity for the student to practice what they have learned. These six teaching methods can be grouped into three groups. The first group, the *modelling, coaching and scaffolding methods,* are designed to assist students in acquiring skills through "observation and guided practice". The second group, the *articulation and reflection* teaching methods, are methods aimed at helping students to bring out their own problem-solving strategies. Finally, the third group, *exploration,* is a method aimed at inspiring a learner to be independent in defining a problem and proffering solutions to defined problems (Sawyer, 2014:109).

i) Modelling - is the act in which an expert in a field performs a task for a learner to observe and the learner develops a step-by-step intellectual framework of how the task has been performed (Dennen, 2016). Jonassen (1999), in his work on the constructivist learning environment, described two types of modelling, namely behavioural and cognitive modelling. He argues that in behavioural modelling the expert demonstrates the psychomotor skills to be learnt and the learner simply imitates the skills whereas in cognitive modelling the expert models a cognitive action which is more difficult to interpret. Modelling is deemed to be more effective when the process is clear to both the learner and the educator who is the expert. In clinical nursing education the professional nurse make use more of the behavioural modelling. The professional nurse models the professional skills the students are to acquire while caring for patients as well as teaching the student nurses.

ii) Coaching - is directed at helping students acquire skills with minimal guidance. It is a method in teaching that is directed at helping the student to bring out the best performance towards a goal or professional growth (Jenkins, Passmore, Plamer &

Short, 2012; Klofsten & Oberg, 2008; Brown; Collins & Duguid, 1989). In education, the term coaching has been used interchangeably with the word mentorship. Although they share many similarities, the characteristic of coaching makes it unique from mentorship. Coaching is always learner-centered and for a short time. According to Grant (2001) as cited in Fazel, 2013:2344), "Coaching is a collaborative, solution-focused, result- orientated , systematic process used within normal non-clinical population in which the coach facilitates the enhancement of the coachee's life experience and performance in various domains and fosters self-directed learning, personal growth and goal attainment of the coachee". In contrast, mentoring is a long-term relationship between an expert and a novice that is directed at the development of the novice's career over a long period of time. It involves transferring of values from the mentor to the mentee. It is educator-centered as the mentee looks up to the mentor for solutions (Mariani, 2012). In clinical nursing education the student nurse serve as the coachee while the professional nurse serves as the coach. For a quality outcome of the clinical nursing education offered there is need for a focused and result orientated supervision during clinical placement,

iii) Scaffolding - can be defined as temporary instructional design that is put in place by an educator to assist the student to achieve the work which he originally could not do (Puntambekar, 2015; Belland,Kim & Hannafin, 2013; Puntambekar & Hubscher, 2005). It is tailored to the student's need and is gradually removed as time progresses and the student no longer requires the scaffolding (Chambers, Theiokkter & Chambers, 2013). According to Lenski and Nierstheimer (2002), scaffolding can be either *directive* or *supportive*. Directive scaffolding focuses more on the strategies educators will use to teach the students while supportive scaffolding focuses more on the how the learner acquires the knowledge in a group (Callison, 2014). For scaffolding to be effective

Mckenzie (2012) posits that there must be clear direction on how to go about scaffolding and that the reason for the scaffolding and what is expected at the end of the scaffolding should be clearly stated. In clinical nursing education students learn the basic skills such as knowing how to vital signs, serving medications, giving bed bath to patients before moving to a more complex procedure such as catheterization etc.

iv) Articulation - is described by Sawyer (2014) as any method that is used by an educator with the aim of encouraging the student to articulate what has been learnt. It includes the use of the inquiry teaching method, thinking aloud.

v) Reflection - Collins, as cited in Sawyer (2014), refers to reflection as the way in which a student looks at their own work in relation to that of their educator or peer in order to move forward or become a better person in their area of expertise. Rodgers (2002) listed four criteria in reflection.

- Reflection is a process that makes meaning out of a previous experience in order to build up ideas and bring out new meaning from an old experience;
- Reflection is scientific in nature and involves a systematic, rigorous, disciplined way of thinking;
- Reflection does not happen in isolation, it happens in a community with interaction with other members of a community and
- For reflection to take place the person must have a culture that values growth within themself and others.

According to Donald Schön (2015) there are two types of reflection: reflection-in-action and reflection-on-action. Reflection-in-action is thinking while we carry out an action. Reflection-on-action, on the other hand, refers to the knowledge that has been accumulated from the reflection- in- action, which can now be used to solve problems (Schön, 2015). The main

aim of reflection in Cognitive Apprenticeship Theory is to enable the student to learn from their previous experiences with the anticipation of improving.

vi. Exploration - is the process by which the educator encourages and guides students to solve problems and generate new problems on their own Collins, Brown & Duguid (1987). It is the process by which students form new ideas and test the ideas they have formulated (Martyn, Terwijn, Kek & Huijser, 2014).

2.3.1.3 Sequencing

Describes the following three principles on which student learning activities should be based:

i) Increasing complexity - the educator gradually builds the complexity of a task. The educator provides support as the student moves progressively through each stage and slowly removes the support as the student progresses up the ladder from novice to expert (Collins, Brown & Newman, 1987). In clinical nursing education, the educator and or the clinical instructor accompanies students to the clinical placement area, perform a task with the student until the student is strong enough to be left alone to perform the task without the help of the educator or the clinical instructor.

ii) Increasing diversity - the student is presented with problems or tasks which are more complicated and which necessitate deeper critical thinking skills such as problem solving. Students are then guided how to select and apply problem-solving skills to several scenarios.

iii) Global before local skills - the student is required to focus on a scenario as a whole before moving to the particulars of the scenario. The educator focuses on whether the student understands the whole problem and then the educator allows the student to look into the details of the procedure.

2.3.1.4 Sociology

Sociology is the fourth and last dimension of the cognitive apprenticeship framework. It focuses on the sociology behind learning by acknowledging the fact that learning takes place in an environment which affects the quality of learning. Collins (1987) describes the four characteristics involved in the learning environment:

i) Situated learning - The term situated learning suggests that for learning to occur the individual must be placed in an environment that is contextualised to the learning and the individual must be actively involved (Aydede & Robbins, 2009). It stresses that with increased active involvement of the learner in the community of practice, which represents the activities and concepts to be learned, he or she moves up the ladder from novice in the community to an expert, provided the environment is effective in providing a community that will enhance learning.

ii) Community of practice - It refers to a group of people that are bound together by a common goal or subject matter and continue in their development and further understanding of the subject matter as a result of their interaction with one another (Wenger, 1998; Wenger, 2015, Probst & Borzillo, 2008; Kerno Jr, 2008). However, it should be noted that any group of people can be termed a community but not every community can be called a community of practice. In nursing, students are placed in the clinical setting to practice among professional nurses to help in the development of their own professional skills.

iii) Intrinsic motivation - This concept refers to the inner drive a student has that spurs them on to achieve a goal or complete a task; not necessarily because of an external reward but because he enjoys doing it (Ryan & Deci, 2014). Intrinsic motivation is very important in learning as it has been identified that a student with a high level of intrinsic motivation is most likely to do very well in school and even engage in

activities that are deemed challenging (Livingsone, Gneezy, List, Qin & Sadoff, 2016; Cskiszentimihalyi & Wong 2014; Cerasoli, Nicklon, Ford, 2014; Froiland, Oros, Smith & Hirchert, 2012). In the Cognitive Apprenticeship Model, Brown, Collins and Duguid (1989) suggest that a student's intrinsic motivation to learn is further developed as he immerses himself in the community of practice and in a situated environment. In Clinical nursing education, Clinical supervisors can encourage students' intrinsic motivation by creating a positive environment for the students during clinical placement.

iv) Exploiting cooperation - This refers to activities organised by the educator that will encourage and motivate students to work together in problem solving (Collins, 1991).

2.4 APPLICATION OF THE MODEL TO THE STUDY

The following key concepts of the Cognitive Apprenticeship Model were used to guide the research and to develop the model:

i) Community of practice - The clinical nursing environment is one which should enhance learning based on the assumption that learning occurs among like-minded students who are developing similar professional behaviour and are working towards a common goal, underpinned by knowledge. The community of practice, in the context of clinical education of a student, is the hospital or any other clinical site where the student is placed for clinical practice. According to Edward et al (2004), a supportive clinical environment will enhance a positive learning outcome for students. It will also improve the intrinsic motivation of the student which will encourage the student to do better and will increase the possibility of success (Froiland, Oros, Smith & Hirchert, 2012).

ii) Purposeful supervision of clinical practice - Purposeful supervision plays a major role in shaping future nurses and guarantees the development of professionalism of the graduate

nurse (Häggman-Laitila et al, 2007). Supervision of nursing students in the Situated Cognition Model is carried out using the cognitive apprenticeship style and the "role of the teacher is that of a facilitator" (NCSBN, 2005:4). The educator models and coaches the student and provides the needed support as the student develops confidence and competence within the clinical field. Different methods are used to stimulate thinking and reflection in the student, which encourage the student to go through the four phases in the cycle of learning as proposed by Kolb (1984) namely - concrete experience, reflective observation, abstract conceptualisation and active experimentation in order to bring about transformation of experience in the student.

iii) Learning styles - Inasmuch as a student have to pass through the four phases in the cycle of learning before learning can take place, it is important to keep in mind that each student has a preferred method or style of learning. Clinical education must therefore be structured in such a way that it encourages the individual learning styles of students and focuses on enhancing critical thinking and clinical judgment rather than that of mastering a psychomotor skill (Kolb, 1984; Sharlanova, 2004).

iv) Reflection - For learning to occur, the student must reflect on their experience to ensure transformation of that experience. According to Bulma, Lathlean and Gobbi (2013) reflective practice does not happen spontaneously, it has to be developed through innovative ways. Reflection by the educator is also important in terms of ways and innovations in which lessons in theoretical and clinical education can be delivered. Clinical instructors and professional nurses who serves as mentor to the student nurses must create enough time for reflection on the daily work of the student so as to improve on the laxity identified in the student's professional practice(Caldwell,2013).

iv) Scaffolding - Acknowledging that all students learn at a different pace, learning should be structured according to a student's need for support. Consequently, the supervisor can gradually remove the support that the student receives once a student's learning improves and deepens, and exposure is continued.

2.5 THE CIPP MODEL

According to Morgan, Oermann, Pathman, Lynn, Kpnrad, Farrar and Barmon (2014) the evaluation of nursing educational programmes is very important, as it gives insight into the merit and challenges of the programme in order to make informed decisions about the programme. Oermann and Gaberson (2016) defined evaluation as a "process of making judgments about student learning and achievement, clinical performance, employee competence and educational programmes, based on assessment data". For an educational programme to be effective it needs to be evaluated from time to time (Khodaveisi, Pazargadi, Yajhmaei & Bikmoradi, 2012).

Since the objective of the researcher is to develop a clinical nursing education model for Nigeria, the evaluation of the effectiveness of clinical nursing education in Bachelor of Nursing Science programmes at universities in Nigeria is crucial. There are several models that can be used to evaluate educational programmes but the CIPP Model of evaluation is most appropriate, based on its comprehensiveness. CIPP is an acronym that stands for *Context* evaluation, *Input* Evaluation, *Process* Evaluation and *Product* evaluation. It was developed in 1966 by Daniel Stufflebeam to guide U.S federally funded projects (Stufflebeam & Zhang, 2017). According to Scriven (2015), evaluation can either be done while the programme is still undergoing development (formative) or can be done when the development is completed and the evaluator wants to know the outcome of the programme (summative).

2.5.1 Key features of CIPP Model

One of the key features of the CIPP Model of evaluation is the involvement of stakeholders in the evaluation process. Stakeholders are those individuals that hold the resources of the company, or a programme and takes decisions about a programme. The CIPP Model requires the involvement of the stakeholder in the process of evaluation because at the end of a credible evaluation process it would be expected of the stakeholder to accept and implement the findings of the evaluation (Stufflebeam & Zhang 2017). This holds true for clinical education. When the stakeholders become aware of the strengths and challenges related to the programme, through the evaluation process, they are more likely to buy into new suggestions such as a new model for clinical education.

Another important feature of the CIPP Model is its focus on improvement. According to Stufflebeam and Coryn (2014), the main purpose of evaluation is "not to prove but to improve". The model emphasises that in order for an evaluation to achieve its aim of improvement, it "should capture and report valuable lessons from both successful and failed efforts" (Stufflebeam, as cited in Mathison, 2005). To this end, the researcher explored the experiences of stakeholders in the programme which served as the prized information that informed the development of the model for clinical nursing education in Nigeria.

2.5.1.1 Context evaluation

Context evaluation in the CIPP Model emphasises the assessment of the needs and the opportunities that are available, as well as the challenges underlining the needs and opportunities within a defined environment (Powell & Conrad, 2015; Ulum, 2016). The data obtained from this evaluation is used in the decision-making process for the programme.

In the context of this research, the CIPP model serves as a structural framework to assess the mission, goal, philosophy of the nursing programme of the four universities that were involved in the study. The accreditation status of the nursing programme offered at each

university was assessed, which was one of the criteria for a university to be eligible for inclusion in the study.

2.5.1.2 Input evaluation

Input evaluation involves the strategies that are employed by a defined environment to achieve the stated goals and objectives. It also evaluates the available resources that will assist in achieving the objectives (Stufflebeam & Zhang, 2017).

In this research, input evaluation is used to explore established resource allocation for clinical nursing education offered at universities in Nigeria. During the interview and focus group sessions and document analysis, the researcher looked into the demographic profile of the faculty, their expertise, the adequacy of the spaces available for teaching and demonstration in the laboratories and classrooms amongst other. The clinical facilities were also assessed for its accessibility to students and its resourcefulness. In addition, the admission profile of the students admitted into the universities offering the nursing degree was also investigated. Since the researcher focused on the clinical education offered in the nursing programme, questions included were: Are the objectives for the clinical practicum stated? Are the students aware of the clinical objectives? Are the professional nurses working with students in the clinical facilities aware of the clinical objectives? Are there written objectives and are they easily accessible and available to everyone that needs to assess it? Additional questions included were: Are the clinical instructors and the educators that accompany the student to the clinical placement area trained to know what to look for? Do the professional nurses in the hospital know how to support the students that are on clinical placement?

2.5.1.3 Process evaluation

Process evaluation, according to the CIPP Model, is the evaluation that looks into the process of delivery of a programme. It looks into the implementation of the programme objectives and it also guides the interpretation of the outcomes (Farsi & Sharif, 2014).

In the context of the research, the researcher looked into the evaluation of the process of delivery of clinical nursing education offered at universities in Nigeria. The researcher asked questions about the process of supervision by clinical instructors, educators and professional nurses.

2.5.1.4 Product evaluation

Product evaluation is the evaluation of the intended and unintended outcomes of a programme. It enables an investigation into the area of the programme that needs adjustment or improvement or even removal if necessary (Stufflebeam & Coryn, 2014).

In the context of clinical education, the effectiveness of the clinical nursing education offered at Nigerian universities came under intense scrutiny. The researcher asked alumni of the universities questions such as: How satisfied are you as a graduate with the nursing programme you completed? How would you describe the new graduate of the BNSc nursing programme in terms of their knowledge and their professional proficiency?

2.6 SUMMARY

The conceptual framework that guided the study in terms of data collection and data analysis, namely the Cognitive Apprenticeship Model and the CIPP Model was reviewed. Furthermore, the strength and suitability of these models for the purpose of this research were firmly established.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

Chapter three describes the research methodology used in this study. Research methodology refers to the step-by-step approach that a researcher undertakes to arrive at a logical conclusion in a research work (Creswell, 2013). It is encompassing because, in addition to providing insight into research methods or tools used in a research study, it states the reason why a particular research method is used and why other research methods are considered as not being appropriate. It also explains the philosophical assumptions behind one's choice of research design, approach and methods (Creswell, 2013). The philosophical assumptions and paradigm underlying this research study was discussed comprehensively in Chapter one. This chapter details the step-by-step methods used in each phase of the study in order to achieve its research objectives.

3.2 RESEARCH APPROACH

Creswell (2013) regards a research approach as a plan or procedure that outlines how to conduct research - from the research design and how to utilise data collection to the analysis of the data collected during the research. In the world of research, there are generally two main approaches: the qualitative and the quantitative approach (Flick, 2015). Creswell (2013) also offers a third approach which he calls the mixed method or multiple methods.

The quantitative approach and the qualitative approach, according to Newman and Benz (2008), exist in a holistic continuum that interacts continuously. The quantitative approach is used to explain existing phenomena using a scientific and précised method for analysis (van

Raan, 2013). A major assumption in a quantitative approach is that previous data generated can be reproduced. In contrast, the qualitative approach is used for assessing subjective data from individual perspectives about a social phenomenon (Creswell, 2013). The mixed method approach, according to Clark and Ivankova (2015), refers to the integration of both qualitative and quantitative methods of research into one single research study. This method is used when a researcher wants to have a better understanding of a phenomenon, when one research approach is unable to provide sufficient background or data to the phenomenon under investigation, and when the data collected from both research approaches would complement one another (Plano Clark, Anderson, Wertz, Zhou, Schumacher & Miaskowski, 2015).

3.2.1 Qualitative approach characteristics and application to study

A qualitative approach is used when little or no knowledge exists about a phenomenon or concept (Holloway & Galvin, 2016; Creswell, 2013). The qualitative research study, according to Denzin and Giardina (2016), takes place in its natural setting and by utilising a qualitative approach a researcher gives meaning to a phenomenon, according to the meaning ascribed to it by the participants.

A qualitative research approach was implemented in this study. The main objectives of the research were to explore the effectiveness of clinical nursing education in Bachelor of Nursing Science programmes at Nigerian universities and to develop a model from the data generated that will guide the clinical education of a nursing programme. At the time of conducting research, little or no knowledge existed about the model that guides the clinical education in nursing programmes in Nigerian universities. The researcher observed that nurse educators conducted the clinical education according to their own understanding.

The characteristics of a qualitative approach described below, as highlighted by Patton (2005), provide the rationale for choosing a qualitative research approach for this study.

3.2.1.1 Qualitative design strategies

- Naturalistic inquiry - refers to the study of a phenomenon as it presents itself without altering or manipulating the findings of the study. The researcher studied clinical education in its natural setting as offered at each university that participated in the study. The researcher visited the location of each university, as well as all major hospitals that are used for the clinical practicum in each university programme.
- Emergent design flexibility - refers to the ability of a researcher to adapt to new ways as events unfold in the study in order to obtain maximum results. Flexibility in this study was applied when the researcher discovered that the focus group discussions among the educators, as per the proposal, were not possible due to the work load of the educators. In addition, challenges were experienced with regard to their availability to come together for a focus group. Consequently, the researcher was required to change the data collection method to semi-structured interviews.
- Purposeful sampling - refers to the choice of participants for the study because of their relationship to the study or the information they hold concerning the study. Since the research focuses on clinical education in the Nigerian universities, the researcher used the following selected universities in the south west geo-political region of Nigeria: two federal universities, one state university and one private. The University of Ibadan was the first university in Nigeria to offer a university degree programme for nursing, albeit their programme was mainly designed for nurses who had finished their diploma in nursing and were already practicing as a nurse. The main philosophy of the programme was to train nurse leaders for the community. The programme focused on nursing education, nursing administration and nursing research. The university has now transitioned to offering a university degree programme that is offered throughout the country and targets secondary school graduates. This

university was selected because it enabled the researcher to get a better grasp of the clinical education offered in the previous programme, as well as the one offered in the current programme.

The second federal university that was selected for the study was the Obafemi Awolowo University, Ile-Ife. This university has the reputation of being the first university to have run a generic nursing programme in a Nigerian university. The programme was adopted by the Nigeria University Commission in 1999 and currently serves as the universal nursing programme in Nigeria.

The third university selected was the state university, Ladoke Akintola University of Technology (LAUTECH) who runs both the part-time and full-time nursing programmes. The rationale for selecting this university was to explore how clinical education is offered in both these nursing programmes.

Babcock University Ilishan- Remo, Ogun State, a private university, served as the final selection. It was selected because it is privately funded. The researcher wanted to establish whether this fact has had any influence on the way clinical education is offered at the university.

3.2.1.2 Data collection and fieldwork strategies

- Qualitative data - refers to data collection methods, such as observation, interviews and document reviews that can be used to generate data about the focus of the study obtained from the participants.

  The researcher used in-depth interviews and focus group discussions as a means of data collection to obtain the participants' personal perspectives. The researcher also

reviewed documents that dealt with the clinical education offered in the nursing schools.

- Personal experience and engagement - refer to utilising a researcher's experience and understanding of the phenomenon that is under investigation, and the ability of the researcher to get close to the participants or to immerse himself or herself in that specific investigation.

In the study, the researcher who is a lecturer at one of the universities that accompanied students to clinical practice has a good relationship with most of the respondents at the other universities. The researcher moderated the focus group discussions herself and conducted all the in-depth interviews. The researcher kept field notes so has to capture all the non-verbal expressions and observations of what was happening during the interview.

- Empathic neutrality and mindfulness - refer to the ability of the researcher to listen to information provided by participants or to observe a phenomenon without being judgmental or biased about the information.

During the interviews the researcher showed the respondents respect by addressing each participant according to their rank, and according to the norms of the cultural setting. Questions that were not understood by the participants were explained in ways that were more understandable to them. The researcher was observant and focused intently on the participants during the interview and focus group discussions.

- Dynamic systems - refer to the ability of the researcher to understand the dynamics, style or any change that may occur at any time of the phenomenon under investigation.

The researcher explored the dynamism in clinical nursing education offered at each of the universities involved in the study.

3.2.1.3 Analysis strategies

- Unique case orientation - refers to the assumption that each subject in a study of a phenomenon is unique and that the researcher accepts and respects the information being given as true. It is regarded as the first level of analysis.

  All the data obtained from the participants were transcribed verbatim without alteration of the data.

- Inductive analysis and creative synthesis - refer to the ability of a researcher to immerse themself in the data in order to identify themes and relationships.
  In the study, the researcher immersed herself into the data by reading and re-reading in order to identify themes and relationships.
- Holistic perspective - entails looking at the components of the phenomenon under investigation as a whole and understanding it as such.
  In the study, though the researcher had four study group participants she viewed the information obtained from the groups as a whole rather than separate.
- Context Sensitivity - refers to the ability to ensure that the research study is transferable. The researcher used the universities that were controlled by the federal, state and private government to ensure that findings gotten from the study can be applied across all types of universities in the country.
- Voice, perspectives and reflexivity - refer to the ability to have one's voice expressed in a research study without losing the richness of the data collected. The researcher added her own understanding during the write-up without losing the uniqueness of the information gotten from the participants in the study

3.3 RESEARCH DESIGN

A research design is viewed as a map that leads a researcher to an expected destination. Consequently, it involves various methods used by a researcher to collect and analyse data that will best answer a particular research question (Van Wyk, 2015; Babbie, 2013; Vos, Strydom, Fouche & Delsport, 2012; Polit & Beck, 2010). A research design can best be chosen when one knows why and what one wants from a research study. An appropriate research design greatly assists in accomplishing the best result in a research work. However, a wrong research design can lead to an incorrect research result and conclusion.

This study was conducted in two phases.

- The first phase was the explorative and descriptive phase, which explored what exists in terms of clinical nursing education offered in the Nigerian universities. It addresses the first main objective, namely, to explore the context in which clinical education is offered, the input for clinical education, the process that was followed to deliver the clinical education and the product that is being offered.
- The second phase encompasses the theory generating design which adopted concept synthesis rather than concept analysis to enable the development of the model for the delivery of clinical nursing education at Nigerian universities. It addresses the second main objective which is to develop the model of clinical nursing education in Nigeria.

3.3.1 Exploratory design

An exploratory investigation is conducted to gain a deeper understanding or knowledge about a concept and to identify concepts and constructs from a study (Babbie & Mouton, 2012). Exploratory research design is appropriate for this study because little is known about clinical education in Nigeria. The researcher therefore explored clinical nursing education in Bachelor of Nursing Science programmes at universities in Nigeria, through the experiences

of student nurses and graduates during their clinical practicum and perception of the educators and professional nurses

3.3.2 Descriptive design

Descriptive research study is concerned with giving a detailed account of a phenomenon or situation without altering or changing anything in the account of the situation. It answers the questions of what, where, who and how but does not give an answer to why a situation presents itself in a particular manner (Babbie, 2013; Babbie & Mouton, 2012; Polit & Beck, 2010). Descriptive research usually follows exploratory research in a qualitative approach. According to Rubin and Babbie (2005:125), descriptive research leads to "a thicker description" of a phenomenon in qualitative research. The descriptive study is therefore appropriate for this investigation because its objective was to give a detailed description of clinical education offered in Nigerian universities as perceived by the students, graduates, professional nurses and educators in the nursing departments of these universities.

3.3.3 Theory generative design

The model for the delivery of clinical education for Nigerian universities was developed following the theory generating process, as postulated by Chinn and Kramer (2011). This study focuses on generating empiric theory as "a creative and rigorous structuring of ideas that projects a tentative, purposeful and systematic view of phenomena" (Chinn & Kramer, 2011:157). This design is suitable since it is based on the experiences of the participants garnered during the exploratory descriptive phase described above.

The research methods for each of the two phases are described comprehensively in the following section of this chapter.

3.4 PHASE 1: EXPLORATORY DESCRIPTIVE

3.4.1 Population and sampling

Research population refers to "the entire aggregation of cases that meet specified criteria", according Polit and Beck (2007:259). The study population in this investigation comprises of all the students in 300, 400 and 500 level of the programme; nurse educators at each university; professional nurses in the wards where students have their clinical practice and the alumni (nurse graduates) of each university. The tables below present the target population at the four schools of nursing included this study.

Table 3.1: Student population

University	300 level	400 level	500 level
University of Ibadan	27	37	42
Obafemi Awolowo University	86	81	80
Ladoke Akintola University of Technology	69	52	109
Babcock University	64	42	48

Table 3.2: Nurse educator and clinical instructor population

University	Clinical instructors	Educators
University of Ibadan	3	11
Obafemi Awolowo University	1	16
Ladoke Akintola University of Technology	1	12
Babcock University	6	13

Table 3.3 Professional nurse population

University	Professional nurses
University College Hospital	1200
Obafemi Awolowo University Teaching Hospital	650
Ladoke Akintola University of Technology Teaching Hospital	650
Olabisi Onabanjo University Teaching Hospital (Babcock University clinical site)	600

For the alumni population in table 3.4 the researcher considered the number of BNSc sets (cohorts) which had graduated at the universities since the inception of the BNSc programme at each university.

Table 3.4 Alumni population

University	Total number of BNSc sets
University of Ibadan	14 sets
Obafemi Awolowo University	36 sets
Ladoke Akintola University of Technology	14 sets
Babcock University	14 sets

Obafemi Awolowo University had the most BNSc sets that graduated. The reason is it is the first university that initiated a BNSc Programme in 1977. The University of Ibadan had only fourteen sets even though it was the first university to start nursing programmes in general. A "set" in this context means the group or cohort of graduates that graduated in a particular year. However, the university only commenced its BNSc programme in 1999. Babcock University and Ladoke Akintola Uiversity of Technology also commenced their respective nursing programmes in 1999.

3.4.1.1 Sampling technique

A sample is a representative unit of a population that is to be studied (Polit & Beck, 2006; Vos, Strydom, Fouche & Delport, 2011). A sample in any given research is very important because choosing a wrong sample size or frame can affect the results of the study (Onwuegbuzie & Leech, 2007). Sampling is therefore the process of choosing the sample units that will represent the population to be studied (Polit & Beck, 2010). Sampling in quantitative study differs from that in a qualitative study because in quantitative study a sample is chosen with the objective to best represent a population that can be statistically tested to prove a hypothesis whereas in qualitative study the sample is not statistically tested (Vos, Strydom, Fouche & Delport, 2011).

Two types of sampling techniques are mainly used in research: probability and non-probability. In quantitative research, the probability sampling technique is used most often while the non-probability sampling technique is used in qualitative research (Polit & Beck, 2010; Vos, Strydom, Fouche & Delport, 2011). The non- probability sampling technique that was used in this qualitative research study is known as judgment or purposive sampling (Tongco, 2007), where informants are selected because of their unique characteristics (Polit & Beck, 2010; Vos, Strydom, Fouche & Delport, 2011; Oppong, 2013).

In this research study, purposive sampling method was used to sample participants who were knowledgeable about clinical education in the Bachelor of Nursing Science programme offered at Nigerian universities. The participants were selected based either on their experience as a student (students and graduates) of the clinical nursing education in Nigeria, as a facilitator of clinical nursing education (educators, clinical instructors and heads of departments), or as a key informant within nursing education (professional nurses).

Participants were chosen based on the following inclusion criteria:

i) Students: students were in their third to fifth year and were currently on clinical placement

ii) Educators: educators involved in phase one and phase two of this study had at least a Master's Degree in Nursing which enhanced the level of expertise and understanding of clinical education.

iii) Professional nurses: a few of the nurses had at least a first degree in Nursing but all were working in the wards that the students use for their clinical practice. This ensured that the nurses involved in the study had a better understanding of what should inform a Bachelor of Nursing Science programme.

iv) Graduates: the graduates who participated in this study had at least two years post-graduation experience and are presently working in a clinical facility. This criterion was based on the assumption that a graduate with two years' post-graduation experience would have a better perspective of the clinical education he or she experienced in the university, as well as the reality of working in a clinical facility. *Representatives from NMCN (Nursing and Midwifery Council of Nigeria)*: all representatives hold a master's degree in Nursing and form part of the accreditation and evaluation team in the education section of NMCN.

v) Participants in the study also had a common language since English is the official language spoken in Nigeria.

3.4.1.2 Sample demographics

The following tables present limited demographics per sample. The demographic information, which was not an objective of this study and therefore not presented in chapter 4, will provide context for understanding the findings.

Table 3.5: Student demographics

University	Sample size	Sample size per gender	Average age
University of Ibadan	29	Male – 7 Female – 22	26 Years
Obafemi Awolowo University	26	Male – 8 Female – 18	28 years
Ladoke Akintola University of Technology	22	Male – 5 Female – 17	26 years
Babcock University	25	Male – 4 Female – 21	23 years

Table 3.6: Nurse Educator demographics

University	Sample size	Sample size per gender	Average age	Qualification
University of Ibadan	7	Female – 7 Male – 0	48	PhD - 4 MSc- 3
Obafemi Awolowo University	5	Female – 2 Male – 3	54	PhD - 3 MSc - 2
Ladoke Akintola University of technology	7	Female – 6 Male – 1	58	PhD - 2 MSc - 5
Babcock University	10	Female – 7 Male – 3	59	PhD - 4 MSc - 6

Table 3.7: Professional nurse's demographics

University	Sample size	Sample size per gender	Average age	Qualification
University College Hospital	22	Female – 22	40	BNSc - 4 Diploma – 18
Obafemi Awolowo Teaching Hospital	12	Female- 9 Male -3	45	BNSc - 4 Diploma – 8
Ladoke Akintola University of Technology Teaching Hospital	21	Female- 21	50	BNSc – 3 Diploma – 18
Olabisi Onabanjo University Teaching Hospital	9	Female- 9	55	BNSc – 2 Diploma – 7

Table 3.8: Alumni demographics

University	Sample Size	Sample size per gender	Average age
University of Ibadan	7	Female - 4 Male – 3	32
Obafemi Awolowo University	7	Female - 2 Male – 5	30
Ladoke Akintola University of Technology	7	Female - 4 Male – 3	32
Babcock University	8	Female - 2 Male – 6	27

3.4.2 Access to the site

The researcher gained access to the study site by obtaining ethics clearance from the ethics committee of each of the relevant universities and hospitals. Appointments were set, according to the availability of participants, through the head of the nursing department at each university. The professional nurses were accessed through the Continuing Education Unit of the hospitals. The researcher met with the head of the unit who selected the participants for the study. A time was arranged based on their availability. For the alumni, the researcher contacted the alumni and made appointments telephonically and then travelled to the place of work of each of the alumni to meet with them in order to interview them.

3.4.3 Data collection methods

There are four major ways of collecting data in qualitative research: active participation, direct observation, interviews and document analysis (Onwuegbuzie, Leech & Collins, 2010). In this research study, a combination of data collection methods were used, which included interviews, both semi-structured and focus group interviews, and document analysis. The data was collected over a period of one-and-half months between 8 March and 30 April 2015.

3.4.3.1 Semi- structured interviews

This type of data collection method is useful when one is interested in questioning participants to receive answers concerning a topic (Polit & Beck, 2010). An interview entails communication between two people, the person asking the questions (interviewer) and the person responding to the questions (a respondent). During an interviewing session the interviewer has a plan and guides by asking questions to the respondent. These questions may not necessarily be in a particular order (Galletta, 2013; Babbie & Mouton, 2012; Crowther & Lancaster, 2009). Interviewing is the most common method of data collection in qualitative

research (Babbie & Mouton, 2012). One-on-one interviews such as semi-structured interviews are useful in a case when it is challenging for a researcher to get more than one participant together at the same time in order to conduct a focus group interview or discussion, and when the researcher would like to probe for depth. The latter was appropriate in this study because some of the participants were not readily available to attend a focus group discussion. Each interview lasted about 30-60 minutes.

i) Interviews with head of departments

The head of nursing departments at each university were interviewed in their respective offices. For the period of the interview, a notice was put on the door so as to reduce interference during the interview session. The study was explained to the participants before the signing of a consent form. The head of departments were interviewed separately because of their busy schedules and because of their role as decision makers in the department. The researcher interviewed them based on their knowledge of the context pertaining to clinical nursing education. The CIPP model emphasizes the importance of the involvement of stakeholders in order to influence their acceptance of the findings which will be generated by the research (Stufflebeam, 2014).

ii) Interviews with educators

The researcher proposed to conduct focus group discussion with educators. However, at two of the universities in the study, the educators were interviewed one on one because there was no suitable time for the educators to meet as a focus group due to their busy work schedules. The researcher reverted to individual interviews with the educators which were conducted in their offices at a time convenient to them. They were also briefed about the study before signing a consent form. The educators were interviewed based on their teaching experience

with the students and their involvement in clinical nursing education. In total 12 interviews were conducted with the educators.

iii) Interviews with graduates

Twenty- nine interviews were conducted with the graduates of the four universities. The researcher contacted the alumni telephonically. The researcher gained access to the graduates through friends and the educators at the universities and was subsequently able to schedule a convenient time for the interview. The researcher selected alumni that were staying in the vicinity of the universities or in a state close to the researcher's place of residence. The interview was conducted in the homes and hospitals of the participants according to their request. When interviews were conducted at the home of a participant the researcher chose a quiet time with little or no interference. In the hospital, the break periods of the participants were used and the participants usually located a room within the hospital where there will be sufficient lighting and reduced noise. Each interview session lasted for 30- 50 minutes and was recorded. Each participant gave his/her consent by signing a consent form.

3.4.3.2 Focus group discussion

This refers to a group interview that is focused on getting in- depth information from the participant concerning a research theme (Vos, Strydom, Fouche & Delport, 2011). Participants in a focus group have a similar background, share certain things in common and freely discuss a topic as guided by the facilitator who keeps the group on track (Cheng, 2014). Focus group discussions help the group members to work together. It is very useful when one needs in-depth probing but speedy results. In this study, the researcher held twelve focus group sessions with students - three in each university, two focus group sessions with educators and five focus group sessions with professional nurses. In total, the researcher held nineteen focus group sessions.

a) Advantages of focus group discussions

- It is a fast and economic data collection method to obtain information at the same time from a group of participants in a study (Krueger & Cassey, 2000).
- It brings together a large group of participants in a study over a short period of time (Babbie & Mouton, 2012).
- It creates a social environment for the participant (Krueger, 2000).
- There is a sense of belonging that comes with the participation in a focus group discussion hence it creates an atmosphere for members to freely talk among each other (Onwuegbuzie, Dickinson, Leech & Zoran, 2009).

b) Disadvantages of focus group discussions

- There is a possibility that the facilitator of the discussion could be bias.
- The discussion could be dominated by few individuals thereby resulting in a change in the focus of the main discussion.
- The analysis of the data obtained in a focus group discussion can be time consuming. Therefore there is need for proper planning well before the focus group discussion takes place.
- Information provided is not at a personal level but at a group level and may not even be representative of other groups.

  Adapted from (Center for Disease Control and Prevention) CDC (2008).

The researcher remained cognizant of the above challenges inherent in focus group and discussions and was able to avoid possible influences on the data collection process.

i) Focus group discussion with students

In order to facilitate a similar background among participants, the researcher used the level of the school year of the students to group them. Hence willing participants of the 300, 400 and 500 level in each of the universities formed a focus group discussion each. Since one of the characteristics of having a good interview is to conduct the interview in a cool, conducive and quiet environment (Vos, Strydom, Fouche & Delport, 2011), the focus group discussions were conducted in the school and hospital environment respectively. For the students who were not on duty on the particular day that the sessions were scheduled to be conducted, the researcher used one of the classrooms in the hospital that were not occupied; the nurses' common room was used for the discussion in the four universities. To ensure that all participants were involved in the discussion the researcher encouraged each participant by asking each person's opinion on the theme that was discussed at a particular time.

ii) Focus group with educators

Two focus group discussion sessions were conducted at two universities. In each of them, participants were allowed to freely indicate their interest in the session, the purpose of the discussion was explained to them and consent forms were signed. At one university, the discussion took place in the nursing demonstration room and the other, in the department's board room. Participants were encouraged to talk and voice their opinions, and when they went off topic the researcher, who acted as the facilitator, brought them back to the focus of discussion.

iii) Focus group with professional nurses

Five focus group discussions were held with professional nurses, two in a particular hospital and the remaining three in the other three hospitals. Participants were informed by their

respective heads of units of the continuing education center, and the names of those who indicated their interest were submitted to the researcher. The researcher then contacted these professional nurses and a time was scheduled for the discussion. The discussions were held in the nurses' common room and each participant signed a consent form and confidential binding form as well. The researcher also acted as the facilitator in each of the focus group discussions and brought the participants back on track when it seemed that they were derailing from the discussion.

3.4.3.3 Document review

According to CDC (2009), document review is a method of data collection for evaluation, which analyses existing documents in order to understand the underlying meaning in a document. There are two main sources of documents, private and public documents, and each is kept for different purposes. Document reviews can be done using different techniques, such as content analysis, textual analysis, semiology and linguistic analysis, depending on the goal of the researcher (Vos, Strydom, Fouche & Delport, 2011). In this study, content analysis was used, which mainly interprets the meaning a document may carry. Documents that shed more information on clinical nursing education, teaching philosophy, objectives of clinical nursing education, as well as guiding principles on practices of the clinical nursing education offered in each of the universities were also reviewed.

3.4.3.4 Field notes

Field notes are simply written records of the researcher's observation of the participants and the researcher's experiences while in the field. It is the written observation of people's expressions, both verbal and non-verbal, that can provide additional meaning to the data collected in the field (Marshall & Rossman, 2014). There are two major types of field notes, descriptive and reflective field notes, according to Bogdan and Biklen (2007). Descriptive

field notes, as the name implies, describe in accurate detail what the researcher observes and experiences in the field by sometimes using the specific words the researcher has heard to give valuable insight into the study. On the other hand, reflective field notes are the field notes that build on descriptive field notes through personal reflection and account of what the researcher is learning and perceiving about the study (Ritche, Lewis, Nicholls, & Ormston, 2013)

The researcher documented both descriptive and reflective field notes of what transpired at each interview and focus group discussion, the words that had an impact, as well as the facial expressions of some of the participants during the interview. These field notes assisted in the classification during transcription to highlight the true meaning of the words that were said in addition to the respective facial expressions.

3.4.4 Data Analysis

Data analysis is the careful examination of systematically gathered information, simplification of the complexity in the data and examination of the data for patterns of similarities and differences for the purpose of coming to an intelligent conclusion on the data (Neuman, 2016; Babbie & Mouton, 2012). According to Vos, Strydom, Fouche and Delport (2011), data analysis generally follows the inductive approach, though traditionally, the analysis of qualitative data is rooted in the various approaches of research, such as grounded theory, phenomenology, discourse analysis and narrative analysis (Polit & Beck, 2010; Thomas, 2006). A common analytic strategy however is the general inductive analysis that is referred to as “approaches that primarily use detailed readings of raw data to derive concepts, themes, or a model through interpretations made from the raw data by an evaluator or researcher” (Thomas, 2006:238). The analysis of data from the semi-structured interviews

and focus group discussions followed a general inductive approach using the following steps as outlined in Vos, Strydom, Fouche and Delport (2011):

- Planning for recording of data - A researcher should plan for the recording of the data in a systematic way that will enhance the analysis even before the data collection begins. The researcher in this study used a Panasonic MP3 recorder for the recording and the recordings were organized according to each university
- Data collection and preliminary analyses - At the end of each day, the researcher transferred the recording to a file on a computer system and on a memory stick for safe keeping with the name of each university and group in the university used as the title of each of the files. At the end of the whole recording session, the researcher grouped all the students of the four universities into one folder and repeated the same procedure for the educators, professional nurses and the alumni, and assigned a code to each one for easy identification. After the first focus group discussion, the researcher sent a copy of the audio to her supervisor to check if the researcher was on the right path with her questioning, and corrections were made to the pattern of asking questions, if necessary. Reflective field notes were kept, especially on facial expressions and the manner in which the questions were answered, the environment, and the enthusiasm of the students, educators, professional nurses and graduates.
- Managing the data - The data, as mentioned was organized into folders - all students of the four universities were placed into one folder, as were the educators, the professional nurses and the alumni. Transcription was done verbatim by the researcher to allow for immersion into the work and further understanding on how to categorize identified themes and concepts. The transcription lasted for a period of six months. The researcher used an online transcription and dictation software from www.transcribewreally.com to facilitate the transcription. The audio files were then

saved on a memory stick and Google cloud for safe keeping. The researcher completed 58 transcripts comprising of between 15 and 27 pages.

- Reading and writing memos - The researcher used Atlas Ti 7 software during the analysis at first but later reverted to reading the transcript manually that is without the use of the software in order to understand them better. Several codes were identified.
- Generating categories and coding the data - At the initial stage, the researcher used Atlas Ti7 for the coding of the transcripts. The researcher used an open coding system, which according to Vos, Strydom, Fouche and Delport, (2011) refers to assigning a name and categories to data after careful examination of the data, which emerges from the data that was read. The researcher printed 115 codes. The researcher further reduced the codes by placing them into categories, sub-themes and themes.
- Testing the emergent understandings and searching for alternative explanations - Themes that emerged were guided by the concepts derived from the cognitive apprenticeship model. The researcher also evaluated the themes that emerged to investigate whether they were relevant to the stated research objectives and if it could assist in answering the said objectives. The researcher also noted certain categories that did not answer the research questions directly but came out significantly in the process of analysis.
- Interpreting and developing typologies and presenting the data - Chapter four provides the full research report of the data.

3.4.5 Measure to ensure trustworthiness of the research

According to Polit and Beck (2010) and Anney (2014), the model proposed by Lincoln and Guba in 1985 for assessing the trustworthiness of qualitative research remains the ‘gold

standard'. Consequently, the study used the following four proposed criteria to establish trustworthiness:

3.4.5.1 Credibility

This criterion seeks to ensure that a study is measuring what it has set out to measure. It is the first and very important criterion in establishing trustworthiness in a qualitative research (Houghton, Casey, Shaw & Murphy, 2013). There are several steps in ensuring credibility in a study, of which four were applied by the researcher in this study, namely, data source and method triangulation; peer debriefing; prolonged engagement and member checks.

i) Data source and method triangulation is the process that serves to strengthen the validity of data obtained from research by using different research methods and sources (Yeasmin & Rahman, 2012; Carter, Bryant-Lukosius, Dicenso, Blythe & Neville, 2014). The following types of triangulation can be present in a qualitative research study: data triangulation; investigator triangulation; methodological triangulation and theory triangulation (Pattson, 1999; Denzin, 1978). In this study the researcher used data and methodological triangulation.

- Data triangulation refers to the use of different data sources, including person, place and time. The data were collected from students from different levels - 300, 400 and 500 levels from the four universities; educators from the four universities, professional nurses from the four teaching hospitals attached to the universities and alumni from the four universities included in the study.
- Methodological triangulation entails using more than one kind of method to understand a phenomenon. There are two types of methodological triangulation, within a method and across methods (Bekhet & Zauszniewski, 2012). The researcher used triangulation within methods, which is the use of different data collection

methods within research. Data collection methods such as document analyses, focus group discussions and semi-structured interviews were also used. For the educators, the researcher used two different data collection methods, namely, interviews and focus group discussions since at two universities; the educators were not available for a focus group discussion. The researcher then merged the analysed data of the educators to form categories and themes. In addition, the researcher conducted semi-structured interviews with the head of departments so as to be free from biases or influences of the educators during focus group discussions.

ii) Peer debriefing is the process a researcher utilises by working with one or more colleague to help clear misconceptions, clarify ideas and to ensure an impartial judgement concerning the research work (Vos, Strydom, Fouche & Delport, 2011; Onwueegbuzie, Leech, & Collins, 2008). In this research study, the researcher's supervisor interviewed her on the questions that were to be asked during the interview sessions and what the researcher was looking for in the relevant documents. Misconceptions were cleared and further clarification and insight were provided to the researcher. In addition to this, the researcher had discussions with her colleagues, who had also use similar forms of data collection methods in the past, to gain their input, which provided further insight into the study. The researcher was also interviewed by a colleague, who is an economist, but experienced in qualitative research to see if the methods proposed were correct and further inputs were also provided. Samples of the transcripts were read by the supervisor and trusted colleagues who had previously had their work transcribed and analyzed to ensure that the researcher was on the right track.

iii) Prolonged engagement. The researcher has an existing relationship with the universities that were used in the study. She was able to engage with participants to

gain a deep understanding of the phenomena. However, the researcher avoided personal bias and remained mindful not to influence the outcome of the research.

3.4.5.2 Dependability

The ability of data to remain consistent - even when the research is carried out at a different time using the same persons and methods - is critical in qualitative research (Houghton, Casey, Shaw & Murphy, 2013). In order to ensure dependability, the researcher employed the inquiry audit technique which entails keeping an audit trail of the process of the research, and which allows for data obtained to be scrutinised by an external reviewer (Polit & Beck, 2010). The supervisor served as the external reviewer. Independent verification of coding was done randomly by the supervisor.

3.4.5.3 Confirmability

Confirmability refers to the "objectivity or neutrality of the data" (Polit & Beck, 2006:336). It can be achieved by developing an audit trail, which serves as documentation of the research process so that an external reviewer can audit the process. This includes documenting the whole process of research starting from the raw data to the final report. The researcher achieved this by involving the supervisor in the various processes - from the collection of the data to the final report so that the process can be thoroughly assessed. Verbatim quotes from the participants were also used in the writing of the report to enhance credibility of the study.

3.4.5.4 Transferability

Transferability refers to the extent to which the result of a study can be transferred to other settings (Polit & Beck, 2006). Transferability can be achieved by providing a thick description about the entire research study. The researcher provided a thick description of the

study as a whole for the objective of transparency and ease of comprehension of the research process for the readers hence the research can be transferred to other settings.

Table 3.9: Summary of phase one methodology process

Specific objectives	Methodology		Theoretical framework
	Data sources/collection method	**Data analysis**	
1. To explore and describe the context for clinical nursing education offered at universities in Nigeria	<u>Population</u> • Student - Focus group discussion • Educators - Focus group discussion - Semi-structured interview • Graduates - Semi-structured interview <u>Sampling</u> • Purposive sampling	Inductive analysis Synthesis	CIPP model • Context evaluation
2. To explore and describe the resource allocation for clinical nursing education offered at universities in Nigeria	<u>Population</u> • Student - Focus group discussion • Educators - Focus group discussion - Semi- structured interview • Professional nurses - Focus group discussion • Alumni - Semi- structured interview <u>Sampling</u> • Purposive sampling	Inductive analysis Synthesis	CIPP model • Input evaluation
3. To explore and describe the process of delivery of clinical nursing education offered at universities in	<u>Population</u> • Student - Focus group discussion • Educators - Focus group discussion	Inductive analysis Synthesis	CIPP model • Process evaluation

Nigeria	- Semi- structured interview • Professional nurses - Focus group discussion • Alumni - Semi- structured interview <u>Sampling</u> Purposive sampling		
4. To explore and describe whether the clinical nursing education offered at universities in Nigeria is effective	<u>Population</u> • Student - Focus group discussion • Educators - Focus group discussion - Semi- structured interview • Professional nurses - Focus group discussion • Alumni - Semi- structured interview <u>Sampling</u> Purposive sampling	Inductive analysis Synthesis	CIPP model • Product evaluation

3.5 PHASE2: THEORY GENERATION

3.5.1 Elements of theory building

According to Polit and Beck (2010), a theory provides an explanation in terms of how events are interrelated, while a conceptual model provides a visual or graphic explanation of how concepts are interrelated. Theories are developed from three basic elements, namely, concepts, statements and theory and can be achieved through the following three basic processes: derivation, synthesis and analysis (Walker & Avant, 2014). In this study, model development rather than theory development has been performed. However, the following process of theory generation was followed:

- **Concepts**

According to Avant and Walker (2014), concepts are the blocks on which theories are built and they represent the image formed in the mind concerning an action. Exploratory descriptive studies, which are free of bias, are useful methods for the development of theories. Concepts are generated through inductive iterative analysis of the data obtained from the exploration (Baxter & Jack, 2008). Chinn and Kramer (2015) opined that we give meaning to a concept through words, events and feelings and attitudes which surround the words and events. Concepts that formed the building blocks of the proposed clinical nursing education model in this study were derived from themes and categories that emerged from the inductive analysis of the data obtained during document analysis, interviews and focus group discussions conducted with participants who were knowledgeable about the phenomenon under investigation.

- **Statements**

Statements represent an important aspect of theory building since it expresses how concepts are related to one another. According to Avant and Walker (2014), statements can be expressed in two forms - relational statements and non-relational statements. A relational statement, as the name implies, refers to two or more concepts in a theory which are related to one another. A non-relational statement gives the operational or theoretical definition of the concepts in terms of the proposed theory. This is very important as it provides the platform for testing and validating the theory (Chinn & Kramer, 2015; Walker & Avant, 2014). Relational statements were developed in this study to clarify how each concept in the model was related to one another. The operational definitions of the concepts in the model of clinical nursing education were given to elucidate a deeper meaning and correct understanding of the concept.

- **Theories**

A theory is a cluster of relational statements that is used in the explanation and prediction of a new idea or occurrence. A model of clinical nursing education was developed that demonstrated how the concepts interrelate with one another.

3.5.2 Approaches to theory building

The process of theory building, according to Walker and Avant (2014), may require the developer of a theory to move back and forth through the various approaches to theory building. The theory building blocks synthesis and derivation are cognisant of the fact that no single approach is sufficient to meet all the needs of theory building (Walker & Avant, 2014). This holds true for this investigation since the researcher moved between the various approaches.

The following three processes inform theory building:

- **Analysis**

Concept analysis is a process that involves clarification of the concepts that is being used in a theory or model. It provides a correct understanding of what a concept means and also serves as a basis for evaluating the model (Avant & Walker 2014).

- **Synthesis**

The process of synthesis was used in this study which enabled the researcher to develop a model for clinical nursing education for Nigerian universities. A process of concept synthesis begins by procuring raw data from existing data or newly generated data obtained from interviews and observations. The raw data for this study was generated from both existing data obtained from the document review and new data obtained from interviews and focus group discussions with participants. The raw data were then analysed to form clusters of categories and themes from which concepts were generated. A detailed description of the process that was followed in this regard is provided later in this chapter.

- **Derivation**

In concept derivation, the concept is defined or redefined as it relates to the theory being developed. In this process, the developer of the theory carefully studies the literature to ascertain the existing meaning of a particular concept of interest, and either juxtaposes that meaning to the current theory, or redefine the concept to suit its present meaning in the theory.

3.5.3 Steps in model development process used in this study

The following three steps were used in the process of development of a model for clinical nursing education in Nigerian universities:

3.5.3.1 Step 1: Concept synthesis

In this study, synthesis commenced by identifying concepts that emerged from *empirical evidence generated through the exploratory descriptive study* in phase 1. The methods used included focused group discussion, semi- structured interview and literature control.

- **Identification of the concepts and main concepts**

The researcher used inductive reasoning to identify the main concepts of the model after the data was analysed inductively. The selection of concepts was guided by the purpose of the study and the researcher's values, beliefs and attitudes about nursing (Chinn & Kramer, 2015). The researcher ensured that the selected concepts were not too broad or too narrow to avoid the possibility of them losing their contextual meaning (Chinn & Kramer, 2015). A total of 15 concepts were identified from the 7 concluding statements developed from horizontal themes, which emerged from the analysis of the data. Concept synthesis was done by examining the similarities and differences of the selected concepts and resulted in six main concepts. These main concepts were used to develop the model for clinical nursing education for Nigerian universities.

- **Classification and definition of concepts**

Chinn and Kramer (2015) suggest that in order to derive meaning from a concept it must be classified and defined. To achieve this, they suggest that it is essential to read widely on materials related to the concept. Concepts were classified according to the survey list of Dickoff, James and Wiedenbach (1968) which highlights the following six questions which the researcher considered:

- Agency (Who or what performs the activity?)
- Recipient (Who or what is the recipient of the activity?)
- Framework (In what context is the activity performed?)
- Terminus (What is the end point of the activity)
- Procedure (What is the guiding procedure, technique or protocol of the activity?)
- Dynamics (What is the energy source for the activity- whether chemical, physical, biological, mechanical, or psychological?)

The concepts were then defined using the following three strategies: dictionary definition, literature, and the input of experts in the field of nursing clinical education. This was performed to ensure that the concepts were fit for purpose. These definitions of the concept, derived from the mentioned three sources, were then synthesised in order to arrive at a definition which was contextually relevant and which would give meaning to the model.

3.5.3.2 Step 2: Statement synthesis

Statement synthesis was conducted by extracting one or more statements from the data to describe and explain the nature of and inter-relationship between the concepts. As suggested by Walker and Avant (2014), these statements are supported by empirical evidence, and the researcher paid attention to substance, direction, strength and the quality of the interaction between concepts when developing relational statements (Chinn & Kramer, 2015).

3.5.3.3 Step 3: Theory synthesis

The next step was to develop a model from a set of relational statements (Walker & Avant, 2014). This process included the following three steps described by Walker and Avant (2014):

- Specifying concepts which would serve as an anchor for the theory /model.
- Reviewing the literature to identify factors related to the above concepts.

- Organising the concepts and statements in an integrated and meaningful way that represents the purpose of the research.

3.5.4 Process of describing the model

The following questions and rationale were used to structure the description of the model:

- What is the purpose of this model or why was it developed? This provides clarity to the circumstances and context for which the model was developed.
- What are the concepts underpinning the model? This provides understanding of the ideas that are structured and related in model.
- How are the concepts defined within the model? This demonstrates how concepts are linked and how they give structure to the model.
- What is the nature of the relationships within the model? This demonstrates how concepts in the model are linked.
- What is the structure of the model? This demonstrates how the structure of the model is based on the conceptual relationships contained within.
- On which assumptions are the model build? This addresses the basic truths underpinning its theoretic reasoning (Chinn & Kramer, 2015).

3.5.5 Guidelines to operationalize the model

Chinn and Kramer (2015) state that deliberative application of the model has the following subcomponents:

- *Selecting the clinical setting*. The clinical setting for deliberate application for this research would be higher education institutions and clinical settings where students are placed for clinical practice.

- *Determining outcomes for practice*. The outcome for this study would be to ensure that clinical nursing education is structured and standardised within the Nigerian context.
- Since this study has limited scope, the model will not be implemented or tested. However, specific guidelines were developed to operationalize the model.

Table 3.10 Summary of phase two methodology

Theory generation process	Methodology		Reasoning strategy
	Purpose	**Framework**	
Step 1. Concept synthesis	Identification of concepts from data generated in step one.	Survey list(Dickoff et al, 1968) Concept synthesis (Walker & Avant, 2014)	Synthesis
Step 2. Statement synthesis	Development of relational statements	Statement development (Walker & Avant, 2014; Chinn & Kramer, 2015)	Synthesis
Step 3. Theory synthesis	The model development.	Theory development (Walker & Avant, 2014)	Synthesis
Model description	Description of the model.	Structure and process description according to Chinn and Kramer (2015)	Synthesis
Guidelines development	Development of the guideline to operationalize the model.	Deliberative guidelines by Chinn and Kramer (2015)	Deduction

3.6 RESEARCH ETHICS

Ethics, as defined by Fouka and Mantzorou (2011), is the branch of philosophy which deals with the dynamics of decision making concerning what is right and wrong. Research ethics focus on the protection of the participants and information published in the research.

3.6.1 Permission

The research proposal was submitted to the University of Western Cape Senate Research and Ethics Committees for approval and ethics clearance (Reg. No.14/10/32) (See appendix 1).

Furthermore, the researcher obtained permission from the Ethics Research Board at each of the universities that participated in this study. The researcher also obtained permission from the continuing education unit and the chief medical director of the hospitals who participated in this study. In some instances, the ethics approval obtained from the university covered the hospitals as well (See appendices 2 -5).

3.6.2 Ethics principles

The researcher adhered to the following three main ethics principles that guide any qualitative research (Fouka & Mantzorou, 2011):

- Autonomy - refers to the recognition of the participants' right, which includes the right to know what the study is about and the right to withdraw from the study when it is uncomfortable (Owonikoko, 2013). One of the ways in which the researcher achieved this was to obtain *informed consent* from the participants (appendix 7). Each participant was given an information sheet informing them about the research (appendix 8). An additional explanation was given verbally followed by the written consent from each participant for inclusion in the study, and for the use of a voice recorder. Participants were made aware that participation was voluntary and that they could withdraw at any stage without any negative consequences.
- Beneficence - simply stated, beneficence refers to minimising the risks that participants are being exposed to (Owonikoko, 2013). In this study, the researcher ensured that each participant was not exposed to any health risk or any form of victimisation from the researcher or co-participants which could possibly stem from their participation in the study. The researcher conducted the research in a private venue to enhance the anonymity of their participation in the study. Support was arranged on standby in the event that any participant experienced unanticipated negative effects from participation in the research.

- Justice - refers to equal rights among participants. The researcher ensured that the participants involved in the focus group had the right to discuss their point of view freely and disallowed the use of language that could potentially intimidate other participants. The researcher set ground rules at the onset of each focus group session. Participants in the focus group were also requested to sign a focus group confidentiality binding form (appendix 9).

3.7 SUMMARY

This chapter presented a detailed exposition of all the methods used in this research. The rigor applied to qualitative research to ensure trustworthiness of the research was also described. This chapter concluded with the principles of research ethics which were adhered to during the research study.

CHAPTER FOUR

PRESENTATION OF FINDINGS AND DISCUSSION

4.1 INTRODUCTION

This chapter is a presentation and discussion of the research findings that seek to address the first objective of the research study, which is to explore the effectiveness of clinical nursing education in the Bachelor of Nursing Science programme offered at universities in Nigeria. The effectiveness of clinical nursing education was explored using the CIPP model of evaluation. A literature review which serves as a control to re-contextualize the research findings against an existing body of knowledge was done. The research findings represents step one of the theory generation, as described by Walker and Avant, (2011) towards developing a clinical nursing education model to guide clinical nursing education offered at Nigerian universities.

This chapter relates to the findings of phase one of the study which followed an exploratory descriptive design as described in Chapter 3. The findings were obtained through the following research methods: document review, focus group discussions and semi-structured interviews that were conducted across the groups of participants in the study.

Data analysis was done using the inductive approach as outlined by Vos, Strydom, Fouche and Delport (2011). The themes that emerged were compared and contrasted with current trends in the literature regarding the clinical experiences of nursing students, and is presented in the discussion.

The presentation is organised in six sections:

Section one presents the findings from the focus group discussions with the 300-500 level students. The discussion also centres on exploring the students' experiences of clinical nursing education as university students.

Section two presents the findings from the focus group discussions and interviews with the educators. The reason for using two data collection methods for this participant group is discussed in Chapter 3. The discussions centred on exploring clinical nursing education offered in Nigerian universities.

Section three presents the findings from the focus group discussions with professional nurses in the exploration of clinical nursing education offered in Nigerian universities.

Section four presents the findings from interviews with alumni of the Bachelor of Nursing Science programme on their experiences of clinical nursing education and how the clinical education had prepared them for the workforce.

Section five presents the findings from the document review to corroborate the findings from the interview and focus group discussions.

Section six presents the summary of the findings that cut across the four participant groups and the document review.

As indicated in Chapter one, the literature review was not conducted before the study. However, an in-depth literature search was conducted after the analysis of the data to serve as a control in the discussion of the research findings. The discussion is based on entire themes and the essence of the categories is embedded within these discussions instead of presenting it as a separate discussion of categories.

The findings are presented using the steps in the CIPP (Context, Input, Process, and Product) model. Concepts such as purposeful supervision, community of practice and situated learning from the cognitive apprenticeship model is used to present the data related to step three (process evaluation) of the CIPP model where appropriate. Therefore the data in each section is presented under the following headings:

i. **Context evaluation** entails the philosophy, goals and problems in clinical nursing education, and premise in which clinical education is offered.

ii. **Input evaluation** details the resources available for clinical nursing education under the following headings (i) human resources (ii) material resources and (iii) fiscal resources.

iii. **Process evaluation** encompasses the ways in which clinical education is delivered and is presented under the headings (i) community of practice (ii) purposeful supervision and (iii) situated learning.

iv. **Product evaluation** describes the level of satisfaction of the students, alumni, professional nurses and educators with the clinical nursing education offered at the universities.

4.2 SECTION ONE: STUDENT FOCUS GROUPS

This section describes the students' experiences of the clinical education programme. The themes and categories presented in the table below are used to answer the first objective of the study which is:

- To explore the effectiveness of clinical nursing education in Bachelor of Nursing Science programmes at universities in Nigeria

The total of 11 themes and 21 categories that emerged are linked directly to the context, process and product of the delivery of clinical nursing education in the Bachelor of Nursing programme offered at Nigerian universities.

Table 4.1: Themes and categories from students focus groups: Context, Process and Product Evaluation

STEPS IN CIPP	THEMES	CATEGORIES
INPUT	**1A:** Optimal clinical learning experience during clinical placement is reduced as a result of lack of material resources and shortage of manpower in the clinical facilities.	Lack of material resources in the clinical facilities leads to excessive improvisation among nurses.
		Improvisation of materials led to student nurses carrying out procedures incorrectly.
		There is a shortage of professional nurses in the clinical facilities.
		Students are viewed as helpers rather than learners to cushion the shortage of professional nurses at clinical facilities.
PROCESS	**2A:** Exhibition of negative attitudes by professional nurses towards the student nurses affects quality learning in the clinical placements.	Professional nurses are viewed as uncaring and unfriendly towards student nurses.
		Professional nurses are said to discriminate between the diploma and university degree student nurses.
		Professional nurses are viewed as unwilling to teach or mentor student nurses from the university.
	3A: Clinical supervision of students during clinical placement is poor.	The number of educators and professional nurses on the ground are inadequate to help students during clinical placement.
		Clinical instructors are rarely available for instructions of the students during clinical placement and are more concerned with taking attendance of students.
		Educational levels of professional nurses affect the quality of supervision of the student nurses.

	4A: A variety of teaching methods are used during clinical supervision by educators and professional nurses.	Educators and professional nurses engage in different teaching methods to help students with different learning styles.
	5A: Non-compliance to clinical learning objectives by professional nurses and educators in clinical facilities.	Clinical objectives are made available to both students and professional nurses during clinical placements.
		Learning objectives are not strictly adhered to by professional nurses and educators.
	6A: Lack of timely feedback to student nurses during the clinical placement.	A lack of regular feedback to the students since clinical instructors and educators are not always available.
		Feedback instead is based on the results from the end-of-semester practical examinations.
	7A: Evaluation of student performance is based on the opinion of professional nurses.	Universities use evaluation booklets provided by them and the NMCN.
		Record of instruction booklets are signed by the supervising professional nurse based on their opinion.
PRODUCT	**8A: A**dequate resources are required both in the nursing school and the clinical facilities.	Resources are needed in the clinical facilities to reduce improvisation by students.
		Resources in the clinical skills lab should include modern technology.
	9A: Increase in government funding for nursing programmes.	Employment of additional educators and clinical instructors will improve supervision during clinical placement.
	10A: Curriculum restructuring for alignment of theory to clinical practice and review of hours of clinical practice.	The gap between theory and practice must be closed.
		More time must be allocated to clinical practice.
		An internship programme should be introduced into the nursing education programme.
	11A: A collaborative structure is required between clinical facilities and the Department of Nursing in the universities.	Clinical facilities and nursing departments in the universities should work more closely in preparing future nurses.

This section presents the discussion of the themes related to the students' experiences of the clinical education programme. The CIPP model is used to structure the presentation. A total of 11 themes emerged from the data generated from the focus group discussions. The context evaluation of the CIPP model will not be discussed here as the students' experience in the clinical education relates more to the input, process and product evaluation of the model.

4.2.1 Input evaluation

Findings on the experiences of students with regard to input evaluation seek to address the second sub-objective:

- To explore and describe the resource allocation for clinical nursing education offered at universities in Nigeria

The students of the 300, 400 and 500 levels were asked to relate their experiences during their clinical placements.

THEME 1A: Optimal clinical learning experience during clinical placement is reduced as a result of lack of material resources and shortage of manpower in the clinical facilities

Clinical placement can be identified as a place where nursing students go to gain their clinical experience in an environment that provides direct care to patients to enable the nursing students to bring what they have learnt in the theory into practice (General Medical Council, 2009; Royal College of Nursing, 2016). The quality of a clinical practical experienced by a student is dependent on a variety of factors that contribute directly or indirectly to that clinical practical experience. According to Kapucu and Bulut (2011), an ideal clinical

environment, according to Turkish nursing students, is that which, amongst many other things, has abundance materials for learning.

The availability of materials that will enhance the students' ability to transfer what they have learnt in the theory to practice during the clinical placement is very important (Serçekuş & Başkalę, 2016). However, in the study, students needed to improvise, as was reported by this student: *"But in the clinical setting when we get there, we realise that what we do there, in fact virtually every procedure you must do one improvisation or the other"(Student 1).*

The student further said they may not be opportune to see what they have been taught in class: *"And of course when you don't have much materials or equipment to work with, you can't really expect to do the procedure in the ideal or right way. I will say generally the hospital practice is very much far from the ideal" (Student 1).*

The improvisation by students resulted in students not following the right steps in the competencies thereby leading them to encode the wrong outlines for the competencies. One student reported: *"And when you get to the class and they ask you make a trolley for wound dressing, you will have to start removing the dirt and in the end you ask yourself what is the right thing to do. And most of the time it is not easy to move away from the ward mode into the normal setting mode* [referring to what is correct]*" (Student 34).*

Another contributing factor to inadequacy of material resources is the fact that patients have to provide these materials. According to the students, it depends on whether the patients can afford it. This is illustrated by the following statement of a student: *"Like if you want to do wound dressing, it is the patient that gets the wools* [cotton wool]*, the bandage; it is the patient that pays for them to go to the CSSD* [Central Sterile Service Department]*". All the . . . instruments, patient that is expected to pay for the forceps . . . like when a patient is being admitted now, they are going to write something for the patient…Savlon* [referring to listing the materials which the hospital will supply but the patient must pay for]*" (Student 54).*

In addition to the shortage of material resources, shortage of staff, for example, professional nurses in the clinical facilities poses challenges to the clinical nursing education offered in the Nigerian context since professional nurses help students with the integration of the theory and practical. The shortage therefore will affect students learning. This student shared her experience of the shortage of nurses: *"In a situation whereby you have two nurses attending to about 30 patients, what do you expect those two nurses to do? . . . their care delivery will not be sound enough. Imagine two nurses to thirty patients they wouldn't be able to give total nursing care to the patients" (Student 65).* Another student said*: "If they are short-staffed, like two people working on 25 patients, they don't have time for us. It is always difficult for them to take us..." (Student 52).*

This shortage affects how the professional nurses view the student nurses−they are being viewed as helpers rather than students that have come for learning at the clinical facilities. One student reported: *"Sometimes when you get to the ward, you overwork yourself, to the extent that what you are supposed to learn you wouldn't be able to learn because you do other procedures" (Student10).* Another student said: *"Once they see student nurses, they will not do anything, they rest their legs, put their legs up and leave the students, they will start directing us go and do this and that" (Student 31).*

4.2.2 Process evaluation

This section presents the findings on the experiences of the students in the process evaluation as related by the students in the focus group discussions and seeks to address the third sub-objective:

- Explore and describe the process of delivery of clinical nursing education offered at universities in Nigeria

The students of the 300, 400 and 500 levels were asked to relate the process by which clinical nursing education is being delivered to them. The following probing questions were used:

- Describe the process of your clinical learning during your clinical placement;
- Explain how and whether the objectives for student's clinical placement are made known; and
- Share your experience of supervision during clinical placement.

THEME 2A: Exhibition of negative attitudes by the professional nurses towards the student nurses affect quality learning in the clinical placements

A safe clinical environment is an important factor that contributes positively to a student learning (Flott & Linden, 2016; BjØrk, Bernsten, Brynildsen & Hestetun 2014). One of the factors that characterises a good and safe clinical learning environment is the attitude of the professional nurse towards the students (Evans, Costello, Greenberg & Nicholas, 2013; Koushali, Hajiamini & Ebadi, 2012; Wawire, Rogers, Claudio, Mwiti, Ndung"u, Katindi & Njeri, 2014). The role of a clinical nurse in the clinical education of a nursing student cannot be underestimated as their attitudes towards the nursing student during a clinical experience can positively or negatively affect how a nursing student view learning or even understand the concept and skill of nursing (Ahonen & Quinlan, 2013). The professional nurses in the study exhibited an uncaring and unfriendly attitude towards the student nurses, as reported by this student: *"I will say these nurses there are kind of aggressive" (Student 23).*

Students reported that professional nurses discriminated between the student nurses from a diploma programme and those from the degree programme: *"They preferred the school of nursing students to the university students and whenever we make mistakes they don't correct us. And the same mistakes a student from the school of nursing will make, is the same we make but instead they correct them and teach them and it create a kind of rivalry between the*

school of nursing and the degree student and that is not good for learning because we will not interact and that does not aid learning" (Student 23).

The students also reported that professional nurses believe that the student nurses from the diploma programme are more knowledgeable in practical skills than the students from the university setting, and as such allow these student nurses from the diploma programme more hands-on opportunities, as illustrated by the following statement from a student: *"During our posting there, all our ward staff on duty they used to say that we don't know anything, we are theoretically based that we are not good practically based. So there are some procedures we are restricted to. And we have some nursing students there from [the diploma program], they are the ones that will be allowed to do some procedures and we will be watching them the way they are doing it" (Student 15).*

The students also reported that the professional nurses are unwilling to teach and mentor the students from the universities, as illustrated by this statement: *". . . because of the fact that we are BNSc nurses, most of the nurses that we have worked with they really don't want to teach us in that sense,…they will rather teach the diploma"(Student 28).*

THEME 3A: Clinical supervision of students during clinical placement is poor

Clinical supervision refers to the support from a professional or more experienced nurse with the objective of helping the student build a satisfactory competence that would lead to confidence through practices (Franklin, 2013). The ability of nursing students to successfully integrate the theory learnt in class with the practice on the clinical setting is highly dependent on the purposeful guidance and supervision provided by either the professional nurse on the ward or the nurse educator that comes to the ward from time to time or both (Löfmark, Thorkildsen, Räholm & Natvig, 2012). Unfortunately, as identified earlier, shortage of nurse educators and professional nurses affects their availability at the clinical facilities and hence

their ability to help students translate the theory learnt into practice, as illustrated by the following statement: *"I don't also blame them but I think it is the problem of been understaffed, we don't have enough staff, we actually have just one clinical instructor and cannot imagine her walking through all the phases of the hospital, she will faint"(Student 14).*

The presence of a nurse educator or a clinician during the clinical experience of student nurses in the clinical facilities has been valued as an important backbone in clinical nursing education (Kristofferzon, Martensson, Mamhidir & Löfmark, 2013).

The inadequate number of educators in the study affects their availability at the clinical facilities. Consequently, the students view the educators as being only interested in the taking of attendance of those present at the clinical facility, and not necessarily supervision or teaching of the students, as reported by this student: *"The truth is that they just come to take attendance of those who are present . . . to count the number of students on the ward and to know the absentee that have not been coming to the ward" (Student 43).*

The students believed that the educators are not really interested in imparting skills at the clinical site: *"The clinical instructors they are not really working as they ought to, at least that is what they are meant to do, clinical instructions, they should instruct us and to monitor us when we are in clinical . . . they should come to the ward and to observe us and even to teach us some of the things we do in the ward, but I think during our clinical this time it is only once they showed face and I think that is not good enough"(Student 32).* The latter part of the student's report refers to the clinical instructor simply making an appearance at the clinical site and not necessarily facilitating clinical learning.

The professional nurses, as mentioned earlier, are meant to support students in the integration of theory and practice. But according to the students, the professional nurses are lacking in the necessary knowledge to enable them to impart knowledge to the students. The students

believe that professional nurses are out-dated in their knowledge: *"You know, it's been long they* [professional nurses] *went to school. So it is the knowledge they have that they are making use of. Even when there is upgraded information and you are trying to carry it out, they tend to tell you that you don't know what you are doing; you don't know anything. This is how we do it, this is how they do it. They don't upgrade themselves, they don't research; they don't do anything" (Student 78).*

THEME 4A: A variety of teaching methods are used during clinical supervision by educators and professional nurses

To accommodate students with different learning styles, the student participants acknowledged that the clinical instructors and professional nurses use different methods of delivery in their supervision, which include teaching and return demonstrations: *"When she is doing something she actually does it well and practice well with us, we will be around her she will be saying it and she will be doing it and sometimes after she finish doing it we have return demonstration" (Student 1).* A comment on giving of assignments about procedures to be carried out: *"Another method is they give us some sort of assignments. They ask us to draw up a lasting care graph for patients and also ask us to dig up some information about the conditions of patients and include the pictures" (Student 77).* Sometimes they do group teaching: *". . . at times they bring the list of procedures they want to teach us on the ward, so they take us to the bedside and take us those procedures" (Student 20).*

The students also reported that the educators sometimes give individual supervision. When they come across a student carrying out a procedure they guide the student through the procedure: *"They also come around during the posting to come and see what we are doing on the ward, if any procedure is going on, they move to the student carrying out the procedure*

and they put the student through or supervise her to see what she is doing at that time" (Student 20);

whereas the professional nurses in the clinical facilities assign a patient to a student nurse for total nursing care, as illustrated in this statement by a student *". . . the nurses on the ward supervise us daily, when we get to the ward, they give us patient to care for, for the day. On that particular patient for the day you have to do totally nursing care for that patient aside doing all our normal nursing procedure you will do the nursing care plan" (Student 20).*

In addition, the students also reported that the clinical instructors conduct clinical conferences; pre and post clinical conference: *"Aside from the hospital . . . aside from the clinical . . . in the wards there is a sort of a meeting, a conference meeting whereby all the students come together to rub minds"(Student 79) and also* use a brainstorming method: *"Our clinical instructors, they come to our clinical wards, they come to ask us questions about what we have learnt and they help us to make sure we have understood what we've done"(Student 92).*

The use of different teaching methods by the educators, clinical instructors and professional nurses in the study accommodates the different students with different learning styles.

THEME 5A: Non- compliance to clinical learning objectives by professional nurses and educators in clinical facilities

According to Lofmark et al. (2012), the effectiveness of the clinical supervisor during a clinical placement can only be seen when there is an achievable clinical learning objective. Student participants in the study acknowledged that the clinical objectives are always made available to them at the beginning of each clinical placement: *"For each posting we have maternal and child health posting, mental health posting etc. and there are objectives for each of these posting. Once they put the posting on the notice board, they put the objectives*

alongside with it on the board, what we are to achieve and they also include it in the letters they send to the nurses" (Student 15).

They said these objectives are also made available to professional nurses in the clinical facilities, as illustrated in this statement: *". . . and at the hospital, a letter was sent to them and inside the letter the objectives were stated what they expect the students to learn. What they should teach us, the emphasis of the posting" (Student 6).*

However, though the objectives are made available to the professional nurses, the students said the professional nurses and the educators do not strictly adhere to it: *"I will not say that they follow the objectives they were given directly but any ward that we are posted to, those things that we are expected to learn on that ward, they put us through and that may have been included on the objectives directly or indirectly*" (Student 20).

THEME 6A: There is lack of timely feedback to student nurses during the clinical placement

Murray et al., in Duffy (2013:51) define feedback as "the situation when output from (or information about the result of) an event in the past will influence the same even in the present or future". However, students in this study understood feedback from the clinical instructors and educators as being related to what they have done and experienced during the clinical placement, as illustrated in this statement by a student: *"When it is an hour to the closing of the clinical, they come back again to assess the students ask them questions about what they learnt and also give them lecture" (Student 72).*

Timely constructive feedback helps the student to bring out the best by applying the corrections given by the clinical instructor or preceptor (Mutua, Seshan, Akintola & Thanka, 2014). Students in the study said there was no feedback from the clinical instructors or the nurses, and there is no other way to know whether they are doing well or not until the final

examination: *"There is practically no feedback, it is almost like giving you, giving you, there is no way for me to find out if I am doing well or not, there is no way for me to find if I have met the objectives, is this atmosphere conducive, there is basically no feedback, they are just passing out information"(Student 26).*

The only time students receive feedback, according to them, is during the examinations: *"Personally on my own ward, I think it is only during the examinations that my clinical instructors evaluate" (Student 25).*

THEME 7A: Evaluation of student performance is based on the opinion of professional nurses

Evaluation of nursing skills competency is very important in nursing education but remains a daunting task for nurse educators (Helminen, Tossavainen & Turunen, 2014; Rafiee, Moattari, Nikbakht, Kojuri & Mousavinassab, 2014). Evaluation of students in the study is conducted by using a booklet known as a record of instruction. It is made available to each student in the nursing programme, as illustrated by this statement: *"We have this record book that once you get to the ward, you put in the date, the ward you are working, the time you came in the procedures you carried out and then the time you leave" (Student 14).*

The student added that the booklets (record of instruction) are meant to be signed by the professional nurse who supervises the student when carrying out the procedure: *"Then the matron on the ward is supposed to sign it and put a remark on it" (Student 14).*

The booklet is meant to standardise the evaluation of the students but the students fault this book because, according to them, some of the professional nurses sign the book without necessarily knowing the student's level of competency. Or because the student is nice to them they won't fail the student. *"The book does not count at all, the book is just to cajole part three students we submitted in 300 level but they did not do anything to it. The book is not*

effective; to me the book is just there" (Student 10). And another student reported: *"The attitude of the matron towards the signing, some of them will say compile them I will sign everything together, and what they just do is look and sign" (Student 11).*

4.2.3 Product evaluation

This section presents the findings on the opinion of the students with regard to product evaluation, as related by the students in the focus group discussions and seeks to address the fourth sub-objective:

- Explore and describe whether the clinical nursing education offered at universities in Nigeria is effective.

Product evaluation, according Stufflebeam (2014), is the evaluation of the outcome of a programme, both intended and unintended. According to Stufflebeam (2003), in a paper delivered during a conference (Oregon Program Evaluators Network) on the CIPP model of evaluation, he said the purpose of evaluation could either be formative or summative. In the formative nature of the evaluation the model seeks to bring out standards that can assist during the summative evaluation in order to inform the decision-making process. In this study, the researcher's objective was to find out the students' opinion about standard clinical education. Therefore, this section is presented as it relates to the students and what they expect in an improved clinical nursing education.

At the end of each focus group discussion the researcher asked what their opinion was of an improved clinical nursing education in the university programme in order to ensure the production of a quality nurse. A discussion of the themes and categories follows.

THEME 8A: Adequate resources are required both in the nursing school and the clinical facilities

One of the challenges the students face in their clinical placement area is the issue of inadequate resources. Therefore, when asked what they would expect in a standard clinical nursing education all focus groups were in agreement about the provision of adequate resources, as illustrated by this statement: *"I think one on clinical education, we need resources, the ministry of our country should at least do something and provide instruments so that we can learn and they should be taught how to teach students" (Student 27).*

THEME 9A: Increase in government funding for nursing programmes

Funding is an important aspect of any programme. The students in the study also pointed out that they would like to see government improving the funding allocated to nursing: *"Funds should be sort for federal government should put in more money into nursing" (Student 7).* Another recommended that: *"Federal government must put money into nursing education" (Student 5*).

One of the reasons they are advocating for increased funding is to allow for the appointment of additional educators and clinical instructors, as illustrated with this statement*: "They should try to increase the number of staff, because if you improve the number of staff they wouldn't have much workload" (Student 61).*

The students believe that clinical supervision will improve when more educators and clinical instructors are appointed: *"There should be more of proper supervision to make sure that we are doing it well and to correct us" (Student 44).*

There is a general belief among the students that they are receiving poor supervision during their clinical placement, as reported in this statement: *"For the weakness I think poor supervision is still a problem" (Student 46).*

THEME 10A: Curriculum restructuring for alignment of theory to clinical practice and review of hours of clinical practice

Curriculum overload is one of the problems the students highlighted in their challenges, as there is limited time for clinical practicum: *"There is more time for clinical practice in [the]school of nursing [Diploma awarding school] than in the university because in the university, the curriculum is so cumbersome . . ." (Student 55).*

The students therefore advocated that the curriculum be restructured to assign more time to the clinical practicum:*"Nursing department should not use the same calendar as other departments are using because the medical school have their own calendar on how they run their semester, so if we are designing our own calendar we will design it in such a way that it will soothe our purpose, so that we can put in all the practical stuff, not to be running semester like other department are doings" (Student 55).*

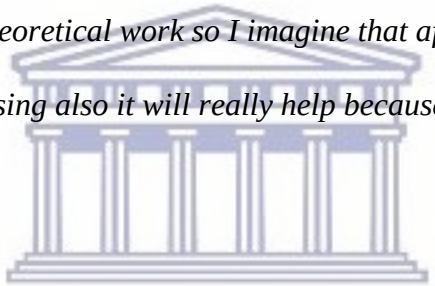
The students also believe that there is a huge gap between the theory that is being taught in class and what is being practiced in the clinical settings: *"I think there should be continuity to what we are been taught in class and what we go to face on the ward. When we are taught something in class, they should take us to the ward and show us vivid examples of what they have just taught us" (Student 4).*

Similarly, another student said that what they are being taught in class is different from their experience in the clinical placement: *"I will say it is not well structured, yes because I went for ENT posting and Ophthalmic posting, if not that I took it as my own personal this thing, do you now that we did not do the anatomy of head and neck before going for the posting. . . .*

we are supposed to go and learn the pathology of the physiology that we learnt you. So when you have not learnt the physiology, then you are going for the pathology, how would you know the simple things" (Student 10).

She suggested that the placement should be in line with what is being taught in class: *"the department should please review the curriculum making our theory aspect to tally with, align with our practice" (Student 10).*

Another point which came out strongly from the students was the approval of an internship program. They believed that an internship will help to cover up the clinical they missed while they were students, as illustrated by the following statement: *"My own is that they should approve the internship, because what I know is that during our five years must of the university spend the time on theoretical work so I imagine that after the university if they can approve the internship for nursing also it will really help because it is based on only practical aspect" (Student 60).*



THEME 11A: A collaborative structure between the clinical facilities and the department of nursing in the universities is required

The students in the study suggested that there should be a unified structure between the universities and the clinical facilities. They believe it will reduce class among the two groups. In so doing, the professional nurse can teach in the university if she has the qualification to do so and likewise an educator can practice in the clinical setting. There will be no segregation or differentiation, whatever the case may be. One of the students said: *"It contributes to the fact that our lecturers will be able to go to the hospital and do like, supervise us and would know what to do when they go there, it is not just about going there to put us through they should be something expected of them to do" (Student 2).*

4.3 SECTION TWO: EDUCATOR FOCUS GROUPS AND SEMI-STRUCTURED INTERVIEWS

This section discusses the findings from focus group discussions and semi-structured interviews with educators. The educators in this study, as clarified in Chapter 1, refers to those who teach the theoretical component of the nursing programme and sometimes accompany the students for clinical practice; the head of departments who are also teaching in the department; and the clinical instructors employed by the university for the sole purpose of clinical teaching in the laboratory and supervising students in clinical practice. As discussed in Chapter 3, the lack of availability of educators for participation in focus group discussions at two universities in the study resulted in the remaining consenting educators being interviewed according to their availability.

The findings from the focus group discussions and interviews were used to address the first objective of the study which is:

- To explore the effectiveness of clinical nursing education in the Bachelor of Nursing Science programmes at universities in Nigeria

The sub-objectives are present in each section of the data presentation. A total of 40 categories emerged from the focus group discussions and 51 from the interviews. The categories were then triangulated into one result to form the themes across the two data collection methods and are presented in Tables 4.2 – 4.5. A total number of 19 themes were elicited from the triangulation of the categories from the focus group discussions and interviews. Based on the expanse of the results in this participant group the table has been split according to the steps of the CIPP model each followed by a discussion.

4.3.1 Context evaluation

This section presents and discusses the findings on the context evaluation after triangulation of the findings from focus group discussions and the interviews. It addresses the first sub-objective of the study which is:

- To explore and describe the context for clinical nursing education offered at universities in Nigeria

The themes and categories that emerged after the triangulation of the findings are outlined in Table 4.2 below.

Table 4.2: Educators themes and categories: Context Evaluation

THEMES	CATEGORIES FROM FOCUS GROUP DISCUSSIONS	CATEGORIES FROM INTERVIEWS
1B.The clinical education programme is aligned to the philosophy which underpins the entire nursing programme.	The philosophy of the nursing programme is based on the values of the school.	The nursing programme's philosophy is shaped by society's expectation of nursing and as such clinical placements of students reflect more of community experiences.
		The philosophy is centred on producing quality, versatile polyvalent nurses
		The length of the nursing programme and the intensity of clinical education are directly influenced by the philosophy.
		At graduation, students are expected to have qualifications as registered nurses registered midwives and registered public health nurses in addition to the BNSc degree.
2B: Transportation challenges for both educators and students arose from the use of a variety of clinical settings.	There is the need to use different locations for clinical placement so as to fulfil the requirement in the curriculum.	There is parallel use of different locations for clinical placement so as to fulfil the requirement in the curriculum.
		Different locations of clinical placement resulted in challenges with transportation for both students and educators.
		The use of personal means of transportation had a negative impact on the clinical supervision
3B: Clinical skills laboratories at the universities do not replicate reality, are not spacious, and lack technology- driven teaching aids although they are fairly well resourced.	The clinical skills laboratory does not replicate the clinical settings. The clinical skills laboratory is too small for the large number of students.	The clinical skills laboratory is adequately resourced, though small for the large number of students.
	There is lack of technologically-driven instructional aids in the clinical skills laboratories.	There is lack of technologically-driven instructional aids in the clinical skills laboratories.

4B: Perceived inadequacy in clinical teaching is compounded by the multiple roles assigned to clinical instructors who are already difficult to retain.	There is perceived inadequacy in the clinical teaching by clinical instructors.	There is perceived inadequacy in the clinical teaching by clinical instructors.
	Clinical instructors are difficult to retain because of their ambition and better job offers elsewhere.	Clinical instructors are difficult to retain because of their ambition and better job offers elsewhere.
		The assignments of multiple roles to clinical instructors affect the quality of clinical supervision and students' clinical learning.
5B: Strikes at health facilities and existing clinical facility policy affect clinical learning opportunities during clinical placement.	Incessant strikes at the clinical facilities greatly reduce the number of hours students have for clinical placement.	Incessant strikes at clinical facilities greatly reduce the number of hours students have for clinical placement.
		Some policies of clinical facilities prevent the student nurses from carrying out certain procedures.
		Competition for learning opportunities between students of various healthcare professions reduces the student nurses contact with patients and hands-on experience.
6B: Negative attitudes of professional nurses and competition for clinical learning opportunities reduce students' exposure to patient care.	Negative attitudes of the professional nurses' leads to lack of teaching and mentoring of student nurses.	Unfriendly attitudes of the professional nurses exhibited as hostility and discrimination toward the nursing students resulted in lack of teaching and mentoring.

Theme 1B: The clinical education programme is aligned to the philosophy which underpins the entire nursing programme

According to Stein (1980), Philosophy is a 'system of principles for guiding practical affairs'. It serves as a background to the establishment of a practice. According to Miller, (1994) contained in the philosophy of an organisation is the concepts and principles that give direction to the organisation. The educators were interviewed in this regard and they showed a clear understanding of the philosophy that guides the nursing programme and how it is reflected in the kind of clinical education that is being offered. One of the educators said that they aspire to meet the objective of the philosophy, which is to produce quality nurses by exposing them to different techniques that will bring out the best in them, as illustrated by the following statement: *"I think part of our philosophy, specific to nursing school is to produce nurses that are . . . that will develop good clinical competency and because of that we have different clinical teaching techniques that will allow them to meet those competencies"(Educator 26, FGD).*

The educators in the focus group discussion of one of the universities also believe that the philosophy of the school is based on the value of the school, as illustrated by these statements: *"Philosophy also reflects, one an entity and also harbours the family" (Educator 22, FGD)*; *"A big part of our philosophy is the inclusion of God in the things we do" (Educator 26, FGD).*

The educators also discussed how the philosophy of a programme influences the type of clinical education that the student nurses receive. It differs from the type of clinical education that the educators were exposed to since there were training nurse leaders during their time and currently the training is geared towards becoming a polyvalent nurse, as illustrated by the following statement: *"The philosophy of the present programme is to develop nurses who are polyvalent and can practice at every level of nursing care and the student and it is believed*

that to get that, to develop such polyvalent nurses we have to start from the basic"(Educator 6, SSI).

In addition to this, one of the educators said the feeling of the society about nursing is also infused into the philosophy that is behind the present nursing programme that is being offered in the university.

The subtle unproven general perception of the Nigerian society is that a nurse should know everything about health, and this philosophy led to the idea of producing a general nurse that is competent in the different aspects of nursing, as illustrated by a statement from one of the educators: *"The philosophy of nursing, when you look at the baccalaureate curriculum is wedged into the philosophy of nursing education, what society feel about nursing"(Educator 12, SSI).* One of the head of departments at the universities said that students have more of a community posting to prepare and direct them to community nursing: "*when you talk of clinical education it is not only limited to hospitals. We have the community-based education that has not reduced because now the students go into community to relate with clients, they work in primary healthcare centres. They go into home and we send then to villages to relate with people in their home level and at market places" (Educator 13, HOD).*

Theme 2B: Transportation challenges for both educators and students arose from the use of a variety of clinical settings

The educators in the study explained that the present type of nursing programme offered in the Nigerian universities is one in which a nurse graduates from the university with four different qualifications, namely, as a Registered nurse, a Registered Midwife, a Registered Public Health Nurse and a BNSc degree:"*. . . but you see the degree it gives consideration for almost every aspect of nursing, for mental health for midwifery, so our student can when they*

finish the programme seat for RN, RM and RPHN, and in addition their degree . . . " (Educator 3,SSI). The statement is referring to the comprehensive training of a graduate. In addition, as Educator 9 (SSI) described below, clinical education has to happen simultaneously in different sites in order to fulfil the requirements for each aspect of the nursing programme, that is, nursing, midwifery and public health at each level on clinical rotations. The educator described the different types of health facilities in the area used for clinical practice based on their focus, for example, teaching hospital complexes, comprehensive health centres and maternal and child health centre.

"Also students also utilise a conglomerate of hospitals around here for clinical education and practice. We have what we called Obafemi Awolowo University Teaching Hospital Complex. It is a complex because it comprises four institutions, I think four or more than four, we have the Ife Hospital unit itself, that is one, Urban Comprehensive Health Centre, that is the community health aspect that is two, we have dental hospital that is three, then we have multipurpose maternal and child health centre, Ilesha, then we have rural community health centre that is six. SO in addition to those ones also we also have aspect of our clinical sites, the SDA hospital here in Ife is also one of our centre and we have another one in EDE so all the conglomerate of clinical sites we utilize them for posting at one time or the other"(Educator 9, SSI).

According to another educator, the use of different locations for clinical placement simultaneously means that transportation has to be provided to these different sites. However, this proved to be a challenge as the clinical instructors and educators had to make use of their own transportation:

"As at now it is a major challenge, there is no official car, before we use to have a bus, but right now it is grounded and we don't have another one as at now, each clinical instructor

depends on her own resources to transport her to the place, no real money for fuel, maybe every now and then you may ask for money" (Educator 3, SSI).

The clinical instructors added that the challenge of transportation as a result of the distance in location of clinical experience has a negative effect on the clinical supervision of the students, as illustrated in this statement: *"For those of us who have to drive down let's say twenty minutes, number one challenge is this, suppose it is raining, you don't have a car and there is no official car to take you, these factors can affect your movements to that place and then our students go to different setting, not only UCH, …" (Educator 3, SSI).*

These findings are in agreement to the findings from a dissertation submitted by Xaba (2014) on the assessment of the facilitation of the clinical training component of an undergraduate nursing programme at a university of technology, which acknowledged that the distance of a clinical placement site can have a negative impact on the quality of the clinical experience.

Theme 3B: Clinical skills laboratories at the universities do not replicate reality, are not spacious, and lack of technology-driven teaching aids, though they are fairly well resourced

The clinical skills laboratory, according to Wellard, Solvoll and Heggen (2008), is a very important aspect of the clinical nursing education. One of the educators in this study agrees with the finding: *"you are looking at the clinical education from class to patient, now if you are looking at it from class to patient that is the purpose of the clinical room, where you have mannequins, you have audio-visuals so that it can mimic the ideal situation*" (*Educator 4, HOD).*

The clinical skills laboratory provides a safe environment for the nursing students to practice what they have learnt theoretically in the classroom before going to the ward to practice it on real-time patients (Wawire, Rogers, Claudio, Mwiti, Ndung'u, Katindi & Njeri, 2014).The

educators in the study also believe that the clinical laboratory provides a safe environment for the students to practice, as illustrated by the following statement: *"The clinical laboratories that we have in the school should be such that will be dedicated to student allowing them to make mistakes over and over again before they are exposed to the hands-on experience out there"(Educator 26, FGD).*

According to Haraldseid, Friberg and Aase (2015), a clinical skills laboratory should be spacious and well-built because it affects the teaching of clinical skills; directly and indirectly. However, one of the educators in this study said the space of the clinical skills laboratory is not big enough to accommodate the students and that poses a challenge in the delivery of the demonstration to the students: *"… From all I can see inadequacy is in terms of space because the numbers of students keep on increasing, the space we are using for our demonstration in the lab is not ok enough so the teaching that they acquire here in the lab may not be as effective as you want it"(Educator 10, SSI).*

An adequately resourced skills laboratory is equally an important aspect in the acquisition of skills by student nurses in a demonstration lab. The skills laboratory should emulate the hospital setting where the nursing students obtain their clinical experience and should be well-furnished to allow for simultaneous practice among the students (Bugaj & Nikendei, 2016).

The universities in the study can boast of adequate resources as illustrated by a quote from the educator: *". . . So in this department we have our demonstration room or the laboratories that is well- equipped and most of the things, that you have there, you may not even see it in some teaching hospitals in Nigeria, what we have there" (Educator 10, SSI).*

An educator in the research study agreed with the idea of having a well-resourced lab that resembles the hospital. However, in her opinion, students should be made to practice in the

skills laboratory as they will in the hospital wards since an ideal setting in the context of Nigerian clinical settings does not exist:

"I will say that, I am always of that school of thought that the clinical experience should be real to the worlds where the client, the students will practice against many people thinking that the clinical teaching, you must every resources, everything that they will need for standardise practice, that is good but that is not the real world" (Educator 7, SSI).

The above sentiment shared is in agreement with the research findings of a work done in Malawi, namely, "The Nurse Educators' perspectives of clinical teaching in the skills laboratory: A Malawian experience" (Msosa & Bruce, 2015). These findings indicate that students have a better experience in the laboratory than in the actual work setting.

Though there is the claim that the skills laboratories are well resourced, but when you compare the resources to the modern technology and evolving world, where the approach to teaching clinical skills to nursing students in the lab has evolved over the years (Khan, Pattison & Sherwood, 2011), the resources seem to be inadequate. Teaching in the laboratories no longer follows the traditional way of demonstration, and return demonstration; it has improved technologically. The clinical skills lab no longer contains only mannequins, but has computerised mannequins and simulators that make teaching complex, but easier and safer for nursing students (Bugaj & Nikendei, 2016; Jeggels, Traut & Kwast, 2010).

Unfortunately, the clinical skills labs in Nigeria have yet to embrace technology. Skills are still being taught in the traditional way, which is in contrast with the articles cited above. The following quote from one of the nurse educators confirms it: *"And I also want to add that technologically, we are behind with what we have because clinical teaching is now focused on simulated learning which we don't have. So because of the absence of that, I will say we*

are not adequate. Whatever we have is not adequate enough for us to teach clinically, you know" (Educator 26).

In addition, another educator said the large number of students admitted each year also added to rendering the resources as inadequate: *"Maybe we are assuming that it is adequate. I don't want to believe that it is not adequate for the number of students and for the requirements" (Educator 27, FGD).*

THEME 4B: Perceived inadequacy in teaching is compounded by the multiple roles assigned to clinical instructors who are already difficult to retain

According to Elliot (2002), the quality of a nurse that is produced by an educational institution is greatly influenced by the kind of clinical experience the nurse went through as a student nurse. This experience is heightened by a number of factors, among which, a competent clinical instructor is regarded as a very important factor (Eta, Atanga, Atashili & D'Cruz, 2011). A clinical instructor therefore is an experienced nurse that guides, teaches and supervises the process whereby a student nurse transfers the theory to practice in order for the student to be a good professional nurse (Toelke, 2012).

Formal training of clinical instructors is very important as it helps them to prepare adequately for their role as clinical instructors and assist in the transitioning of their role from taking care of patients to the new role of training of the nursing students. (Toelke, 2012; Botma, Jeggels & Uys, 2012; Cangelosi, Crocker & Sorrell, 2009; Dahlke, Baumbusch, Affleck & Kwon, 2012). Unfortunately, there is the belief that an experienced clinical nurse will be a good clinical instructor, which was confirmed in this study, as illustrated by the statement from a clinical instructor: *"At the point of employment at the interview, what the department ask for is years of experience, registration with the nursing and midwifery council of Nigeria. It is expected that the person can teach" (Educator 3, SSI).*

Botma et al., 2012 and Tolke, 2012 recommend that clinical instructors be taken through a programme of training in order to optimise their delivery towards the training of students. However, the clinical instructor went further to say that they have to go online to get whatever training or clarification they need. *"the thing is that all of us have these basic clinical background in our nursing education, so we already have a broad knowledge base and field base but for improvement and in case of uncertainties we try to seek expert advice or opinion or consult books and also go online for clarity" (Educator 3,SSI).*

In spite of the importance of the work of a clinical instructor in nursing education, the shortage in faculty has also indirectly affected the availability of clinical instructors. The availability and retention of clinical instructors has become a major obstacle for most nursing programmes (Glynn, Kelsey, Taylor, Lynch & Delibertis, 2014; Nardi & Gyurko, 2013). This research study substantiates the findings of this report, since the educators in the study lamented the shortage of clinical instructors as quoted below: *"I will say that it is 30:1 or 40:1 because we have 120 students from 200-500 level. We have students in different settings and we can have students in about nine settings when the students start clinical and there is no official car and we are three clinical instructors, and even if you drive yourself to one setting" (Educator 31, FGD).*

The shortage of clinical instructors is in agreement with the findings from Gerolamo, Overcash, McGovern, Roemer and Bakewell-Sachs (2014) that the world is experiencing a shortage of health workers, especially the nurse educators. This study included the clinical instructors since they are being employed by the university to assist in the teaching of the clinical skills to the nursing students.

According to Allen (2008), clinical instructors are hard to find and retain, as most of the clinical instructors move to better jobs or would rather not enter the nursing education programme at all. Clinical instructors receive better remuneration outside the classroom.

This study confirms that one of the contributory factors to the clinical instructor shortage was the movement of the clinical instructors to greener pasture for better remuneration and prestige: *"we supposed to have three, but presently there is a slight re-arrangement, a slight restructuring or re-assignment. We have three and two have been redeployed as lecturers. Though they still assist in the clinical supervision" (Educator 9, SSI).*

Another point that arose from the discussion with the educators is the issue of using the available clinical instructors for other jobs other than clinical instruction. The clinical instructors are used as administrators in the department, as illustrated by this statement: *"we are so busy with other things, results, administrative and all those stuff, which does not actually give us enough time to focus on this, if students are on supervision . . ." (Educator 3, SSI).*

THEME 5B: Strikes at the health facilities and existing clinical facility policy affect clinical learning opportunities during clinical placements

The training of any nursing student cannot be complete and meaningful without the clinical education since the clinical aspect creates an avenue where the theory learnt in the classroom can be brought into practice.(Sandy, 2014; Cassidy, 2009; Cooper, 2014) In every nursing programme there is a stipulated number of clinical hours that a student nurse must attain in order to qualify as a professional nurse and in order to attain this, nursing students spend a number of hours in different clinical placements (McClimens, Kenyon & Cheung, 2012; MacIntyre, Murray, Teel & Kashmer, 2009).

In this research study, educators spoke about the clinical hours being cut short as a result of strike action. Strike actions in Nigeria have an adverse effect on the clinical hours students spend during clinical placement. Doctors and nurses go on strike to drive home their points whenever they feel they are experiencing injustice as shown in this statement: *"incessant*

strike if they can curb it so that it will not jeopardise the clinical exposure"(Educator 4,HOD).

According to another educator, strikes at the health facility have a direct effect on the students' practice hours since there will be no patients and when there are patients there may be no professional nurses around to guide the students: "*It is now strike every minute. For one year the teaching hospital was closed down because doctors will go on strike, nurses will go on strike, and other health workers too. Good that does not make for good continuity for learning experience and acquisition of skills" (Educator 12, SSI);*

"Then two the issue of strike in teaching hospitals have also reduce the clinical experience for students" (Educator 13, SSI).

Another factor that the educators complained about is the hospital policy in all the teaching hospitals. They believe it militates against meaningful clinical experiences for the student nurses, as these policies were formulated to favour the medical students, as illustrated in the following statement: *"the new approaches that there are some procedures that doctors must do predominantly as we have in teaching hospitals we were allowed to do all those procedures, giving of nasogastric feeding, getting into the veins as early as my second year in the school of nursing, I have started trying hands on getting into the patient's veins so we have these wild opportunities that have been restricted because of the new policies on now" (Educator 13, HOD).*

The same educator spoke on the issue of reduction in opportunities to have hands-on experiences with patients. This resulted because of the increased number of students and students from other healthcare professions such as the medical students, physiotherapy students and so forth who are all using the same teaching hospital for learning experiences and will have to struggle to find patients: *"Now the students population have increased enormously in my university, my university trains medical students, physiotherapy students,*

occupational therapy students, dentistry students, nursing students then you also have in the hospital attached to us, the teaching hospital they have many post-basic nursing students so you have many students fighting for the same patients"(Educator 13, SSI).

THEME 6B: Negative attitudes of professional nurses and competition for clinical learning opportunities reduce students' exposure to patient care.

Another factor that reduces the learning opportunities available to student nurses in the study is the attitude of the professional nurses towards the students. According to Fitzgerald, Kantrowitz- Gordon, Katz and Hirsch, (2012), clinical education cannot be successful without the help of professional nurses working in the hospital or clinical facilities where students go for their clinical practicum. Many of the educators who participated in the study complained bitterly about the negative attitude of the professional nurses towards the students that are coming to learn at their hospital, as illustrated in this statement: *"On two occasions I have called on one of the clinicians because she was screaming on my students and telling her you don't know anything, you call yourself BNSc students. I was there she did not stop I did not say anything" (Educator 23, FGD).*

The educators believe that the professional nurses are very hostile to their students: *"In terms of hostility sometimes they just, they are hostile they are not friendly not all the time and not all of them but some of them" (Educator 6, SSI).*

And according to another educator, one of the ways the hostility is exhibited is discrimination between the diploma student nurses from the School of Nursing and the undergraduate student nurses from the universities: *"I saw that there is a disparity between the kind of treatment they give our students and the students from the schools of nursing around. In fact I see that they prefer to work with them, than to work with our students." (Educator 30, SSI).*

Refusal to teach or mentor the students has been common among students attending clinical practice, as documented in research articles (Mnzava & Savage, 2005; Carr, 2008). Educators in the study also highlighted refusal to teach as one of the negative attitudes exhibited by the professional nurses towards their students on clinical placement: *"when I came here not as HOD and I learnt that the people on the ward were not involve in teaching, i went back to them and said to them if you don't teach them, they will be the one to send you to your early grave" (Educator 4, HOD).*

Another educator believes that the hostility exhibited by the professional nurses affect their predisposition of teaching the nursing students: *"then sometimes there is hostility, I think that is the major problem they have, not the practice, most of the time student complain that they are not allowed to practice what they learn on the ward, most of the time they just sit down or maybe check temperature, but major procedures they will not, they will even allow the students from the school of nursing to carry out the procedures but will not allow the BNSc students" (Educator 6, SSI).*

4.3.2 Input Evaluation

This section presents and discusses the findings on the perceptions of the educators in the input evaluation and seeks to address the second sub-objective:

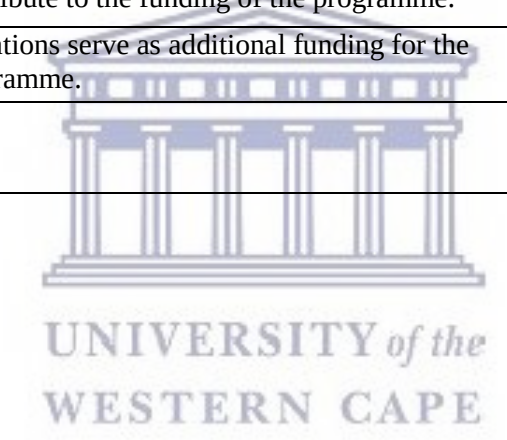
- To explore and describe the resource allocation for clinical nursing education offered at universities in Nigeria

The themes and categories that emerge in the input evaluation are outlined in Table 4.3 below.

Table 4.3: Educator themes and categories: Input Evaluation

THEMES	CATEGORIES FROM FOCUS GROUP DISCUSSION	CATEGORIES FROM INTERVIEW
Human resources **7B**: Successful implementation of the curriculum is dependent on the qualifications of educators and professional nurses.		Staff qualifications affect the overall quality of staffing in the universities.
		Differences in the type of qualifications educators hold and the type of degree they are required to teach affect implementation of the BNSc programme.
		The levels of education of professional nurses affect the teaching and mentoring of the nursing students in the clinical facilities.
8B: Shortage of manpower has a negative effect on clinical experiences and clinical training of student nurses.	Too few educators for the large number of students admitted into the nursing programme.	Too few educators for the large number of students admitted into the nursing programme.
		Professional nurse shortages in the clinical facilities.
Material resources **9B**: Lack of basic infrastructure and resources render the clinical setting non-conducive for student learning.	There is lack of much-needed infrastructure in the clinical facilities.	There is lack of much-needed infrastructure in the clinical facilities.
	The lack of material for patients' care affects student learning.	
	The inadequacy in much-needed resources in the clinical facilities leads to excessive improvisation	The inadequacy in much-needed resources in the clinical facilities leads to excessive improvisation.
	Hoarding of clinical facilities equipment by the professional nurses contributes to the inadequacy of resources.	

	The use of university resources is needed in the clinical facilities to enhance clinical training of student nurses.	
Fiscal resources **10B**: Funding of the BNSc programme poses challenges for clinical learning.	The university is responsible for the funding of the materials needed for clinical education through funding from government.	
	Allocation of money is given by the university to the departments as requests are made.	
	Tuition and clinical fees paid by students contribute to the funding of the programme.	
	Donations serve as additional funding for the programme.	Donations serve as additional funding for the programme.
		Irregular research grants also contribute to the funding of the nursing programme.



Theme 7B: Successful implementation of the curriculum is dependent on the qualifications of educators and professional nurses

In nursing education, the educators play an important role in the advancement of nursing education (Salminen, Stolt, Saarikoski, Suikkala, VArito & Leino-Kilpi, 2010; National League for Nurses (NLN), 2013, AACN, 2012). According to Robert Wood Johnson, who funded the Institute of Medicine report (2011) as cited in National League for Nursing (NLN, 2013), there is a need for doctoral prepared nurse as it has a direct impact on the future of the nursing profession. There are several articles that support the fact that advancement in nursing education has direct input to nursing education and ultimately nursing care.

In Nigeria, according to a study conducted by Ayandiran, Irinoye, Faronbi and Mtshali, (2013:7) there is "relative shortage of manpower in almost all the nursing university programmes". According to one of the educators in this research, quality of staffing is a problem: *"you see one of the problems of academics environment today is quality staffing. When you don't have somebody with the commensurate qualification, experience and understanding of the curriculum it may be difficult to manage and managing it maybe in error, looking at it from this perspective" (Educator 12, SSI).*

He further commented on the fact that the differences in qualification have a direct effect on how the content of the curriculum is delivered. In Nigeria, the type of BSN programme that was delivered in the past required the nurse to specialise either as an administrator or nurse educator which is in variance with the type of nursing that is currently being offered in Nigerian universities. These programmes target secondary school leavers and encompass all aspects of nursing. Unfortunately, most of the present-day educators are products of the previous type of nursing qualification, where they either specialised as a nurse educator or as a nurse administrator, as the following participant said: *"I have a BSc even though tagged nursing I say I have specialization in administration, education. Now you are now into a*

programme that is not really talking of education or administration specific it is talking of the totality, comprehensive totality of nursing be it in the clinical setting, or in the public environment, or industry, or in the mental health institution and it is a polyvalent sort of thing and you have no exposure of that" (Educator 12, SSI).

In response to research conducted by Aiken, Clarke, Cheung, Sloane and Silber (2003) on educational levels of hospital nurses and surgical patient mortality which highlighted that hospitals with higher level of BSN nurses have a lower mortality rate compared to those with a lower number of BSN nurses, The American Association of Colleges of Nursing recommended in 2008 that 80% of nurses without their baccalaureate degree should have proceeded to attain the degree by 2020. In Nigeria, despite the fact that the ability to move up the ladder in nursing and attain the necessary qualifications to attend to patient care in the technologically sophisticated 21st century nursing care, the turn-out in hospital-based nursing graduates has increased greatly (Ayandiran, Irinoye, Faronbi & Mtshali, 2013). The educator who commented on the academic qualifications of the educators also said that professional nurses do no not have the required educational qualification needed to implement the curriculum in the clinical setting: *"Their helping process is not as adequate because they don't have the commensurate level of education and at the same time we allow in fighting to divide us the more. I rest my case" (Educator 12).*

THEME 8B: Shortage of manpower has a negative effect on clinical experiences and clinical training of student nurses

Globally, the nursing profession is experiencing a shortage of human resources, (NLN, 2015) which is further compounded by the shortage of nurse educators who are expected to train upcoming nurses. According to the 2015 report of NLN, the American Pre-licensure institutions turned away 38% of qualified applicants due to lack of faculty. Africa is in the

same position, according to Fhumulani, Daniels, Direko and Uys (2014). Their article explains the current status of the education and training of nurse educators in South Africa and they alluded to the fact that there exists a need to train nurse educators since South Africa is also being affected by the global epidemic of shortage of nurses. Nigeria is not an exception either as the looming shortage of educators affects the student-educator ratio of 1:10, proposed by the National University Commission.

All universities, except one that participated in this study experienced a shortage of educators, and that includes clinical instructors. The educators mentioned that there are between one and three clinical instructors: *". . . For now . . . We are two" (Educator 20, FGD).*

"We have in the last two years we had one and of course the ratio is small and recently . . ." (Educator 10, SSI).

Another educator though explained that they have an inadequate number of instructors and have to go for supervision in all the different locations students use for their clinical placement: *"We use the teaching hospital, state hospital at Adeoyo ring-road then we use even the Catholic hospital, Eleta, but mostly is the other one OLuyoro, then we use the primary healthcare centre, Igboora community, and we use community settings outside in the rural" (Educator 7, SSI).*

The shortage of staff at the university badly affects the quality of supervision that is being provided to the students. In order to improve the supervision, one of the head of departments said it is compulsory for the educators to accompany the students to clinical practice: *"Mandatory, you see, that is the requirement. In fact, when I came we had to change the appointment letter of some people that has to be to teach in the clinic, in the hospital, at all setting and also in the classroom. Otherwise who is going to teach?"(Educator 2, HOD).*

However, it is not always the case. Another educator commented that the educators also have to struggle with teaching students in the laboratories and in the classrooms as well: *"Yes sometimes ideally we should but the current shortage of staff is the thing especially with the post-graduate programme on, if you are not teaching undergraduate, you are teaching post-graduate, you are supervising, you are going for one exams and things like that"(Educator 7, SSI).*

In addition, some universities have to rely also on the professional nurses in the hospitals to teach and supervise the students when they are on clinical placement without any special appointment, as illustrated by the statement by an educator: *"then on the wards we do not have professional that are appointed but the working relationship, with all the institutions we work with, professional nurses supervise them" (Educator 7, SSI).*

However, some of the universities, according to another educator, identify experienced nurses and train them as preceptors that will help in the supervision of the students: *". . . but in addition to that in all our clinical site, we have some that have been appointed as preceptors which the department is responsible for their activities and we expect them that in addition to what other nurses do that they also go extra miles in ensuring that students learn what they should learn in the clinical area"(Educator 9, SSI).*

The same educator, however, pointed out that the shortage of nurses on the ward affects the teaching and supervision of the students during clinical experiences: *"Also where you are supposed to have the staff complement and you don't have them and the fewer number of staff present to really impart maximally on the students" (Educator 9, SSI).*

THEME 9B: Lack of basic infrastructure and resources render the clinical setting non-conducive for student learning

Material resources referred to in this section include the physical structures in both the hospital and the school, and the equipment and instruments both in the school and at the hospital where students go for their clinical experience. The equipment and resources in the school laboratories have been previously discussed in section 4:2 above and will not be repeated here.

One of the educators, when asked about whether the hospital environment was conducive for clinical education, responded as follows: *"We can't say it is conducive I am sorry. One, in terms of facility, how adequate is the facility itself in terms of space, and other factors such as aeration and lighting and so on . . ." (Educator 12, SSI).*

Inadequate infrastructure and insufficient material resources for patients are the main reasons why hospitals do not talk about the teaching of students. According to one of the Head of Departments interviewed, patients have to purchase materials needed for their treatment and this fact alone means that the students have to be careful when carrying out the procedure to prevent wastage of material: *"Like patients they do a lot of things on their own, they buy their drugs and you know the purchasing capacity, purchasing power, if what they need are not available, what will the student do, or what the educator do, so do you understand the issue of ideal"(Educator 4, HOD).* Even when the material is there, it is not enough so you have to improvise and this affects students' learning since there is a difference between what is being practice and what is being in the classroom, as illustrated by the statement of an educator: *"On the ward I will say that the resources are available but not adequate, you know the difference, they are available but may not be adequate all the time, there is a lot of improvisation which make sometime bring difference from what they have learnt in the lab and what is done during clinical practice"(Educator 6, SSI*).

One of the educators said the materials and equipment needed maybe present in some wards but because the professional nurses have to account for the equipment in a good condition during inventory, it is stored away and not made available for student use thereby contributing to the already existing shortage: *"You know these things are available on your ward . . . They are being kept so that they cannot be defaced that is why they are kept" (Educator 14).*

However, according to another educator, in order to combat the lack of materials for teaching the students, the institutions take instruments from the school to the hospital, especially during examination period: *"Okay, we still give them instruments for exam to augment from the school" (Educator 20, FGD).*

THEME 10B: **Funding of the BNSc programme poses challenges for clinical learning**

Fiscal Resources, according to Merriam- Webster Online Dictionary, is money or anything relating to money that an organisation or business earns, spends and owes. Under this section, 'Funds available to the departments', sources of funds and allocation of funds will be discussed.

Findings from the focus group discussions and interviews with the educators concerning the fiscal resources reveal that the major source of funding for the departments of nursing is through government allocation in the case of government-owned institutions, and school fees in the case of the private-owned institution, as illustrated by the following statements from educators:

"The university is responsible of course it is a federal institution and they pay, so it is the university that gives us the allocation of resource" (Educator 10, SSI);

"I can only say it is the university, and you know the university is a federal university, so it will take money from the federal government and I think that is the major source of funding" (Educator 11, SSI).

Despite school fees being the major source of funding in the private institution, an educator said he believes that the school authority adds funds to the fees obtained from students as this will not be enough to cater for all student clinical needs: "*Well, I'm not gonna say that the major source of the funding for clinical is students. That one will not be enough to really take, although it takes care of part of it but I don't really think it's the major money that we use for . . .the university is responsible for student's clinical" (Educator 25, FGD).*

Other educators said that money from the government is then allocated for use through governing bodies of universities: *"The University used to have IGR. (Internal Governing Revenue) they have the budget for the university. They give to the university. It is from the budget that they allocate to all faculties. From faculties to the department" (Educator14, FGD).*

Notwithstanding government allocation to the federal and state universities which the universities then disseminates to the department, the student also pays for some things in addition to their school fees. According to the educators, the student pays for the clinical placement they attend, fuel and transportation and also departmental fees. This is illustrated by some statements from some of the educators in the government-owned universities: *"The funding is in two ways, we have government support and the students pay school fees, and they pay for lab, clinical posting, and transportation" (Educator 6).*

". . . the students also pay for their posting. The students have to fuel the two buses that convey students to their places of posting" (Educator 13, HOD).

However, funding from the government is a problem and is also very irregular, as illustrated by a statement from this educator: "*We have problems about money in this part of the world, nursing education, generally is poorly funded by the government" (Educator 8).*

In addition to the sources of funds listed above, the Head of Department at one of the universities, that also runs a part-time distance learning programme, stated that part of the money they receive from the programme is put back into the department to train and pay preceptors for students clinical nursing education: *"so funds from the distance learning programme was used to train clinical preceptors, they were trained and given everything they will need, the booklet they will use, they were introduced to it" (Educator 13, HOD).*

Donations serve as an additional source of funding and emerged from the discussion with the educators. According to one of the educators, the school gets donations from the alumni: *"We have donors, maybe our alumni who will donate something for us" (Educator 8, SSI).*

Another educator said some organisations donate things that are needed: *"Yes, some people donated some mannequins, some books, audio visual to assist clinical teaching" (Educator 27, FGD);* and according to another educator, they get funding from philanthropists: *"We have alumni. And then we have individual Adventist. Like somebody who has donated 600m for a new school of nursing" (Educator 2, HOD).*

Some of the educators also receive grants, though not regularly or big amounts, but they acknowledged grants as an additional source of funding: *"We don't really have much of grant here. the only person with grant is Doctor X for her own and is NIH from the grant she got us a generator which when she did her program, she got us something again for the lab what they use for, I have forgotten the name, at least we got a little donation from it but we don't have much of it, it is not regular" (Educator 6, SSI).*

4.3.3 Process Evaluation

This section presents and discusses the findings from the educators on the process evaluation and seeks to address the third sub-objective:

- Explore and describe the process of delivery of clinical nursing education offered at universities in Nigeria

The themes and categories that emerge in this process evaluation are outlined in Table 4.4 below.

Table 4.4: Educator themes and categories: Process Evaluation

THEMES	CATEGORIES FROM FOCUS GROUP DISCUSSION	CATEGORIES FROM INTERVIEWS
Community of practice **11B**: Perceived collaboration between educators and professional nurses towards a common goal in clinical education.	The students are not accepted by professional nurses.	The students are in the midst of professionals that can help with the acquisition of their professional skills.
	Educators perceived the professional nurses at the clinical setting as their colleagues working towards a common goal.	Educators perceive professional nurses at the clinical setting as their colleagues working towards a common goal.
		Educators organised seminars to bridge the gap between professional nurses and them.
Purposeful supervision **12B:** Clinical supervision is negatively impacted by the use of multiple clinical setting and availability of staff to accompany students.	Simultaneous use of different locations for clinical placement affects the availability of clinical instructors at a given time during clinical placement.	Simultaneous use of different locations for clinical placement affects the availability of clinical instructors at a given time during clinical placement.
		Student accompaniment during the clinical placement is reduced due to shortage of staff and heavy workload.
13B: Different teaching styles are used in clinical supervision of students	Educators engage in different styles of teaching during clinical supervision of students.	Educators engage in different styles of teaching during clinical supervision of students.
14B: The clinical placement objectives are not strictly adhered to.	To align the theory to practice the clinical placement objectives are derived from the theoretical objectives of a course.	Clinical placement objectives are derived from the theoretical objectives of a course.
	Clinical instructors and professional nurses do not adhere to the clinical objectives set for students.	
	Having objectives during clinical placement places limitation on the extent student experience learning.	
15B: Evaluation of students' competence is carried out in both structured and unstructured ways and serves as feedback to the students.	Different methods are used to for the formative assessment of students during clinical placement.	Different methods are used for the formative assessment of students during clinical placement.
	Evaluation of "record of instruction booklets" submitted by the student nurses is irregular.	Evaluation of "record of instruction booklets" submitted by the student nurses is irregular.

	The summative assessment is conducted by an examination that is patterned after the professional practical examinations.	The summative assessment is conducted by an examination that is patterned after the professional practical examinations.
	Weekly evaluations are endorsed by students, professional nurses and the clinical instructors.	
	Students receive feedback by means of examination results.	
		Feedback to students during formative assessments is mainly unstructured during procedures.
		The grade obtained from the evaluation is part of the promotion grade of the students.

i) Community of practice

THEME 11B: Perceived collaboration between educators and professional nurses towards a common goal in clinical education

Community of practice, according to Wenger-Trayner (2015), refers to groups of people who are brought together as result of similar interest and this interest improves as a result of daily interaction with one another. In nursing education, students are placed in a clinical setting to bring into practice what they have learnt in theory and this experience is carried out among the professional nurses who engage in the care of patients. According to Wenger-Trayner (2015), community of practice is characterised by:

(i) The *domain*: the members of a community of practice must have what we call "mutual engagement" (Hoadley, 2012), common knowledge and goal or commitment to the agreement and shared goal. It is not limited to a space or environment in as much as there is a shared goal and commitment (Wenger-Trayner, 2015).

In this study, educators believe that they are in collaboration with professional nurses and that the professional nurses are their colleagues in the professional ward setting:

"What we both stand to gain by working together and we tried as much as possible to reduce the gap between the academia and the practitioners the clinicians, and we were able to achieve a degree of success" (Educator 4, HOD); "they are in the practice area we are in the teaching area and of course there should be a synergy, collaboration" (Educator 8, SSI).

(ii) The *community* relates to achieving the shared goal. Members build relationships that enable them to engage in activities with one another in which they can learn from one another. Hoadley (2015) refers to this as joint enterprise; members look out for one another and are accountable to one another. One of the educators said they believe they are working towards a common goal which is to produce a quality nurse: *". . . really we have been*

working hand in hand with the nurses in the clinical area, through the clinical education unit. . ." (Educator 30, SSI).

(iii) The *practice* includes the shared repertoire that exists between members−their shared experiences, tools and resources. One of the educators in the study spoke about inviting the professional nurses to seminars held in the department as a way of improving the knowledge of the professional nurses, as illustrated in this statement: "*But when we are having seminars that are not because of practicum there are theoretical issues in nursing themes, we invite them [professional nurses] and we have had them coming" (Educator 7, SSI).*

ii) Purposeful supervision

THEME 12B: Clinical supervision is negatively impacted by the use of multiple clinical settings and the availability of staff to accompany students

Clinical supervision refers to the support from a professional or a more experienced nurse with the aim of helping the student to build a satisfactory competence that leads to confidence through reflective practices (Cruz, Carvalho & Sousa, 2012; Diogo,Cariro, Sousa & Rodrigues, 2016). The presence of a nurse educator or a clinician during the clinical experience of the student nurses in the hospital has been valued in clinical nursing education (Lambert & Glaken, 2005; Kristofferzon, Martensson, Mamhidir & Löfmark, 2012) since the successful integration of the theory in class with the practice in the clinical setting is highly dependent on the purposeful guidance and supervision provided by either the professional nurse on the ward or the nurse educator that comes to the ward from time or both (Löfmark, Thorkildsen, Räholm & Natvig, 2012).

The manner in which supervision is carried out affects the view of the students about nursing and the acquisition of clinical skills. According to Ashbourne, Fife, Ridley and Gaylor (2016) and the Australian Institute of Professional Counsellors (2011), there are four key ways to

supervision: individual, dyadic, group and live supervision. *Individual supervision* refers to one-on-one supervision where the supervisors meet with the supervisee. *Dyadic supervision* refers to a supervisor meeting with two supervisees at the same time. *Group supervision* refers to the supervisor working with a group of students at the same time and exerting influencing on one another, but not necessarily from the supervisor. Lastly, *live supervision* refers to when the student, who is the supervisee, acts as a supervisor for another person, with the supervisor present and continues his/her direct influence on the process.

In the research study, it appears that the educators and clinical instructors are engaging more in group and live supervision. The researcher is of the opinion that this is the case because of the following reasons: too many students, few clinical instructors and lots of sites to visit at the same time as clinical for different group is happening simultaneously. As such, the clinical instructor takes the most convenient way of supervision, according to this statement from one of the educators that when one meets a student performing a procedure one seizes the opportunity to teach; not necessarily identifying patients beforehand and deciding on what the students will do: *"what we try to do is that when we go the students, usually we meet them doing something, so we check what they are doing and we correct for instance, if a student is carrying out vital signs for a patient for instance, you want to observe what the student is doing at that point in time and then you now try to correct"(Educator 3, SSI)* .

However, the use of different clinical sites at the same time threatens the effectiveness of the clinical supervision as clinical instructors have to be present at all the sites as well. This becomes impossible due to the number of the educators and clinical instructors, as expressed in the statement by one of the clinical instructors: *"We can have students in about nine settings when the students start clinical and there is no official car and we are three clinical instructors" (Educator 1, FGD).* According to an educator, the use of different clinical sites reduces the time and chances available for educators to accompany students to the clinical

placement sites as educators become tired as a result of moving from one place to the other. "*it is not easy for a woman, to be driving, after driving you climb stair case and you will be on your feet throughout the day, and then drive from point one to two and three"(Educator 1, FGD).*

In addition, one of the clinical instructors said that the level of student determines the ward he/she is posted to and the procedure he/she is allowed to carry out: *"What happens is it depends on the level. For instance, those in 200 level- they cannot do higher procedures like catheterisation so by the time they are graduating, you know when gradually and gradually on that" (Educator 20, FGD).*

THEME 13B: D**ifferent teaching styles are used in clinical supervision of students**

According to Kolb's theory of experiential learning, there are four types of learners: the assimilating learner, the diverging learner, the converging learner and the accommodating learner. These learners go through the four steps in the cycle of learning and enter at different stages but would eventually pass through the four stages for learning to take place (Kolb, 2014). In the nursing curriculum, this factor is considered when developing the nursing curriculum and its implementation (Lisko & O'Dell, 2010). In the study, clinical instructors and educators engage in different teaching styles in the teaching of nursing students during clinical supervision: *"There are different methods that we use, we can use the methods where students are asked questions and they are able to bring out whatever it is that we want them to do" (Educator 22, FGD).*

One educator identified an additional method of teaching, namely that of students' presentation of cases: *"When they are doing concentrated clinical when there is no classroom teaching, we expect that every person goes to the ward, they document their experience, they present it, they do case presentation, case analysis, we even do role play so*

that we can easily know those who are not there apart from people going there" (Educator 4, HOD). Another educator from the focus group discussion said they engage the students in pre and post clinical conference: "*we also engage in discussion, the idea of post clinical conference involves some level of discussion" (Educator 23, FGD).* The same educator went on to talk about individualised care as a method to teach students: *"… student by the time they go to the various wards there are assigned on patients, for individualised care and it is expected that whatever activity that pops out during the interaction between the patient and the student will have to be summarised or give the report of at the post clinical conference" (Educator 23, FGD).*

THEME 14B: Clinical placement objectives are not strictly adhered to

According to Lambert and Glacken (2005), a student's acquisition of skills in the clinical setting requires the presence of a supervisor and the effectiveness of the clinical supervisor can only be seen when there is an achievable clinical learning objective (Lofmark et al., 2012). From the four universities that participated in this study, only two had written objectives for their students on clinical practice. One of the universities that does not have written objectives for the clinical experience of the students, believe that it is not important and that it limits the learning experience of the students. They believe that students are aware of who they are. If they have written objectives, the objectives will be a passport for laziness. The students will not be interested in other works that are not included in their objectives. These universities also maintain that the possibility exists that students may not experience any additional experiences throughout their clinical experience if they are limited to the mentioned objectives, as illustrated by the following statement from an educator: *"One of the advantages is that the students will want to concentrate on it and make sure that they learn what is expected. The disadvantages is that some students may not even try to learn other*

things which you may not have advantage to [again].(Educator 17,FGD) This educator also believes that one should allow students free reign and that objectives would restrict them: "*You allow them to do self-study. That will help them a lot. I am not saying we should not have objectives. We can have objectives. But when we so much streamline it so that they can do it - it doesn't allow them to learn other things … to use all their senses to learn other things . . .*" *(Educator 17, FGD).*

A second university with no common clinical objectives is of the opinion that each clinical instructor normally formulates her own objective for the student as expressed in the statement by one of the educators from the university: *"I think individual instructors develop objectives from the student that they work with. But this has not been . . . we are not doing it well" (Educator 27, FGD).*

However, one of the educators at a university with written objectives, said that the objectives from theory serve as a guideline to those of the clinical practice: *'It is the clinical aspect of these courses so each lecturer gives us the objectives and the course outline at the beginning of the semester, so then our teaching is based on the course outline" (Educator 30, SSI.)*

Even though the objectives of these universities have been written from the perspective of the researcher it seems that they were written to fulfil all obligations as they are not strictly adhered to. This is illustrated by a statement from the clinical instructor who believes they are not in charge of the ward; they simply follow what they see in the ward: *"You can't really change the ward routine let me put it that way because you want to teach the students something, we are not sure of what we will meet so it is what we meet that we teach because if we go there without teaching them on life patient then we can as well stay in the clinical lab"(Educator 3,SSI).*

The educators have the responsibility of sharing the learning outcomes with the professional nurses on the ward (Harden, 2007). One of the clinical instructors in the study said they pass

written information to the nurses on the ward via the continuing education unit of the hospital: *"really we have been working hand in hand with the nurses in the clinical area, through the clinical education unit, usually before we send them, the students to the college, we write a letter through the dean of our faculty, to CMD and we route it through the director of nursing, then who will route it to the in-service education unit" (Educator 30, SSI).*

THEME 15B: Evaluation of students' competence is carried out in both structured and unstructured ways and serves as feedback to the students

Evaluation of nursing skills competency is very important in nursing education but it has remained a daunting task for nurse educators (Helminen, Tossavainen & Turunen, 2014; Rafiee, Moattari, Nikbakht, Kojuri & Mousavinassab, 2014). In the study, one of the educators from one of the universities said the university has developed a booklet to monitor the progress of students in addition to the records of instruction provided by the Nursing and Midwifery Council of Nigeria: *"We have at least three for that; we have two designed by the department. i think we have more than two but at least we have this one(showing the book to the researcher) for the general nursing, so student are expected to fill in their log in their activities in it and to be counter-signed by the staff in the hospital. We also have another one for the midwifery and we have the clinical procedure guide that we expect them to utilise, we also expect them to utilize the record of instructions from the nursing council also" (Educator 9, SSI).*

Another educator reported that these booklets are to be signed by the nurses that supervise the student or that performed the procedure with the student: *"they are supposed to after each day's activity record what they have done and then give to the matron or the nurse in charge to sign."(Educator30, SSI).*

However, from field notes and observation by the researcher, some of the matrons in the hospital just sign off the booklet without necessarily checking or supervising the students. In three of the four universities that participated in the study, no structured feedback is provided to the students to monitor how he or she is progressing. The only form of structured feedback that exists is the end-of-semester examination. According to one educator, a student gets to know his/her performance only through an examination: *the summative is what is usually only used in terms of the examinations, how did you perform. But the on-going which is the formative, is usually not structured it is when you now have the summative results that you say that student is poor, she has not been doing well. The last time I was there, do you get, but there is no record" (Educator 7, SSI).*

In contrast, the fourth university in the study, is the only university that has a structured weekly evaluation, according to the Head of Department where the student is expected to agree or disagree with what is written about her: *"And we have weekly evaluation that will assign grade and comment that student will either agree with or disagree with; so that they can improve.* He further highlighted that the cumulative progress of the weekly evaluation and end-of-semester examination determine whether the student progresses to the next level. This report is signed by the student, the clinical instructor and the nurse in charge of the ward: "*And then after that we have cumulative, we have both summative and cumulative and then at the end to be able to pass, you must satisfy all the criteria and then we will sit and say whether your experience has been successful or it has not been successful; if it is not successful, not by only one person, by two or three examiner, or preceptor then you repeat the posting. You repeat the posting. You will not move forward" (Educator 2, HOD).*

The grades from either the weekly or end-of-semester examination contribute to the overall progress of the student. The only difference between the weekly and the end-of-semester

evaluation is that students get to know their performance in the weekly evaluation and can work towards improving while with the end-of-semester evaluation students get the feedback late which results in no room for improvement unless the student repeats the posting.

4.3.4 Product Evaluation and Educators' recommendations for improvement

This section presents and discusses the findings from the reports of the educators with regard to product evaluation and seeks to address the fourth sub-objective:

- Explore and describe whether clinical nursing education offered at universities in Nigeria is effective

It was indicated earlier that evaluation could either be formative or summative. In the formative nature of evaluation, the model seeks to bring out standards that can help during the summative evaluation in order to inform the decision-making process. In this study, the researcher set out to ascertain from the educators how they view improved clinical education. This section is therefore presented in two parts: firstly, the feedback the school received from the employers of their graduates and the professional nurses presently working with their student nurses is presented. Secondly, the opinion of the educators on how to improve clinical education is presented.

The head of departments (part of the educator participant group) were asked about feedback they received from employers and professional nurses regarding the student in the programme and graduates from this programme. As such, theme 16B represents findings from the head of departments only.

Table 4.5: Educator themes and categories: Product evaluation

THEMES	CATEGORIES FROM FOCUS GROUP DISCUSSIONS	CATEGORIES FROM INTERVIEW SESSIONS
16B: Satisfactory reports from examination body, professional nurses and employers on the professional skills of students.		Professional nurses report positively on the student's acquisition of professional skills
		The pass rate for the professional examination has greatly improved.
		Employers have reported positively on the graduates from this programme.
17B: Clinical skills laboratory should be spacious and equipped with modern technology and should replicate the clinical facilities.	The clinical skills laboratory should be well-spaced to prevent overcrowding of students.	The clinical skills laboratory should be well-spaced to prevent overcrowding of students.
	The laboratory should be well equipped and with improved technologies.	The laboratory should be well- equipped with improved technologies.
	The clinical skill laboratory should be a replica of the clinical facilities.	
18B: The nursing programme should allow for more practical exposure during the programme and after graduation.	An internship should be introduced into the nursing programme.	An internship should be introduced into the nursing programme.
		The curriculum should be rearranged to allow for more practical exposure.
19B: Human resources should be increased to improve the quality of students' clinical supervision.	There should be improvement in monitoring of students during clinical placements.	There should be improvement in monitoring of students during clinical placements.
	An adequate number of educators should be employed.	An adequate number of educators should be employed
	There should be provision of timely feedback to students.	There should be provision of timely feedback to students.
	There should be good collaboration between the educators from the universities and the professional nurses in the clinical facilities.	There should be good collaboration between the educators from the universities and the professional nurses in the clinical facilities.
20B: The clinical facilities should be well-equipped with human and material resources.	The shortage of professional nurses in the clinical facilities must be addressed.	The shortage of professional nurses in the clinical facilities must be addressed.
	The clinical facilities should be well-equipped with the necessary materials for patient care and student learning.	The clinical facilities should be well-equipped with the necessary materials for patient care and student learning.

THEME 16B: Satisfactory reports from examination body, professional nurses and employers on the professional skills of students

In the study, educators are of the opinion that the clinical education offered in the university programme is successful. Their reports were based on reports from the professional nurses working with their present students and graduates of their nursing programme. According to a Head of Department in the study, they have been receiving positive reports about their current students on clinical placement, as illustrated by his statement: *"And report that we are getting, I was so happy this year when they came back with the report that our students did very well" (Educator 2, HOD).* He attributed the progress to the improvement on the quality of supervision in the clinical education as a result of the increase in the number of clinical instructors that are accompanying the students for the clinical experience: *"The quality of supervision has improved. We have people that follow them. So we have so many people, and we have people like six-eight people following them and nobody will follow more than 2-3 people at the same time"(Educator 2, HOD).*

In addition to the reports from the clinical placement area, he said he believed that the clinical education has greatly improved because students obtained 100% in their practical examinations when sitting for the professional examinations. They have had 100% pass rate for three years in a row: *"Yeah . . . it's been…if you say…because for example in the last two-three years they've all passed the clinical exam set up by the government. When they come to look at our students, they've triumphed successfully, they've done well" (Educator 2, HOD).*

Another Head of Department looked at the effectiveness of the clinical education offered in the university programme from a different perspective, and she said the market survey conducted by them showed that their products are sound. She attributed it to the effort they put in during the clinical experience of the students:

". . .we did a market survey, people commended our product that they are very sound on clinical judgement, and why because of the efforts we put on clinical exposure that you cannot corner them, you understand that kind of thing…" (Educator 4, HOD).

THEME 17B: Clinical skills laboratory should be spacious and equipped with modern technology and should replicate the clinical facilities

As indicated earlier, the clinical skills laboratory is an important component in the nursing programme as this is the first point of call for the student nurses to acquire and practice professional skills before going to the clinical settings to practice on real live patients. It is not surprising therefore that the educators in the research emphasised establishing good clinical skills laboratories at the universities. One of the challenges mentioned earlier was the lack of space in the clinical skills laboratories. The educators pointed out that they would like to see a situation where the laboratory is big enough to accommodate the number of students that are admitted into the nursing programme, as illustrated in the following statements from the educators: *"It starts from our lab here and there are challenges in terms of space and of course we need more mannequins where we have enough space" (Educator 10, SSI);*

"If we even we can have more space for more, larger space in the lab because they are normally crowded" (Educator 6, SSI);

In the same vein another educator commented on having more teaching aids and equipment that involve modern technology: *"we are hoping when we get enough fund we will have more computerised mannequins" (Educator 13, HOD).*

Another suggestion made by an educator was that the clinical skills laboratory should be made to look like the clinical facility where the students have their clinical experience. The students would be used to the environment before getting to the clinical facility and this will boost the confidence of the students: *"the clinical laboratories that we have in the school*

should be such that will be equipped to look like hospital so that when they get to the hospital they are not disputed by the hospital environment, it should be such that everything that the procedure or skills that will be learnt out there will be demonstrated" (Educator 26, FGD).

THEME 18B: The nursing programme should allow for more practical exposure during the programme and after graduation

According to Agbedia (2012), the Nigerian nursing curriculum is overburdened with too many courses leaving no room for practical exposure for the student nurses. The educators in this study agreed with this article and suggested the nursing curriculum should be rearranged to allow for more time for clinical exposure, as expressed by one of the educators: *"I think what we have now is okay. It's only we need more time to implement the clinical" (Educator 2, HOD).*

In addition to rearranging the curriculum to accommodate for more time for clinical exposure, one educator suggested that student nurses can have time allocated for internships which focus only on clinical education: *"There is this focus thing that they are saying internship or no internship, it should be included so that they will be exposed. If I am going to spend 3 months in the maternity- that one will expose me" (Educator 16, FGD).*

THEME 19B: Human resources should be increased to improve the quality of students' clinical supervision

As stated earlier in the sections that presented the reports on the input and process evaluation, supervision of the student nurses is one of the challenges of clinical nursing education in the Nigerian nursing programme. In view of this, and with regard to improved clinical nursing education, the educators suggested that effective monitoring of the student nurses during the

clinical placement will assist in ensuring standards in the clinical education: *"My ideal situation for clinical will be to have, for the students to know what they are going to be doing either per day or per week so that they can know whoever is going to monitor them or supervise them will be able to determine whether those have been achieved or not achieved"(Educator 25, FGD).*

But according to another educator, this can only be achieved if there is an adequate number of educators that can accompany the students during their clinical experience, and only if the government employs more educators. *"I will start with the issue of manpower; they should have adequate number of lecturers, because ideally the lecturers are supposed to follow their students to the ward to supervise to ensure that they are learning, you know we say BNSc, so they should be sure that they are translating this knowledge into practice, so we need more lecturers" (Educator 6).*

Timely feedback is also an important aspect in quality supervision, as it had been identified that students do not receive timely feedback. Feedback is only provided at the end of the semester. According to an educator, it is essential for students to get feedback on time about their progress in order to ensure that the students are progressing and to provide time for improvement if there is any need. *"And we need enough time for feedback . . . enough time for students to practice the skill to get the feedback" (Educator 2, HOD).*

Besides monitoring the students and giving feedback to the students and providing time for practice, collaboration between the educators and professional nurses is another factor that could contribute positively or negatively to the quality of supervision students receive during clinical placement. According to the following educator, if students do not have good clinical experience the professional nurses need to help the students, as clinical is not practice in the office but in the clinical facilities. *"This is clinical; you don't do clinical from the office. It is those who are working in the clinical set up, those are the ones that can help the student in*

terms of their clinical exposure" (Educator2, HOD). There exists therefore a need for good collaboration between educators and professional nurses.

THEME 20B: The clinical facilities should be well equipped with human resources and material resources

The clinical facilities in the study have been identified as being under-staffed and poorly equipped. One of the suggestions from the educators, in order to ensure a standard clinical education in the nursing programme, is to ensure that clinical facilities are well-equipped with professional nurses and materials for patient care and students' learning, as illustrated by this statement: *"the clinical site for the sake of the students should be properly staffed and equipped so that students can used it for maximum learning"(Educator 9, SSI).*

One of the educators also mentioned a need for the government to be interested in the training of the professional nurses so as to help the students during clinical experiences. *"We need government to . . . there should be political will . . . the government should have interest in health and that will encourage an aspect of training. It is very important. We don't have well trained staff that will . . . you know . . . that will send down the knowledge to the students. It doesn't help the system" (Educator 17, FGD).*

4.4 SECTION THREE: PROFESSIONAL NURSE INTERVIEWS

This section presents and discusses the perceptions of the professional nurses in the clinical nursing education offered in Nigeria. Professional nurses refer to registered nurses and midwives that are working with students during the clinical placement. A total number of 10 themes emerged from the focus group discussion and seek to address the first broad objective:

- To explore the effectiveness of clinical nursing education in Bachelor of Nursing Science programmes at universities in Nigeria

Table 4.6 presents the categories and themes for this participant group.

Table 4.6: Themes and categories from professional nurse focus groups

STEPS IN CIPP	THEMES	CATEGORIES
INPUT	**1C:** Lack of human and material resources in the clinical setting negatively impacts students' clinical learning.	Shortage of manpower places pressure on the nurses and leads to ineffective facilitation of students' clinical learning.
		Inadequacy of material resources leads to improvisation which negatively affects learning.
PROCESS	**2C**: Perceived lack of commitment by professional nurses in supporting university student nurses and a lack of incentives for facilitating student learning existed.	The differences in the educational level of the educators and professional nurses' cause a dichotomy between the two and lack of commitment of professional nurses towards the student nurses.
		Lack of teaching incentives for professional nurses discourages them from teaching the students.
	3C: Assignment of too little time to practical exposure in the curriculum.	The curriculum assigns more time to theory than clinical practice.
		Allocation of two days per week for clinical practice is too short for a meaningful clinical experience. The resumption and closing time of student nurses to the clinical settings affects their learning experiences during clinical placement.
	4C: Student absenteeism from clinical practice placements negatively affects their clinical learning and experience.	Lack of student motivation and absenteeism among students further reduces the clinical time spent in clinical practice.
	5C: Active supervision of student nurses by professional nurses is reduced due to their heavy workload.	Professional nurses engage in non-active supervision of student nurses during clinical placement.
		Heavy workload affects the availability of professional nurses to support students during their clinical placement.
		Limited availability of clinical instructors at the clinical sites negatively affects student supervision.

	6C: Students' clinical learning objectives are not always made available to professional nurses.	The clinical objectives are not always made available to professional nurses working directly with the students during clinical placement.
PRODUCT	**7C:** Graduates from the universities are not proficient when it comes to professional skills.	University graduates lack good proficiency and professional skills.
		The graduates become proficient in the professional skills over time.
	8C: Establishment of an internship for the university nursing programme to boost students' practical experience and acquisition of professional skills.	Introduction of internship into the nursing programme should be approved by federal government to boost the practical experience of students.
	9C: Adequate material resources and employment of more human resources are required at the universities and the clinical facilities.	More human resources are needed in the universities and clinical facilities.
		The clinical facilities should be well-equipped for patient care and students' teaching and learning.
	10C: Collaboration between professional nurses and educators should be improved.	Educators from the school should work in the clinical facilities alongside professional nurses and qualified professional nurses in the universities as well.
		There should be good working relationship between professional nurses and educators.

This section presents the discussion of the themes related to the professional nurses' perceptions of the clinical education programme. The CIPP model is used to structure the presentation. A total of nine themes emerged from the data generated from the focus group discussions. In this section, the input, process and evaluation segment of the CIPP model are discussed as these were the related segments that emerged from the focus group discussion with the professional nurses

4.4.1 Input Evaluation

This section presents and discusses the findings on the perceptions of the professional nurses in the input evaluation and seeks to address the second sub-objective:

- To explore and describe the resource allocation for clinical nursing education offered at universities in Nigeria

The themes presented here are similar to the themes that emerged from the student focus groups discussions and the focus group discussion and interviews with the educators.

THEME 1C: Lack of human and material resources in the clinical setting negatively impacts students' clinical learning

Shortage of nurses is a global issue that has threatened effectiveness of the healthcare system. In 2006, the World Health Organisation (WHO) published a report regarding shortage of human resources in the health industry that stated its negative effect on the healthcare industry worldwide. According to Mwale and Kalawa (2016), shortage of clinical nurses in Malawi has been identified as one of the factors directly affecting the acquisition of psychomotor clinical skills among the student nurses and midwives. In this study, when nurses were asked about what they view as an ideal clinical learning environment, they were quick to say that an ideal clinical learning environment should include abundant resources

and adequate nursing staff. Shortage of manpower is one of the challenges that emerged from the evaluation of the resources available. This challenge identified by the professional nurses is the same as identified by the students in section, and the educators in section. One of the professional nurses said professional nurses on the ward are in short supply as there are two nurses on duty in a ward with 26 patients and sometimes maybe more: *"What we mean by manpower is that in a ward when you have . . . have two nurses in a very busy ward with 24-33 patients" (Nurse 13).* According to one professional nurse, the shortage in staff affects the learning of students: *"I think shortage of manpower is really affecting the kind of education they get[students], or the kind of training they get from the nurses, as in, the nurses on duty"(Nurse 19).* The shortage of manpower affects the efficiency of the nurses' output to patients thereby limiting time to supervise the student nurses: *"What we mean by manpower is that in a ward when you have like ten students and you have two nurses in a very busy ward with 24-33 patients. The nurse will not have the opportunity or time to really teach them appropriately or supervise their work, so it will just be like OK these are the routine you are supposed to do go and carry it out. She can't be everywhere supervising" (Nurse 13).* According to another professional nurse, the shortage results in tension among professional nurses and transfers of aggression to students: *"If a student comes up with a question, the question that you are supposed to tackle very well, to explain to the student, sometimes you will be fed up. Sometimes you will be annoyed. It's not that you don't know what they are asking but because you are tensed up. Sometimes shout on them, please let me rest. Later, later I will tell you and you won't tell the student again" (Nurse 24).* This inability of the nurses to teach the students as a result of the workload was supported by research conducted by Mnzava and Savage (2005). In this study, the students acknowledged that the nurses could not teach them because they were burdened with their workload.

The shortage of manpower among the nurses can be viewed from two perspectives; shortage in terms of BNSc-prepared nurses and shortage in terms of the total of the nurses available to work on patient care on the wards. In Nigeria, in spite of the ability to move up the ladder in nursing and attain the necessary qualifications to attend to patient care in the technologically sophisticated twenty-first century nursing care, the turn-out on hospital-based nursing graduate has increased greatly (Ayandiran, Irinoye, Faronbi & Mtshali, 2013). There is therefore a larger ratio of diploma-prepared nurses to the BNSc-prepared nurses. This inconsistency however causes a lot fighting among the nurses. The diploma-prepared professional nurses perceive the BNSc-prepared nurses as looking down on them and acting superior to them, as illustrated by this statement: *"Like in UCH, they can say we are have a meeting and it is for the graduate nursing alone, when they say that the diplomats will not be happy and when the two of them are on duty, they may not do the right thing for the patient and the patient will suffer, but if they see themselves as one they will work together will achieve results" (Nurse 5.)* As a result, according to a professional nurse, the diploma-prepared nurses continue with this sentiment towards the student nurses from university. So when they completed their qualification at university they will behave in a superior manner and would rather not teach them at all: *"I mean the workforce especially the diplomats but you know there is this sentiment that what do you expect me to give to you at the end of the day you come out to say that you are my boss are you getting that sentiment. So that is one of the grievances that make them not to really open up to these ones. It is not a, i won't say it is an official thing it is just sentiment that people have within them" (Nurse 10).*

One professional nurse believes they don't have the qualification to teach the students from the university: *"is it I the diplomat that will teach the first degree students. Is that the right thing to be done, since we are talking about quality?" (Nurse 18).*

Besides the shortage of manpower, which makes the ward not ideal for clinical teaching and experience for the students, the issue of inadequate resources is another important factor. Normally, quality in patient care requires adequate material that is needed for care at the right time and in the right amount (Angheluta, Gutan, Popovici & Sasu,2012), but unfortunately, in most developing countries, hospital materials are inadequate, and therefore health personnel improvises for the patient's sake. Stenlund (2015), in their article "We have to keep on Improvising", speaks about the need for nurses to improvise materials for lack of none for patients' use. Adequate resources are not only an issue for quality patient care, but effective teaching of student nurses also requires adequate resources (Bvumbwe, Malema & Chipeta, 2015). Professional nurses in the study expressed a similar sentiment about improvisation and its effects on clinical teaching of student nurses, as illustrated by the following statements: *"there is a list of equipment that should be in an ideal dressing pack of which students use to practice when such is not available what do you do, we will now be improvising and telling them that you are not supposed to do this and you have to have this and that" (Nurse 9).* The professional nurses acknowledge that they do in fact improvise during students' examination: *"We improvise a lot o, everything we improvise. We even teach the students to improvise. Tell your examiners that this is what I'm supposed to do. So that the examiner will know that you know what you are doing. So we improvise a lot" (Nurse 19).*

4.4.2 Process Evaluation

This section presents and discusses the findings from the professional nurses in process evaluation and seeks to address the third sub-objective:

- Explore and describe the process of delivery of clinical nursing education offered at universities in Nigeria

i) Community of practice

THEME 2C: **Perceived lack of commitment by professional nurses in supporting university student nurses and a lack of incentives for facilitating student learning existed**

As previously discussed, community of practice, according to Lava Wenger (1991), refers to an environment where the student is situated so that effective learning can take place. And this community of practice, according Hoardley (2012), should have the following three characteristics amongst its members: mutual engagement, shared goal that is existing among the members and shared experiences among the members. Professional nurses complained that there is dichotomy in the relationship between professional nurses and educators and that no cordial relationship exists between them as shown by the statements below:

"Let me correct one notion we are not working in collaboration with the university, we are supposed to be working with them but that very tie is not there" (Nurse 16);

"There is a dichotomy between nursing education and nursing practice especially the university system" (Nurse 9).

The nurses perceive the strained relationship as a result of differences in educational attainment. A professional nurse said that the educators see themselves as superior and see the professional nurses as inferior to them: ***"****I think the problem has to do with the certificate because the nurses in the university believes that they are the brain, they have the degree and Ph.D. teaching the nursing students while those that are working in the hospital are majorly diplomats with only RN and RM" (Nurse 17).* Another professional nurse stated that educators believe that they are superior to them: *"To me I see that nurses in the clinical area see themselves as been different from those that are lecturing while those that are lecturing also see themselves to be different superior. There is no good professional relationship between us" (Nurse 11).* One professional nurse said that the lack of cordiality between the

professional nurses and the educators affects the way professional nurses relate to the students, as illustrated by the following statement: *"This dichotomy they are talking about because if we don't bridge the gap between the practicing nurses and then the teaching nurses or those in academics, schools there is going to be a big problem and if two elephants fight it is the grass that will suffer" (Nurse 10).* And according to another professional nurse, this perception has led to lack of commitment towards the student nurses from the university, as they are more committed to the student nurses from the diploma schools: *"We have students from both the university and the school of nursing for training. But I will say that much of our commitment is to the students from the school of nursing who are parts of the hospital environment" (Nurse 11).*

Providing incentives to motivate professional nurses was another category that emerged from the process evaluation. Previously in Nigeria, nurses who were teaching were paid a teaching allowance. But in late 2014, nurses embarked on a strike that the federal government removed the teaching allowance (Vanguard, 2015). This however had its own effect on the teaching of student nurses as nurses claim that they are not liable to teach the student nurses since they are not being paid to teach students but to take care of patients, as can be seen in the following statement by a professional nurse: *"We are not ready to teach because we are not been paid there is no ground to teach. The workload is there and they will face the workload they are been paid for and student will not be a priority. If they are been paid the teaching allowance they will not have an option but to teach the students" (Nurse15).*

THEME 3C: **Assignment of little time to practical exposure in the curriculum affects the clinical experience of student nurses**

Adequate time for clinical exposure is very important if a student is to gain mastery of the professional skills. The length of stay of the student, according to Warne et al. (2010),

determines the level of satisfaction of a student during clinical placement and Bilodeau (2003) opined that students feel more accepted into the community when they have a longer clinical placement in the hospital. The professional nurses in this study complained that the student nurses are not getting enough clinical exposure. This was also one of the problems identified by the students and educators in the study. However, they attributed the problem to the numerous irrelevances in the curriculum. Professional nurses believe, as illustrated in the following statement, that the curriculum allocated too much time for theory and too little time for clinical experience:

"from the university, they are using most of their time for lectures then little time they will post them to the clinic for about two- four weeks" (Nurse 37);

"There is lot of irrelevancies with the degree, there is need for more practical than theory" (Nurse 8).

In the curriculum, the implementation of the clinical experience is only assigned two days in a week−Tuesday and Thursday during the semester and three months concentrated clinical posting during the holidays. During the focus group discussion the professional nurses queried how students are expected to have mastery of the professional skills when they don't even have time to practice what they have learnt: *"But for UCH they have only Tuesdays and Thursdays those two days will not be enough" (Nurse 42);*

"I will like to say that one of the things that militate against quality clinical education especially those that are your students from the university, is that the quality of time that they spend on the ward is small. They don't really have much time to spend on the ward" (Nurse11).

Some of the professional nurses said, besides the fact that they have just two days a week for their clinical experience, they also resume late and close early on clinical days, as illustrated

by the following statements: *"For instance if they are to resume 8 am, some will come 9 am and will start with i want to go and sign, and all that" (Nurse 31);*

"They will come by 9 in the morning that they were waiting for school-bus, by 12 they are leaving and saying they have group discussion in the school"(Nurse 26).

This affected what the students can learn within the short time frame, according to the professional nurses. Most of the time, morning procedures would have begun before their arrival and they do not participate in handing over and taking over. The students only have time to observe most of the time and little opportunity for practice as the nurses are not confident enough to allow them to carry out the procedures: *"Within those three hours even though they are observing, they still need time to ask questions but by the time you are ready to face them they are on their way going" (Nurse 26);*

"By the time they come you have virtually done the treatment room and everything, who do you want to" (Nurse 36).

A professional nurse said that even though the students resume late they still have different excuses lined up that will further reduce the time: *"For instance if they are to resume 8 am, some will come 9 am and will start with I want to go and sign, and all that" (Nurse 31).*

THEME 4C: Student absenteeism from clinical practice placements negatively affects their clinical learning and experience

Another thing which came up from the discussion that contributes to the reduced time exposure for clinical experience is the fact that the student nurses lack intrinsic motivation, which is exhibited sometimes as absenteeism from clinical experience. Absenteeism can be defined as deliberate or non-deliberate action by a student to absent himself or herself from a scheduled class, workshop or tutorial without prior permission from the concerned authority (Thekedam & Kottaram, 2015; Shahzada, Ghazim Nawaz & Khan, 2011). Absenteeism can

be authorised, unauthorised or partial. In this study, professional nurses said that students engaged mostly in partial absenteeism; both authorised and unauthorised, as illustrated by these statements: *"they have these attitude of dodging it and that is the major problem to me i feel, because for learning to take place, somebody must be willing, the willingness is not there, they are reluctant and I find out that" (Nurse 45)*;

"*They don't have willingness to learn like what she said that students must be willing, they just come and go away, they don't take permission" (Nurse 35).*

Lack of motivation among the students, according to one of the professional nurses, may be one of the reasons why they absent themselves from clinical practice. As illustrated in her statement below, some of the students are doing nursing not necessarily because they have the passion for nursing but because their parents asked them to enter the field of nursing: *"those from the secondary school into the university have carefree attitudes as if they are forced into nursing, since nursing is lucrative and i want to travel at of the country, so they go into nursing" (Nurse 37).* A professional nurse narrated a conversation she had had with one of the students when they were working night shift. The story illustrated how the parent of the student forced her into nursing:

"What's the problem? You know, ma I don't really like this profession. My mum asked me to come and do it" (Nurse 22).

Another problem that contributes to lack of motivation, according to one professional nurse, is the negative orientation that the students have about bedside nursing. She believes this orientation is brought into the clinical practice and it affects their ability to learn during clinical placement: *"I don't know maybe the orientation has changed we all want to do paper work, we don't, must of them don't believe in clinical set- up. 75% of them will tell you that I am not coming to the clinical setting. That orientation has already limited them" (Nurse 29).*

ii) Purposeful supervision

THEME 5C: **Active supervision of student nurses by professional nurses is reduced due to their heavy workload**

Professional clinical nurses, according to Sharif and Masoumi (2005), are expected to engage in teaching, mentoring and the supervision of student nurses during clinical placement. The professional nurses in the study claim that they engage in the supervision and mentoring of students by firstly, allowing them to observe what they do during a procedure, and then allowing the student nurse to practice correctly what is being done as illustrated in the following statements:

"You allow them to watch a procedure, in their presence, you tell them how to go about the procedure, you can just allow one of them to do it after they have watch, then when she does it, you see whether she has gotten the procedure or not, and if they get it right then, you can allow them to carry on" (Nurse 4). One of the professional nurses claims that they engage with students during supervision: *"Through discussion, group discussion, we create hypothetical cases, assignments sometimes we tell them to like hypothesise do some literature search and the like . . ."(Nurse 9).*

However, as identified by Budgen and Gamroth (2008: 274) "heavy workload and inadequate resources" have prevented the nurses from doing a good job. As illustrated in theme 1C, professional nurses in the study have to struggle with the care of patients and minimal resources, and its effect on the teaching of student nurses.

It has been established in the literature that for students to have meaningful clinical experiences, the clinical supervisors must be on the ground to help students translate their theory into practice (Amsrud, Lyberg & Severinson, 2015; Moked & Zahavy, 2015). According to a professional nurse, the clinical instructors from the university are not always present with the students. This point was also raised by the students in theme 3A. The student

added that the fact that they don't know the clinical instructors has a direct impact on the supervision of the students as well: *"Another thing is that the school and the clinical should learn to work together, I want to agree with what she has said, the school, you can ask some of these nurses on the ward, i am sure some of us don't know who their clinical instructors are" (Nurse 42).*

This point, which was raised by the professional nurses in the study on the availability of the clinical instructors and working together with the professional nurses, agrees with the findings of research conducted by Evans, Costello, Greenberg and Nicholas (2012) on attitudes and experiences of registered nurses who teach and mentor students in the acute setting. One of the findings states the importance of clinical instructors working hand in hand with professional nurses for a favourable outcome in student learning.

THEME 6C: Students' clinical learning objectives are not always made available to the professional nurses

According to Lambert and Glacken (2005), a student's acquisition of skills in the clinical setting requires the presence of a supervisor and the effectiveness of the clinical supervisor can only be seen when there is an achievable clinical learning objective (Lofmark et al, 2012).

The educators, according to Harden (2007), have the responsibility of sharing the learning outcomes with the professional nurses on the ward. The professional nurses in the study provided conflicting statements on the availability and accessibility of the clinical learning objectives. Some of them indicated that the clinical learning objectives were made available to them: *"from our own experience here in this hospital, they come, and they give maybe the expectation what they expect these students to learn within that space of time. The objectives are given to us and then we work toward that.* And some alluded that the objectives are

provided and they know what the students have to cover in the clinical learning objective: *"Even they don't come with the list of what they have taught them. It's only their procedure manual that they used to bring at the . . ." (Nurse 22).*

4.4.3 Product Evaluation

This section deals with the result of findings with regard to product evaluation of the CIPP model. Product evaluation, according to Stufflebeam (2017), is the evaluation of the outcome of a programme both intended and unintended, as explained earlier. This aspect was directed to the professional nurses working with the graduates on the ward to elicit their opinions on graduate nurses they have worked with or are presently working with in the clinical facilities and what a standard clinical education should entail. This exercise seeks to answer the fourth specific objective:

- Explore and describe whether the clinical nursing education offered at universities in Nigeria is effective.

THEME 7C: Graduates from the universities are not proficient when it comes to professional skills

Nursing has transitioned from "gallipot nursing" (Ajibade, 2012) to professional nursing where nurses are trained in the university to the highest level of a university degree. However, this change was accompanied by lots of challenges with the core challenge being clinical education. When the professional nurses in the study were asked to give their opinion about the graduate nurses they were working with presently, they mainly commented negatively about their proficiency level, as illustrated by this statement: *"Fresh graduate, we call them regular students they are usually ranked on fair most of them are not even average in terms of carrying out procedures, but when it comes to cognitive most of them are very*

good and excellent. Even on their affective part I can say fair because most times they don't want to work on the ward" (Nurse 9).

Another professional nurse in the statement below believes the graduate nurse is proficient in theory rather than practical and avoids procedures at all cost: *"Hmm . . . I can say theoretically she is good but there are some cases in the ward she wouldn't like to attend to. But those people that are not BNSc, if you see the way they work like this. It's like the BNSc they are like plastic can. They don't like doing some of the procedures; do you understand they don't like doing it. Maybe they are seeing themselves as superior to others" (Nurse 19).*

Many of the professional nurses have this believe that the fresh graduates prefer not to work on the ward. They prefer to stay in the classroom settings or anywhere else besides the ward, as illustrated by the following statement: *"In my own opinion if we are going to look at this hospital as an example fresh graduates from the university, i don't think we have up to twenty of them so we don't really, just like they have said many of them don't like to work on the ward and we don't really have them come to the ward to come and practice. Many of them would rather go to the school of nursing to go and teach" (Nurse10).*

THEME 8C: Establishment of an internship for the university nursing programme to boost students' practical experience and acquisition of professional skills

Post-graduate internship in nursing is a programme that has been developed to help new professional nurse graduates to move successfully from being the life in the school environment to being the life in the working environment (AACN, 2016; Chandler, 2012; McDonald & Ward-Smith, 2012). According to the March 2014 newsletter from RWJF (Robert Wood Johnson Foundation), Van Dyke observed that newly-recruited nurse graduates left their job before the second year of employment. Factors such as "being

unprepared to perform basic skills and lacking the ability to connect their classroom experiences to real-life clinical practice" were identified by Welding, (2011:35). However, the implementation of the internship and residency programme enhanced the retention and commitment of the newly-recruited professional nurses (AACN, 2016). As illustrated above, professional nurses in the study identified that university graduates lack professional skills, and as such prefer to work in a non-clinical setting. The professional nurses further identified that inclusion of post-graduate internship programme in the university nursing programme will assists the new graduates to improve their professional skills, enhance their practical experiences and their desires to work in the clinical setting. According to a professional nurse, medical doctors only perfect their skills during their internship. She therefore advocates for internship: *"Internship should be approved because it is yet to be approved in Nigeria, and that is where doctors learn because they don't know anything during their school time, that is when they learn to be a doctor (Nurse 4).* But another professional nurse said internship will help expose fresh graduates to clinical practice: *"So I want to believe that is why we need internship to bridge the gap and expose them to the clinical area" (Nurse 16).*

THEME 9C: Adequate material resources and employment of more human resources are required at the universities and the clinical facilities

Inadequate material resources and shortage of manpower, both in the clinical setting and at the universities, are part of the challenges of clinical nursing education that were identified in the study. It is therefore not surprising that professional nurses said that the provision of adequate material resources is what they expect to see in an improved clinical nursing education. A professional nurse indicated that adequate material resources for teaching are necessary if the product of a university nursing programme is to be sound: *"There must be*

equipment and facilities enough within the hospital" (Nurse 3). In addition to the provision of adequate material resources, a professional nurse spoke about employing more staff, especially in the universities to oversee what the students are doing while on clinical placement: *"I want to talk on the issue of manpower honestly I think manpower is very important. If we have great ideas and good thoughts and there is nobody to carry it out it is has empty as not having the idea" (Nurse 9).*

THEME 10C: **Collaboration between the professional nurses and educators should be improved**

Wenger (2014) states that shared repertoire is a feature that makes community of practice successful and that shared knowledge refers to knowledge shared by members in order to become successful. Professional nurses expressed a wish to see educators working together with professional nurses. They cited the examples of the medical practitioner, the consultant who teaches the student goes back to the hospital to work in the hospital and oversees what the students are doing without any discrimination: *"I want to emphasise on what he has just said, with manpower we are talking about people working, if you look at the medics, you will see that the registrar, senior registrar, and consultant still teach in the university and still come back to the clinical. So those people are just stationed there and it is not right when they teach they can come also to the clinical to bring down this knowledge especially new trend in nursing" (Nurse 10).*

The professional nurses also spoke about good working relationships between those in the universities and those working in the clinical facility. They reiterated that quality clinical education offered to the student nurse will depend on the relationship between the aforementioned:" *so if they can integrate here that the clinical instructors will be those that are working on the ward, it will be better for the programme" (Nurse 42).* The professional

nurse further complained that the clinical instructors will come and check the roster of the students, but will not speak to the professional nurses on the ward: *"not that the clinical instructors will be from the school in which we might not even know them at times, or they will just walk in face their students and go" (Nurse 17).*

One professional nurse complained that the clinical instructors are not there to perform procedures with their students'−they just use word of mouth: *"And usually, a more . . . it's usually on the word of mouth that they use to correct the students… I have never seen them actually performing the procedure and teaching them. They just come to check their roaster. No hands on…the procedures. They don't teach them procedures" (Nurse 19).* This last point was also raised by the students. They believed that if the clinical instructors can work together with the professional nurses and be on the ground for most of the time it will enhance the clinical nursing education.

4.5 SECTION FOUR: ALUMNI INTERVIEWS

This section presents and discusses the findings of interviews with the alumni of the BNSc nursing programme at the participating universities. The themes and categories presented answer the first objective of the study which was:

- To explore the effectiveness of clinical nursing education in Bachelor of Nursing Science programmes at universities in Nigeria

The researcher discovered during the analysis of the data from the interviews with the alumni that the experiences they had were very similar to that of the present nursing students at the universities. In most cases the alumni used almost the exact words the present students used to describe their experiences of the clinical placement. The themes and categories that emerged from the interviews are presented in Table 4.7 below.

Table 4.7: Themes and categories from interviews with alumni

STEPS IN CIPP	THEMES	CATEGORIES
INPUT	**1D**: Inadequate number of professional nurses negatively affects the clinical learning experience during clinical placements.	Professional nurses do not have time to pass down the knowledge to the students as they are already overworked as a result of shortage of staff.
		No proper supervision of the procedures carried out by the student nurses as professional nurses are available to them.
		Students are viewed as helpers rather than learners to cushion the shortage of professional nurses at clinical facilities.
	2D: Lack of basic infrastructure and material resources in clinical facilities inhibit optimal learning experience of the student nurses.	Some of the clinical facilities lack basic infrastructure that makes the environment non-conducive for learning.
		Lack of material resources in the clinical facilities leads to excessive improvisation among professional nurses and students.
		Improvisation inhibits students from carrying out procedures correctly.
PROCESS	**3D:** The structure of the curriculum leaves little room for students' clinical exposure and learning.	The number of hours assigned to clinical practice during normal semester is very little.
		The limited time allocated for clinical practices reduces learning and the time students spend interacting with patients and the professional nurses.
		The time is further reduced when students arrive late at the clinical facilities because of transportation problems and clashes with lecture time.
		Students try to make up for the clinical exposure by engaging in voluntary clinical jobs during holidays.
	4D: Ineffective supervision of student nurses by clinical instructors during clinical placement negatively affects their learning.	An inadequate number of clinical instructors is available to the student nurses during clinical placement.

		The clinical instructors are rarely available for instructions of the students during clinical placement but are more concerned with taking attendance record of students and punishing the absentees.
		Translating the theory into practice is very difficult for student nurses as they receive no guidance throughout the process.
	5D: Negative attitudes of professional nurses towards the university student nurses obstruct their learning experiences.	Professional nurses discriminate between students from the universities and students from the School of Nursing.
		Professional nurses prevent hands-on experiences for university nursing students.
		Professional nurses are unwilling to neither teach nor mentor student nurses from the university.
	6D: Friction in the relationship between the educators and professional nurses on the clinical sites affects the learning experiences of the university nursing students.	Professional nurses express their dislike towards the educators from the university.
		The strained relationship between educators and professional nurses affects the learning experiences of the student nurses from the university.
PRODUCT	**7D:** The university graduates proved to be more resourceful and skilled in the long run.	The diploma-based professional nurse seems to be more versatile in practice than the university graduate.
		The university graduates become better professionally and theoretically and can build on their clinical education.
	8D: Adequate resources are required in both the school and clinical facilities.	Materials and resources should be available in the clinical facilities to reduce improvisation.
		Resources in the clinical skills lab should include modern technology.
	9D: Employment of more educators and clinical instructors will improve supervision.	Employment of more educators and clinical instructors to improve supervision during clinical placement.
	10D: More hours should be allocated to clinical practice and alignment of theory to practice.	Theory and practice must be aligned.
		More time should be allocated to clinical practice.
		An internship programme should be introduced into the nursing programme.

4.5.1 Input Evaluation

This section presents and discusses the findings on the experiences of the alumni in the input evaluation as related by the alumni in the interview sessions and sought to address the second sub-objective:

- To explore and describe the resource allocation for clinical nursing education offered at universities in Nigeria

THEME 1D: Inadequate number of professional nurses negatively affects the clinical learning experience during clinical placements

Nursing shortage is a global issue that has ravaged and eaten the health sector like a cankerworm (Buchan and Aiken, 2008). In a recent post (2016) on the Nursing World Nigeria (www.nursingworldnigeria.com) an article titled "Nurses express concern over shortage of Manpower in Public Health Sector", the president of the National Association of Nigeria Nurses and Midwifery expressed fear on the imminent shortage of professional nurses in the health sector, especially in the government sector. This is in agreement with the experiences of the alumni in the study, where chronic nursing shortage affects the clinical and learning experiences of the student on clinical placement, as professional nurses are already overworked with the care of patients. An alumnus reported that: *"But mostly, most times you are in encounter with a nurse who maybe a nurse to about 25 patients. I mean how she would teach you. She is going to attend to like 25 people. So she . . . there is no way she is going to still attends to you" (Graduate 2).*

Another alumnus expressed that they are already overwhelmed with caring for the patient; there is little or no time left for them to pass the knowledge down to the students, as illustrated in his statement:

"The nurse already has enough problems so if the nurse is not able to take you, teach you, ideally, you don't need to complain; I understand" (Graduate 1).

The alumni expressed that most of the time they had no real supervision as a result of the shortage of professional nurses, as expressed by one alumnus: *"But I can't remember seeing a senior colleague around me to tell me do this, and do that. In fact it's as if we were working hand in hand with the doctor that had a patient. She was even the one to say help me o, do this, do that. Thank you, this and that" (Graduate 6).* According to the alumni in the study, students were viewed as workers that have come to alleviate the strain instead of being learners: *"… It does not come like learning, it comes like a work. So we have to blend into the work. You have to do what you are told. The nurses tell you, do this, do this . . . So you have to do what you are told. So it becomes like a job. It's not coming to you like an education now" (Graduate 2).*

THEME 2D: Lack of basic infrastructures and material resources inhibits optimal learning experience of the student nurses

Basic infrastructures in the hospital, according to WHO (2006), includes space, water, hygiene and sanitation equipment, as they influence the delivery of care provided by the healthcare provider. In the research study, an alumnus complained that the environments are not necessarily conducive to learning as basic infrastructure such as water, power supply is not available: *"It was clumsy, no space. Even if you want to keep 20 . . . you are showing me a 20 bedded ward with just a small room. At times the rooms are not well ventilated. The environment is dirty, everywhere is just there. Looking from the environment just that" (Graduate 5).*

Improvisation in nursing has always been one of the major challenges in nursing practice, as pointed out previously in literature and by the other group participants in the study. The alumni also pointed out that there were insufficient basic materials for the treatment of patients during their student days, as illustrated in the next statement: *"Like I said earlier, the resources are not*

[always] enough. For instance when you want to carry out wound dressing, you know what we are used to before is artery forceps, and dressing forceps and all that but now we have to improvise" (Graduate 13). The lack of basic materials, said one alumnus, leads to improvisation among the professional nurses that spills over to the student nurses in training: *"On the ward we do a lot of improvising it will shock you the level of improvising that go on in the ward. If these instruments are on ground there will not be the need for improvising all the time" (Graduate 14).*

Unfortunately, according to another alumnus, improvisation affects the learning outcome of the students, as students have to use incomplete materials for a procedure: *"we want to give injections there is no cotton wool or spirit maybe we use water those kind of things so it will affect practice . . . so those things affect outcome of patients and student [learning]"(Graduate 23).*

4.5.2 Process Evaluation

This section presents and discusses the findings on the experiences of the alumni in process evaluation and seeks to address the third sub-objective:

- Explore and describe the process of delivery of clinical nursing education offered at universities in Nigeria

THEME 3D: The structure of the curriculum leaves little room for students' clinical exposure and learning

According to Agbedia (2012), the nursing curriculum in Nigeria is loaded with content which the alumni in the study agreed with: *"For instance, we were made to undergo courses that were inconsequential to my discipline. This is unlike diploma nurses that were taught what they should know. Secondly, they spend longer hours at the hospital than we do" (Graduate 9).* In contrast, another alumnus viewed the content of the curriculum as a major strength: *"One thing about the curriculum is that it is very versatile. We go to so many places to get experiences, social sciences,*

education, different departments. So it is like they tell us we borrow a lot of courses around and that gives us a wider view even political science and some others. So that is the major strength I can say the curriculum has" (Graduate 23). Though the versatility of the curriculum prepares the nurse to be broadminded, the alumni perceive it as one of the major disadvantages since it provides little room for clinical exposure. The students end up going for clinical placement for a number of days during the weeks in the semester: *"we do postings just Tuesdays and Thursdays which I feel is not sufficient and we start eight in the morning and leave three in the afternoon"(Graduate 27).*

Furthermore, the alumnus pointed out that the academic calendar of the universities affects the balance between practice and theory: *'I will say we need more days to spend on the ward, the challenge also is the academic calendar, because it specifies the number of days for theory and clinical somehow we need to be able to balance it"(Graduate27).* However, one alumnus said that they try to compensate for the lost days during the semester by having clinical placement of three months: *"For those in 200- 400 level there is what we call industrial training, so you will do three months posting at a stretch" (Graduate 10);* and engaging in voluntary jobs in the hospital during short holidays, according to another alumnus: *"I wouldn't just sit at home. I would find a place to work, even if it's just voluntary job. You gain more, so that it will prepare you better" (Graduate 5).*

The limited time available for clinical exposure, according to another alumnus, is further affected by lateness to the ward or clashes of lecture time with the clinical time: *"For us we go once a week and maybe the bus might not pick us on time and we get there in the middle of handing over and we have to leave because of one lecture or seminar" (Graduate 23).*

THEME 4D: Ineffective supervision of student nurses by clinical instructors during clinical placement negatively affects their learning

Supervision of student nurses during clinical placement is very important as it gives support to students when translating theory into practice (Amsrud, Lyberg & Severinson, 2015; Moked & Zahavy, 2015). Therefore, availability of the supervisors is very important during clinical placement. The alumni reiterated that their clinical instructors were not always around because they are too few: *"The ratio of clinical instructors to students that time was not enough. Then we had two clinical instructors" (Graduate 18);*

"Only one clinical instructor then, so I will say in terms of my personnel, it was not that sufficient as we were left with just one clinical instructor until I finished my program" (Graduate 12).

An alumnus reported that the inadequacy in the number of clinical instructors affected the supervision as they are not always around to supervise students because they have to be in number of places at the same time: *"Yeah, they come; they just come like on rounds . . . sometimes, most times they are few, you know, maybe like a person to the whole hospital so they have to go all round. So it's not possible for just one person to stay with you" (Graduate2).*

And when they are around, according to another alumnus, they are mostly interested in taking the attendance of the students: *"They have days that they come. Sometimes they don't tell us they just come. They don't really teach us like that. They mostly come in randomly to check the attendance see the register to know who is around and who is not around" (Graduate 13).*

THEME 5D: Negative attitudes of professional nurses towards the university student nurses obstruct their learning experiences

According to Evans, Costello, Greenberg and Nicholas (2013), it is required of a professional nurse to give professional expertise and to instruct students on the ethics, professionalism and theoretical knowledge of nursing.

However, the negative attitude exhibited by professional nurses towards the students inhibits the transfer of knowledge to the students. In the study, one of the alumni recounted an experience during her professional examinations, which clearly depicted the discrimination against BNSc students, exhibited by professional nurses: *"I recollect when I was to write my qualifying exam, on getting to the ward, the matron in charge of the female medical ward, defer the bed bath which should be a morning procedure because the school of nursing students were to have their own practical about the same time. That same day, the moment the school of nursing students finished their own exams all the matrons at the wards left leaving the graduate students with no supervision. So I was like why did they dislike BNSc students like this, so that has been the situation" (Graduate 12).*

Another alumnus said the professional nurses discriminate against the university students because they believe that the student nurses from the universities have less knowledge than students from the School of Nursing: *"They believe we don't know anything. They believe that we are majorly in theoretical aspect" (Graduate 20).* The alumni further said the professional nurses were very hostile to them and she believes the reason was because most of the professional nurses are diploma-prepared nurses: *"It is not always an interesting . . . it is a hostile environment then because those practicing nurses . . . majority of them, they're graduates of schools of nursing. They don't like us" (Graduate 20).*

Due to these negative attitudes, the alumni said the professional nurses prevent the university students from having hands-on experiences, as illustrated by the following statement: *"Well, I can*

tell you that when we were student the practical exposure that I had was not enough. This is because there were a number of things that we were not allowed to do while we were at the wards. Some of the nurses don't allow us to do anything they will say they don't want trouble and that really affects us" (Graduate 13).

As stated above, both teaching and mentoring are vital to students' learning of practical skills during clinical placement (Winterman, Sharp, McNamara, Hughes & Brown, 2014). The role of a clinical nurse in the clinical education of a nursing student cannot be underestimated. In spite of this established fact, some nurses in clinical practice do not see teaching or mentoring a student as an obligation or duty. In this study, one of the alumni participants recalled his experience about the nurses' lack of readiness to teach or mentor the student nurses: *"You know but most of them just wanted to do what they wanted to do. They came to work then they have to work. So most of them don't take time to teach . . ." (Graduate 2).* Another alumnus claims that the professional nurses do not have time to teach: *"The staffs don't even have time for us. They may even allow you to witness once. They may try but they don't care if you do it well or not because they are interested in their primary work not teaching you" (Graduate 14).*

The alumni in the statement below believes some of the professional nurses are not ready to teach the students because they are not well motivated in terms of remuneration–a point also raised by the professional nurses: *"In terms of the nurses of the wards, the nurses at the wards should be properly motivated in terms of enumerations and other means so that they can deliver efficiently because they are not giving them good motivation they are also not teaching the students" (Graduate 14).* In contrast, another alumnus said that professional nurses are not teaching the students because of their individual personalities. as most are ready to teach while few are not: *"The attitudes of the nurses differ from ward to ward. In some wards the nurses were receptive, in others they were not. But the ones that were not*

receptive are few especially when you bring yourself to learn. A few however tried to resent you specifically because you are a degree student" (Graduate 15). Among the professional nurses that teach, said this alumnus, some prefer you to ask them questions and this prompts them into teaching you: *"Another thing with them [professional nurses] then is, if you don't ask the matrons and the nurses questions, they are not ready to carry you along. They will just be looking at you, if you like work, if you like don't work so you must prove to them that you want to learn, if you are the type that don't care, they too will be looking at you" (Graduate 12).*

THEME 6D: Friction in the relationship between the educators and professional nurses in the clinical sites affects the learning experiences of the university nursing students

As stated earlier, professional nurses noted that the clinical instructors do not work together with the professional nurses in the clinical facilities with regard to the teaching of the students. A point noted by Evans, Costello, Greenberg and Nicholas (2013) as being important in the favourable outcome of students' learning. The alumni in the study also highlighted that there is no real relationship between the educators and the professional nurses: *"It would have been better if there is this forum, you know, if there is this forum, every college of nursing, every university of nursing or something or college of nursing in the university or in the whatever . . . if there is this association or this communication between the people in the lecture room and the people in the clinical setting" (Graduate 2).* He went further to say that the non-existing relationship among the educator and the professional nurses had a negative impact on them during clinical placement since the professional nurses often just look at them and leave the students alone: *"But because of that gap, the people in the clinical settings see you as you come to learn, just to learn. Open your eyes. That's what*

they told us, open your eyes. No specific teaching that okay, [by the professional nurses]" (Graduate 2).

4.5.3 Product Evaluation

This section deals with the result of findings and the discussion of the last part of the CIPP model. Product evaluation, according Stufflebeam (2017), is the evaluation of the outcome of a programme; both intended and unintended, as explained earlier. This section focuses on the graduates who are working in the clinical facility and who shared their experiences of being a graduate nurse from the programme. They also shared how they thought the clinical education could be improved. This answers the fourth specific objective which was to:

- Explore and describe whether the clinical nursing education offered at universities in Nigeria is effective.

THEME 7D: The university graduate proved to be more resourceful and skilled in the long run

In an article written by Pijl- Zieber, Grypma and Barton (2014), "Baccalaureate Nursing education: Has it Delivered a retrospective Critique", it was argued that preparation of nursing at the university has not really achieved its aims. Instead it has succeeded in dividing nursing into two tiers. These two tiers are the practical nurses that are working at the bedside and the baccalaureate nurses that are working in the preventive role of diseases and research, as they are not as good as the practical nurses in acute care role.

However, the alumni in the research disagreed with the findings in this article. According to an alumnus, they acknowledged that their counterparts from the School of Nursing seem to possess superior professional skills at the initial stage: *"the practical aspect of it can be given to the diploma yeah in nursing they are much more exposed well in school frankly speaking they are much more exposed because they do have a lot of clinical postings than the degree student"*

(Graduate 22). A point supported by another alumnus when he acknowledged in his statement below that the clinical education they received may seem inadequate because they spent little time on clinical placement and they discovered this when they were exposed to the work setting: *"Soon I discovered I was really lacking in the practical aspect, the clinical education I received was good to an extent but for practical work, it was not good. The fact that I trained in the teaching hospital there were so many rules that will deprive the nurses of so many procedures, for instance nurses don't set line but in a private hospital it is different all together"(Graduate 9).* He said he had to learn a lot of things on his own as the employer expected a lot from him: *"To my employer all those things were minor and he was expecting that I should be able to do all these but to me it was major because I couldn't learn it while I was in school. I had to start learning on the job" (Graduate 9).* His experience represents most of the alumni experiences when they started working.

But when the researcher asked the alumni how they felt after a few months on the wards, the response was: *"By the time I . . . I was more familiar with the environment and gained the required level of confidence...And whenever I practice, I get lots of commendations from my patients that why is your own nursing different. A patient used this word that I use to think that does that go straight to the university don't know anything" (Graduate 15).* One alumnus added that the university nurses are more knowledgeable in terms of the theory and this places them at an advantage because with few days of practice they will be on the same level of the diploma graduate and will soon overtake them in the professional skills as well: *"Well personally, I don't see where a school of nursing graduate will outshine me either in clinical procedures or judgement. The kind of encompassing education or knowledge that a graduate nurse had cannot be compared to that of a school of nursing graduate" (Graduate 12).*

The alumni in the study acknowledged that though they had to prove themselves to their employers, the exposure they had in school assisted in preparing them to develop as a nurse, as

illustrated by their statements: *"And one thing my education has helped with is that somehow you were trained to do the right thing and we learnt under tension and there is no amount of tension on the ward that can distract me because I am used to the tension" (Graduate 15);*

"It actually helped me. If I have not received the clinical education I will not be able to carry out some clinical procedures. With the exposure it is still helping .Till date I have not been to anywhere for further trainings. It is what I learnt at that period that is still beneficial to me till date. Except for periods I go to the Internet to read and research journals" (Graduate 12).

At the end of each interview the researcher asked the question to the graduates to relate their personal opinion with regard to improved clinical nursing education based on their own experience. The following themes and categories which emerged were very similar to that of the students, educators and even the professional nurses.

THEME 8D: Adequate resources are required at both the school and the clinical facilities

One of the challenges the alumni faced as students during their clinical placement was the issue of inadequate resources. Therefore when asked what they will expect in an improved clinical nursing education they all agreed on the provision of adequate resources, as illustrated in this statement by one of the alumnus': *"The right resources made available. We should not keep on improvising. They should make the hospitals to have the materials. It should be made into policy that the hospitals should have all the necessary equipment needed for the patient well-being" (Graduate 10).* Another alumnus added that there should be availability of modern equipment in the school and clinical facilities: *"Yeah like the resources actually, you know. Everything is now new technology and that technology will help to make work easier as students. It will help them as well. So I think in that aspect, there are a lot of things to do on that" (Graduate 6).*

THEME 9D: Employment of more educators and clinical instructors to improve supervision

During their school days, the alumni highlighted that they experienced problems with supervision since the clinical instructors were not always around because of the number of the clinical instructors available and the number of students. They therefore advocate for the employment of more educators as illustrated in their statements below: *"There should be adequate staffing"* (*Graduate 14);*

"There should be more lecturers and clinical instructors. For even for each classes should have enough clinical instructors, not that the three set or four sets. There should be enough clinical instructors" (Graduate 19).

An alumnus said if they had more lecturers and clinical instructors they would have had better supervision and it would have also improved the learning outcome in the students: *"If there were enough personnel specifically clinical instructors, I would have been able to express my fears and have it addressed. But with only one clinical instructor to a large number of students, it was impossible to have her attend adequately to all of our questions. You will not even be able to talk to her because she is very worn out" (Graduate 12).*

THEME 10D: More hours should be allocated to clinical practice and alignment of theory to practice

One of the major complaints from the alumni is the issue of insufficient time for clinical. Therefore, as seen in the following statement by an alumnus, they advocated that the curriculum be restructured so as to accommodate for more clinical hours: *"So they should reduce the curriculum and throw away those that are not so relevant. They should increase the practical hours" (Graduate 25).*

One of the alumni in the study believes that an internship programme should be introduced into the nursing programme as it will help to improve their practice: *"What I am trying to bring out is*

that this issue of internship would have been something that would be helping the nurses a lot. So, I feel it should be included in the curriculum of the nurses" (Graduate 21).

4.6. SECTION 5: RESULTS FROM THE DOCUMENT REVIEW

This section presents and discusses themes that emanated from the document review. As stated in Chapter 3, the document review in the study was used to corroborate the themes that were elicited from the interviews and focus group discussions.

4.6.1 Context evaluation

This section presents findings from the review of the documents on context evaluation. This sought to address the first sub-objective which was to:

- Explore and describe the context for clinical nursing education offered at universities in Nigeria

The researcher reviewed the documents from the four universities from which the context evaluation theme emerged.

THEME 1E: The clinical education programme is aligned to the philosophy which underpins the entire Bachelor of Nursing programme

The researcher reviewed the documents in the four universities on their philosophy and mission statements, which clearly depict their values in relation to nursing education and clinical education, and is illustrated by the following excerpts: *"The mission of the school is to provide high quality, broad- based nursing education that is based on Christian values. The school will prepare men and women of various ethnic and religious backgrounds to become dedicated and committed nursing professionals who are ready to advocate the principle of preventive healthcare and are willing to take on leadership roles. They will be equipped with clinical skills and research*

on client- centred nursing care practice, and holistic approach to learning in the context that integrate faith and learning" (Mission statement of university iv).

"The faculty believes nursing is a process of interactions, which aims to assist the individual, family and community in maintaining or establishing an optimal level of healthy living. The nurse is an inherent part of the transaction, which helps the individual, family and community to modify their pattern of daily living according to their requirements". (Mission statement of university ii)

THEME 2E: Hours allocated to clinical education and how it is to be achieved is clearly stated in the curriculum

The curriculum clearly includes planned clinical nursing education experiences that enable the students to put into practice what have been learnt in the classroom. Below is an excerpt on the clinical course included in one of the universities curriculum.

NURS 307 – Clinical Posting/Practical:

The clinical posting/practical experience would expose the students to four weeks of concentrated experience in male/female medical and surgical wards during the long vacation of 200 level plus another five weeks of concentrated experience in male/female medical and surgical wards, gynaecology and causality during first semester of 300 level after which a practical examination will be taken.

4.6.2 Input evaluation

This section presents and discusses the findings from the review of documents in relation to input evaluation.

THEME 3E: Majority of the educators have their second or third degree outside the nursing field

One of the educators commented on the shortage of staff and especially staff having identical qualifications to teach the students. After careful analysis of the staff profile of the educators in the participating university, it was discovered that almost 50% of the teaching staff are doctoral prepared students, of which 90% of the 50% obtained their PhDs in fields outside of the nursing field, while 10% obtained a PHD in Nursing. The remaining 50% have Master's degrees and about 30% of them have obtained their Master's in Nursing while others obtained their Master's degree outside of the nursing field. This is in agreement with a statement from an educator. (Educator 11)

4.6.3 Process evaluation

This section presents and discusses the findings on the process of clinical nursing education in Nigerian universities

THEME 4E: Each university has assessments tools for the assessment of clinical skills

The researcher also ascertained that the universities have documents that are attached to the curriculum which is accessible to each student of the department. The documents clearly state the number of procedures they are to carry out in order for the student to be viewed as proficient. In the document, the professional nurse that supervises them has to append his/her signature and provide remarks on the student's proficiency. Some of these documents are either in book form or in a sheet form, as illustrated in the figure below

ECIAL DISTINGUISHING ACHIEVEMENTS OF THE STUDENT:

ND OF POSTING EVALUATION

No of times absent from posting:

No of times reported late;

No of times student left before time:

No of times absent from posting/clinical conference:

No of times reported sick:

Student's comment:

Ward Leader's Name and Comment:

Clinical Instructor's Name & Comments:

DAILY RECORD OF CLINICAL EXPERIENCE (SPECIAL MEDICAL SURG. POSTING)
E. N. T. POSTING

Date	Ward	Time in	Time out	Procedures	Name & Sign of Supervisor/ Preceptor /Ward Leader	Time of conducting procedure	Supervisor's / Preceptor's remark.	Clinical Instructors Remark.

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Figure 4--1 Excerpt showing evaluation pattern

4.7 SECTION 6: SUMMARY OF FINDINGS AND CONCLUDING STATEMENTS FROM THE THEMES ACROSS PARTICIPANT GROUPS

This section presents the vertical themes of each group of participants and then the horizontal themes, which will be the concluding statements that cut across the participant themes. These concluding statements will serve as step two of the model development phase in chapter 5, according to Avant & Walker (2005), which is the concept synthesis. As indicated in Chapter 2, the Cognitive Apprenticeship Model will be used to structure the concepts in the development of the model. At this stage the themes are also structured according to the Cognitive Apprenticeship Model. It is presented in Table 4.8 below.

Table 4.8: Summary of vertical themes relating to clinical nursing offered in Nigerian universities according to the cognitive apprenticeship model

SUMMARY OF VERTICAL THEMES RELATING TO CLINICAL NURSING OFFERED IN NIGERIAN UNIVERSITIES ACCORDING TO THE COGNITIVE APPRENTICESHIP MODEL					
COGNITIVE APPRENTICE-SHIP MODEL	**VERTICAL THEMES AND RELATED CATEGORIES**				**CONCLUDING STATEMENTS**
	STUDENTS	**EDUCATORS**	**PROFESSIONAL NURSES**	**ALUMNI**	
CONTENT	**Theme 10A:** Curriculum restructuring for alignment of theory to clinical practice and review of hours of clinical practice.	**Theme 1B**: The clinical education programme is aligned to the philosophy which underpins the entire nursing programme. **Theme 4B:** Perceived inadequacy in clinical teaching is compounded by the multiple roles assigned to clinical instructors who are already difficult to retain. **Theme 7B:** Successful implementation of the curriculum depends on the qualifications of educators and professional nurses. **Theme 18B:** The nursing programme should allow for more practical exposure during the programme and after graduation.	**Theme 3C:** Assignment of too little time to practical exposure in the curriculum.	**Theme 3D:** The structure of the curriculum leaves little room for student's clinical exposure and learning. **Theme 10D:** More hours should be allocated to clinical practice and alignment of theory to practice.	1. The clinical programme lacks sufficient human resources and clinical learning experiences to ensure that the desired outcome of a versatile, polyvalent nurse is reached.

COMMUNITY OF PRACTICE	**Theme 2A:** Exhibition of negative attitudes by professional nurses towards the student nurses affects quality learning in the clinical placements. **Theme 11A:** A collaborative structure is required between clinical facilities and the Department of Nursing in the universities.	**Theme 6B:** Negative attitudes of professional nurses and competition for clinical learning opportunities reduce students' exposure to patient care **Theme 11B:** Perceived collaboration between educators and professional nurses towards a common goal in clinical education.	**Theme 2C:** Perceived lack of commitment by professional nurses in supporting university student nurses and a lack of incentives for facilitating student learning existed. **Theme 10C:** Collaboration between professional nurses and educators should be improved.	**Theme 5D:** Negative attitudes of professional nurses towards the university student nurses obstruct their learning experiences. **Theme 6D:** Friction in the relationship between the educators and professional nurses in the clinical sites affects the learning experiences of the university nursing students.	1. Negative staff attitudes towards students and poor relationships between university and hospital staff affect students' clinical learning. 2. A lack of commitment and strong collaboration between the educators and professional nurses impacted negatively on the clinical programme.
PURPOSEFUL SUPERVISION	**Theme 3A:** Clinical supervision of students during clinical placement is poor. **Theme 4A:** A variety of teaching methods are used during clinical supervision by educators and professional nurses. **Theme 5A:** Non-compliance to clinical learning objectives by professional nurses and educators in clinical facilities. **Theme 6A:** Lack of	**Theme 12B:** Clinical Supervision is negatively impacted by the use of multiple clinical setting and availability of staff to accompany students. **Theme 13B**: Different teaching styles are used in clinical supervision of students. **Theme 14B**: Clinical placement objectives are not strictly adhered to. **Theme 15B**: Evaluation of students' competence is carried out in both structured and unstructured ways and serves as feedback to the students.	**Theme 5C:** Active supervision of student nurses by professional nurses is reduced due to their heavy workload. **Theme 6C:** Students' clinical learning objectives are not always made available to professional nurses.	**Theme 4D:** Ineffective supervision of student nurses by clinical instructors during clinical placement negatively affects their learning.	1. Clinical supervision by clinical instructors and professional nurses was irregular, non-standardised and non-supportive. 2. Educators' feedback to students and communication of learning objectives by the educators to the professional nurses were inadequate.

	timely feedback to student nurses during the clinical placement. **Theme 7A:** Evaluation of student performance is based on the opinion of professional nurses.				
SITUATED LEARNING	**Theme 1A:** Optimal clinical learning experienced during clinical placement is reduced as a result of lack of material resources and shortage of manpower in the clinical facilities. **Theme 8A:** Adequate resources are required both in the nursing school and the clinical facilities.	**Theme 2B:** Transportation challenges for both educators and students arose from the use of a variety of clinical settings. **Theme 3B:** Clinical skills laboratories at the universities do not replicate reality, are not spacious, and lack technology-driven teaching aids, although they are fairly well-resourced. **Theme 8B:** Shortage of manpower has a negative effect on clinical experiences and the clinical training of student nurses. **Theme 9B:** Lack of basic infrastructure and resources render the clinical setting non-conducive for student learning. **Theme 17B:** Clinical skills laboratory should be spacious and equipped with modern technology and should replicate the clinical facilities.	**Theme 1C:** Lack of human and material resources in the clinical setting negatively impact student's clinical learning. **Theme 9C:** Adequate material resources and employment of more human resources are required at the universities and the clinical facilities.	**Theme 1D:** Inadequate number of professional nurses negatively affects the clinical learning experience during clinical placements. **Theme 2D:** Lack of basic infrastructure and material resources in clinical facilities inhibit optimal learning experience of student nurses. **Theme 8D:** Adequate resources required in both school and clinical facilities.	1. Inadequate infrastructure and resources at universities and clinical facilities render the clinical learning environment non-conducive to learning.

EXTERNAL SUPPORT	**Theme 9A:** Increase in government funding for nursing programmes.	**Theme 5B**: Strikes at health facilities and existing clinical facility policy affect clinical learning opportunities during clinical placement. **Theme 10B:** Funding of the BNSc programme poses challenges for clinical learning.		**Theme 9D:** Employment of more educators and clinical instructors will improve supervision.	1. The nursing programme lacks sufficient support from the government.

The following concluding statements emerged and were aligned with the concepts in the Cognitive Apprenticeship Model used in the study.

4.7.1 Content

1. The clinical programme lacks sufficient human resources and clinical learning experiences to ensure that the desired outcome to produce a versatile, polyvalent nurse is reached.

Critical learning experiences are indispensable learning experiences that a student must have within a programme before successful completion (Billings and Halstead, 2015). Learning experiences are designed so that students attain the three aspects of learning: knowledge, skills and attitudes. These aspects are reflected in the nursing curriculum (Taylor, 2014). These learning domains are interconnected, though distinct from one another. In nursing education, as identified earlier, the clinical nursing education is regarded as the centre of nursing education. As such we can say the psychomotor aspect of the nursing curriculum is as important as the cognitive aspect.

However, in nursing education in Nigeria, the curriculum seemed to be skewed more to the cognitive domain. Participants in the study held the opinion that the hours allocated for the clinical practice are not sufficient to attain the programme outcome, which is to produce a versatile, polyvalent nurse. According to the professional nurses, the student nurses have to divide their clinical time between the community experience, acute care, midwifery and public health. To the professional nurses, this reduces the contact time they have with the students at each clinical placement. The students and the alumni participants also reported that they have limited hours to spend on their clinical placement. According to the student nurses, they are required to move to another placement when they are just beginning to understand the ward. This finding is supported by Ford (2010) in an article posted on *Nursing Times* website "Student nurses call for longer clinical placements". Ford identified that

students complain of getting irrelevant placements and too short placements and they wish they could have longer time in their placements, as this will enable them to have more time with their mentors.

The educators agree that the curriculum should be restructured to reflect more clinical hours. They are of the view that clinical hours within the programme are sufficient for any serious student to achieve the minimum skills required: "*To me I am a product of this programme and so I can say based on my experience I feel the programme is enough for any student who is willing to develop the necessary competency that is required for an individual to become a nurse, that is all been dependent on who this student is and there disposition to learning" (Educator 9)*.

Educators however advocated for the inclusion of internship in the nursing programme, which is an opinion also held by the study participants. The educators believed that by including internship the nursing education will enable the new graduate to improve the professional skills acquired and will encourage better integration into the work environment. This opinion is supported in the findings of Ndiwane, Klar, Koul, Dunker, Remington and Kathleen (2015) who worked on a geriatric education model for graduate entry students in which they proposed an internship programme as part of the model. Their findings suggest that students improved their professional skills and knowledge and demonstrated an increased interest in geriatric nursing.

4.7.2 Community of practice

1. Negative staff attitudes towards students and poor relationships between university and hospital staff affected students' clinical learning.
2. Commitment and strong collaboration between educators and professional nurses were lacking which negatively impacted on the clinical programme

The feeling of belonging and acceptance in a society is a human need (Gilbert and Brown, 2015). In nursing education, it has been established that there is relationship between student belonging, acceptance and performance in classwork and clinical education (Ablousshi and Ferguson, 2016). Similarly, in the study, students and alumni reported that they experienced hostility and a lack of acceptance that were displayed as discrimination against them during clinical placement. The educators also perceived lack of acceptance of their students among the professional nurses. Interestingly, the professional nurses reported that they do not really welcome the students from the university and that they prefer to work with students from the diploma school. In research work carried out by Dale, Leland and Dale (2013) on the factors that facilitate good learning experiences in clinical studies in nursing, namely, "Bachelor students' perceptions", the findings of the research article support the findings of the study in that professional nurses do not readily accept students that are on clinical placement in their clinical facility. The lack of acceptance that students experienced during clinical placement had an effect on their learning experiences during clinical placement. Some students in the study preferred to view the medical doctors they are working with as their role models, rather than the professional nurses: "*It is the doctors that are like role models not the nurses yes the nurses are discouraging" (Student 44).* According to Baldwin, Mills, Birks, and Budden (2014), role modelling refers to the admiration and emulation of the behaviour and attitude of another person. According to them, it is easier for a student to emulate the professional attitude of the professional nurses they work with in a clinical setting when they feel accepted in the community, and when they feel that their opinion and knowledge count as well. According to Nasrin, Soroor and Soodabeh (2012), professional nurses serve as the first role models of students during clinical placement. This point emerged from the research study as well since students felt that their opinions do not count: "*they will feel you don't know what you are doing" (Student 75).* Furthermore, Baldwin et al. (2014) further that in their review

of literature, students easily identify good and bad role models during their clinical placement. In this study, the researcher also discovered that students identified good and bad role models and reported that they would like to behave like a particular professional nurse*: "I worked with a particular chief nursing officer. I think she is a BSc holder and Master degree holder. She was so distinct among all of them such that she interacts well with doctors, she does her procedure correctly, she does not wait for anybody, when you make mistakes she corrects you in polite manner and she teaches you. I really respected her, i see her as an expert i want to be like her" (Student 45).* Academic motivation is the driving force that encourages a student to know more about a phenomenon (Wilkesmann, Fischer & Virgilitto, 2012). There are three types of motivation according to Ryan and Deci (2008): intrinsic motivation, which is the motivation that comes from within an individual, for example, the desire to pass the Nursing Board Examinations; and extrinsic motivation, which is the motivation that is a result of a reward. A student desiring to pass the Nursing Board Examinations in order to be empowered to earn a better salary; and demotivation which is the state of not being motivated, for example, a student failing the Nursing Board Examinations because she was not interested in doing nursing but was forced to study nursing for the prestige it represents. The most important of these three motivations related to academia is intrinsic motivation. According to Karabulut, Aktas and Kucuk (2015), a positive clinical learning environment will enhance the academic motivation of nursing students. In the study, professional nurses and educators expressed the opinion that students are not intrinsically motivated to study nursing. They are studying nursing as a result of parental influence or because of the salary they would earn if they worked abroad. With regard to the students not being intrinsically motivated, the professional nurses is of the opinion that students' learning during clinical placement is affected since students absent themselves from clinical placement for different reasons. Students and alumni however hold a different opinion as to

why students are not motivated at the clinical placement. They believe that clinical facilities are not welcoming; that professional nurses are hostile towards them, and that they are not accepted by the professional nurses. This finding concurs with those of Karabulut, Aktas and Kucuk (2015), which state that the support provided to students by educators and professional nurses during clinical placement assist in keeping students academically motivated. The Merriam-Webster dictionary defines collaboration as 'working together to achieve a goal'. Collaboration among nursing professionals has been identified as a way to bridge the gap between nurses in the service and nurses in academia (Bruce, 2013). In a paper titled "Bridging the gap between education and practice in nursing: the experiences in Malaysia", Buncuans (2010) points out that one of the that nurses in practice do not have current knowledge in nursing compared to those in academia.

However, this can be bridged when the professional nurses and nurse educators plan and execute seminars to share knowledge which leads to capacity building on both sides. Participants in this study agreed with this finding as they clamoured for improved relationship between the nurse educators and professional nurses. In this regard, students and alumni suggested that an improved collaboration between the educators and professional nurses will enhance capacity building and will seek to improve the professional nurses' knowledge on current trends in nursing.

The professional nurses argued that the existing gap between the educators and the professional nurses negatively affects the learning experience of students.

4.7.3 Purposeful supervision

1. Clinical supervision by clinical instructors and professional nurses was irregular, non-standardised and non-supportive.

2. Educators' feedback to students; and communication of learning objectives by the educators to the professional nurses were inadequate.

Supervision of student nurses during clinical placement is as important as the students' attendance in the clinical placement (Browning & Pront, 2015). However, if supervision of students is not done in a supportive way it will not yield the best learning outcome for the student (Kristofferzon, Martensson, Manihidir & Löfmark, 2013). Supervision of the student nurses is carried out by both the nurse educators and professional nurses in the hospital, but the weight of supervision falls more on the professional nurses who the students will meet first and stay with during clinical placement (Franklin, 2013; Nasrin, Soroor & Soobadeh, 2012). Professional nurses however sometimes find it very difficult to supervise the student nurses due to factors such as heavy workload, inadequate resources and lack of knowledge on how to carry out supervision (Karabulut, Aktaş & Küçuk, 2015). According to Emanuel and Pryce-Miller (2013), most professional nurses are not trained to carry out the role of supervision effectively. In the study, professional nurses and educators referred to the inadequacy of the professional nurses to teach, supervise and mentor the students during clinical placement. In addition, students and alumni in the study believed that the professional nurses are out-dated in their knowledge and do not seek to improve their knowledge and are therefore unable to be positive role models to them in practice. The students acknowledged that a need exists for professional nurses to be trained and for them to be engaged in capacity development that will enable them to perform their roles effectively as supervisors and good role models. This finding is supported by Anarado and Nwonu, (2016) in their article on Factor hindering clinical learning environment to nursing students in selected nursing institutions in South-eastern Nigeria, which reports that students also recommended training of professional nurses.

The relationship between professional nurses and the students has a marked effect on the acquisition of professional skills and the learning outcomes of the students (Lapeñ a-Monux, Cibanal-Juañ, Orts-Cortés, Maciá-soler & Palacios-Ceña, 2016). Effective communication between supervisors and students is crucial during clinical placement and is supported by Allen and Molloy (2017), who argues that ineffective communication between professional nurses and student nurses is one of the major barriers of feedback to nursing students during clinical placement. Prompt constructive feedback has been established as beneficial to students learning in clinical placement (Allen & Molloy, 2017; Fowler & Wilford, 2016). Students and alumni participants in the study claimed that feedback from their supervisors was infrequent mainly because of the unavailability of the instructors; both professional nurses and educators from the school. In this regard, educators reported that they provide feedback to students although it is not structured and that structured feedback happens only after an examination or final assessment. All participants in the study mentioned the use of the record of instructions booklets for evaluation of the students. However, students and alumni fault the use of the booklet as being subjective, mainly because the booklets are only signed at the end of the clinical placement and professional nurses sign with bias and may not even know the students when signing.

4.7.4 Situated learning

1. Inadequate infrastructure and resources at universities and clinical facilities render the clinical learning environment non-conducive to learning.

Situated learning is when a student is placed in an environment that is contextualised to his learning (Gonen, Lev-Ari, Sharon & Amzalag, 2016). One of the uses of situated learning in nursing education is placing students in the clinical setting where they practice with the professional nurse to acquire the professional skills needed to practice as a professional nurse

in the future. According to Herrington, Reeves and Oliver (2014) as cited in Spector, Merrill and Bishop (2014), one of the characteristics of situated learning is the ability of the environment to reflect a real-life context and accessibility to experts that will model the skills to be acquired. In the study, students reported that what they experience in the clinical facilities is very different from what they learn in the classroom. They suggested that a clinical skills laboratory should be adequately resourced more than the clinical facilities. In addition to the lack of resources in the clinical facilities, there exists a shortage of professional nurses that will model the professional skills the students are required to learn. These factors render the clinical learning environment unsupportive to student learning. The educators suggested that they try to make the place supportive to learning by taking equipment required for learning from the universities to the clinical facilities but the students argued by saying it is only during the examinations that equipment is brought out for them to use. The challenge remains that if the student has not had an opportunity to practice with the equipment during the placement, they may not do well during the examinations.

4.7.5 External support

1. The nursing programme lacks sufficient support from the government.

There are several definitions for support. In this study, “external support” relates to the help obtained from outside of what the university does to sustain clinical nursing education. The government is the source of funding for the universities and all the clinical facilities that are used for clinical placement in the study. All the participants in the study said the support from the government is poor most especially in the clinical facilities as evidenced by the lack of material and human resources for patient care.

4.8 SUMMARY

This chapter presented and discussed the findings emanating from investigating the effectiveness of clinical nursing education in the Bachelor of Nursing Science programme offered at universities in Nigeria by using the CIPP model. From the findings, it can be concluded that clinical nursing education offered in Nigerian universities is challenged mainly by the lack of human and material resources, ineffective relationships between stakeholders in nursing education, lack of support from the government and ineffective implementation of the curriculum. These challenges made the environment in which the students learn non-conducive and non-supportive to achieving learning outcomes. The following chapter deals with the development of the model for clinical nursing education.

CHAPTER FIVE

DEVELOPMENT OF CLINICAL NURSING EDUCATION MODEL TO GUIDE CLINICAL NURSING EDUCATION OFFERED AT NIGERIAN UNIVERSITIES

5.1 INTRODUCTION

This chapter discusses the second phase of this study (model development) as described in Chapter 3. As mentioned in Chapter 3.5, this phase is referred to as theory generation and it follows a series of steps outlined by Walker and Avant (2014), Chinn and Kramer (2015) and Dickoff, James and Wiedenbach (1968). This chapter focuses on achieving the second main objective of the study which was:

- To develop a clinical nursing education model for universities in Nigeria.

The following steps as outlined in Table 3.10 in Chapter 3 guide the presentation of model development:

Step One: Concept synthesis−Identification of concepts from data generated in phase one.

Step Two: Statement synthesis−Development of relational statements.

Step Three: Theory synthesis−the model development.

An overview of the model; the purpose, the context and assumptions of the model, model structure; description of the concepts in the model; the guidelines to operationalise the model and the evaluation of the model are presented after step three.

5.2 STEP ONE: CONCEPT SYNTHESIS

According to Walker and Avant (2014), concept synthesis is the extraction of concepts from a body of data which is used to gain new insights about a phenomenon and which can add to the development of theory. In this study it refers to extracting concepts from data derived

from the document review, focus group discussions and interviews conducted with participants which can be examined and used in the development of a model for clinical nursing education in Nigeria. The empirical findings referred to are presented in Chapter 4. True to procedure, concept synthesis is an iterative process requiring the researcher to move back and forth between steps (Walker & Avant, 2014). A broader process described by Bruce and Klopper (2010) was used in this study and included i) identifying; ii) classifying and iii) describing or defining the concepts. According to Shoemaker, Tankard and Lasorsa (2004: 15) "concepts are the blocks on which theories are built" and they represent the image formed in the mind concerning an action (Avant & Walker, 2014).

5.2.1 Concept Identification

The process of concept identification was guided by the purpose of the study which was to develop a model that will give direction and guide clinical nursing education (Chinn & Kramer, 2015). This process was started by critically examining the seven concluding statements developed from the themes that cut across all the participant groups in phase one of the study and consequently, deriving meaning from of the concluding statements on how it relates to guiding clinical nursing education in Nigeria. The researcher then made use of the tenets of the Cognitive Apprenticeship Model to assist with clustering the concepts. These included the following as reflected in Table 5.1 below: content, purposeful supervision, community of practice, situated learning and external support.

A total of 15 concepts were identified from the concluding statements. The researcher then examined these 15 concepts for hierarchical structure. Consequently, two concepts that were similar or related to each other were combined to form a higher order concept. The next step was to name the concepts. Five main or core concepts, as presented in Table 5.1 below, were

generated from this process viz. positive learning experience; capacity building; effective clinical education process; supportive learning environment and government support.

Table 5.1 Concept identification from the concluding statements

Cognitive Apprenticeship Model	Concluding statements	Concepts	Core concepts
Content	1. The curriculum design is deficient in critical learning experiences that bring about the desired nursing programme outcome which is to produce a versatile polyvalent nurse.	- Appropriate curriculum structure - Critical learning experience	**1. Positive learning experience**
Community of practice	2. Students experienced lack of acceptance and role modelling among the professional nurses and this resulted in absenteeism from their clinical placement and lack of motivation in students. 3. Lack of collaboration between the educators and professional nurses prevent capacity building of professional nurses, educators and student nurses.	- Acceptance and belonging - Role modelling - Attitude – professional nurses and educators - Motivation - Collaboration - Capacity building	**2. Capacity building**
Purposeful supervision	4. Students experienced irregular, non-supportive clinical supervision from clinical instructors and professional nurses as a result of heavy workload, unavailability and non-compliance to clinical placement learning objectives. 5. Students experienced lack of prompt and effective communication on their performance during clinical placement.	- Purposeful supervision - Availability of clinical instructors - Effective communication Timing Objectivity Prompt feedback	**3. Effective clinical education process**
Situated Learning	6. Students experienced a non-supportive clinical learning environment during their placements and the clinical facilities lacked human and material resources.	- Supportive learning environment - Adequate learning materials - Adequate human resources	**4. Supportive learning environment**
External support	7. The nursing programme lacked appropriate policy and sufficient support from the government.	- External support - Funding - Policy	**5. Government support**

5.2.2 Classification of concepts

The five concepts were classified according to the survey list of Dickoff et al. (1968), which responds to the following six questions relating to the tenets of the survey list as presented in Figure 5.1:

i) Agency - Who or what performs the activity?

ii) Patiency or recipiency - Who or what is the recipient of the activity?

iii) Framework - In what context is the activity performed?

iv) Terminus or goal - What is the end point of the activity?

v) Procedure - What is the guiding procedure, technique or protocol of the activity?

vi) Dynamics - What is the energy source for the activity?

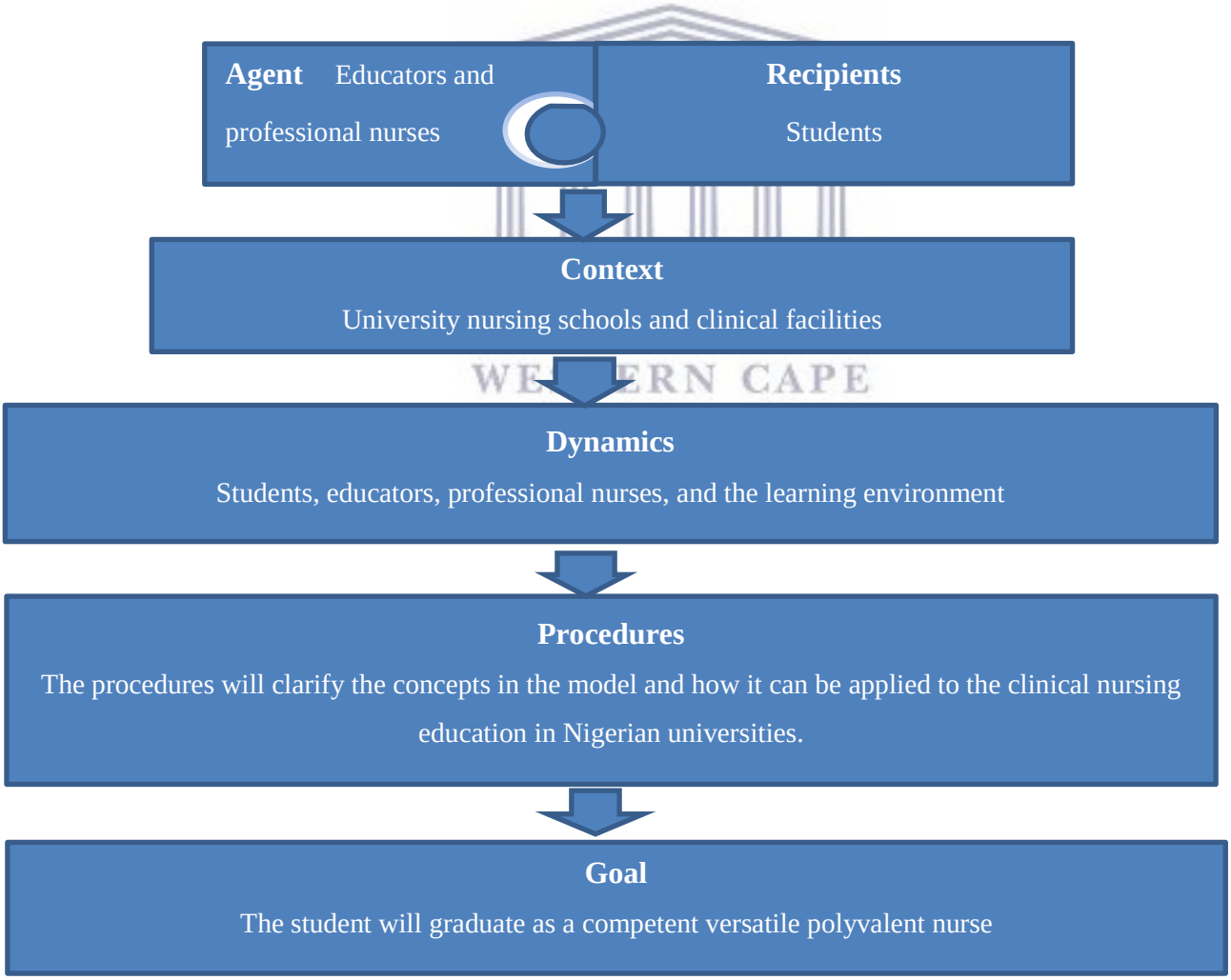
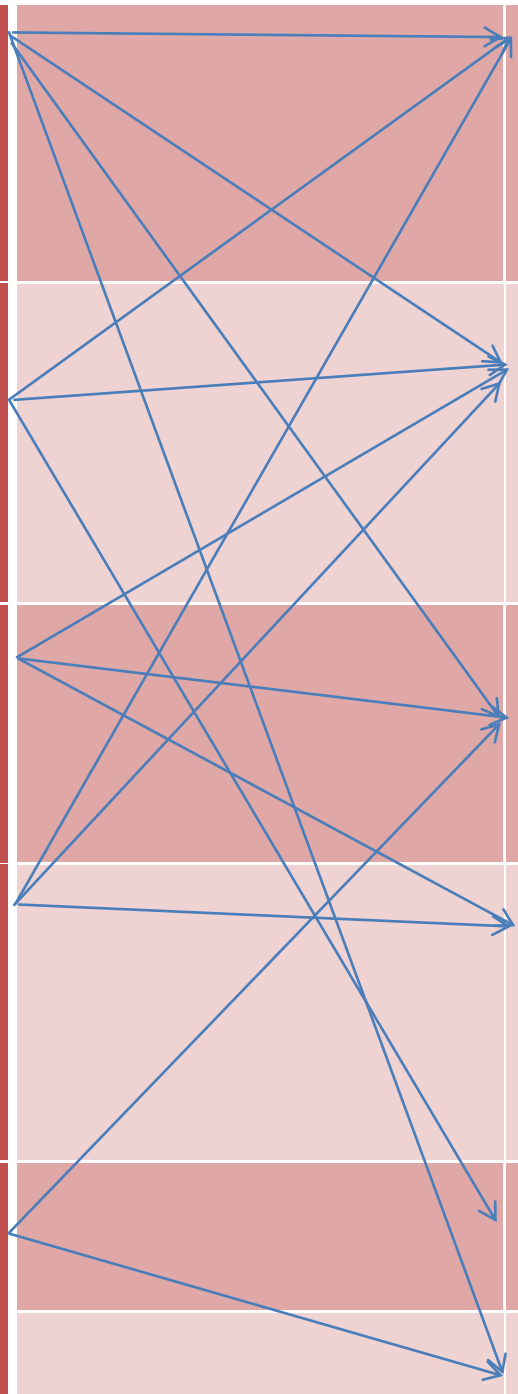


Figure 5.1: Researcher's reasoning map adapted from Dickoff et al., (1968)

Table 5.2 Systematic ordering of concepts in relation to the six elements of the survey list

Core and related concepts	Arrows depicting logical arrangement of concept identification and concept classification	Concept classification (Dickoff et al, 1968)
1. Positive learning experience - Critical learning experience - Appropriate curriculum structure		**Agents:** Educators Professional nurses
2. Effective clinical education process - Purposeful supervision - Available clinical instructors - Effective communication		**Recipient:** Students
3. Supportive learning environment - Adequate learning resources - Adequate human resources		**Context:** Clinical placement sites and universities
4. Capacity building - Collaboration - Positive attitudes - Role models - Motivation - Acceptance and belonging		**Dynamics:** Synergy between educators, professional nurses, students and the environment
5. Government support - Policy - Funding		**Procedures:** Educating stakeholders on the use, acceptance and adherence to the model.
		Goal: A versatile quality polyvalent nurse

5.2.2.1 Description of classified concepts

The following is a brief description of how the concepts and the core concepts relate to the survey list:

i) Agent

Dickoff et al. (1968) ask the question: Who will be responsible for carrying out the clinical nursing education? This responsibility rests on educators, who are classified as the clinical instructors employed by the university for the sole purpose of clinical training and the educators who are responsible for both theoretical and clinical teaching of the nursing programme. In addition, professional nurses in the clinical facilities are also seen as agents because they are the first point of contact for students when they are on clinical placements. Professional nurses are also expected to be role models in professional ethics and skills that the students need to emulate and practice when they themselves become qualified professional nurses. In capacity building, the educators and professional nurses serve as agents to each other and also collaborate for their personal and professional development. The related core concepts are:

- Positive learning experience
- Effective clinical education process
- Capacity building

ii) Recipient

Recipient refers to a person who receives the activities performed by the agents. In the model, the student nurses are the recipients of the clinical teaching provided by educators and professional nurses in a supportive environment. The educators and professional nurses are also recipients of each other's shared knowledge that leads to capacity building. The following core concepts were identified:

- Positive learning experience
- Effective clinical education process
- Supportive learning environment
- Capacity building

iii) Context

Dickoff et al. (1968) ask the question: In what context will the model be used? As the name suggests - a clinical nursing education model for universities in Nigeria, the model will be used primarily in the clinical facilities used for clinical placement of BNSc students by universities in Nigeria. However, because clinical nursing education starts at the clinical skills laboratory, the model will also be used in the universities. Core concepts identified include:

- Positive learning experience
- Supportive learning environment
- Government Support

iv) Dynamics

Dynamics refer to the source of energy; the motivating factor. In the model, the motivating energy will come from the educators who will ensure a positive learning experience for the student nurses. The source of energy will also come from the professional nurses who will implement the model and create a supportive learning environment for the students. Another source of energy includes the students' motivation and readiness to learn and the availability of resources in the environment where the students will learn. The following core concepts were identified:

- Supportive learning environment

- Capacity building

v) Procedures

The procedure, according to Dickoff et al. (1968), includes the path or the principles that will guide or lead to the goal. This includes educating the stakeholders about the concepts in the model. It also includes the acceptance of the model and adherence to the concepts and steps in the model. It also includes the process the educators take when students are on clinical placement. As a result, it will ensure the production of a versatile quality polyvalent nurse.

- Effective clinical education process

vi) Goal

Goal refers to the purpose of the whole activity. The purpose for developing this model is to ensure that students have quality clinical learning experiences that will ensure that they become versatile polyvalent nurses. The core concepts identified include:

- Positive learning experience
- Government support

5.2.3 Definition of concepts

The next step in concept synthesis involved verifying the concepts empirically by consulting literature, dictionaries, field notes, and experts such as the researcher's study supervisor. The classification of concepts according to the survey list by Dickoff et al. (1968) provided guidance for deeper understanding of the concepts and the creation of conceptual meaning. The following five concepts are defined:

- Positive learning experience
- Capacity building

- Effective clinical education process
- Supportive learning environment
- Government support

5.2.3.1 Positive learning experience

The first core concept is the positive learning experience which has the following related concepts: critical learning and appropriate curriculum structure.

Dictionary definition of positive learning experience:

According to online Oxford Dictionary (https://en.oxforddictionaries.com), one of the definitions of *positive* is 'a desirable or constructive quality or attribute', while *learning experience* is defined as 'the knowledge or skill acquired by a period of practical experience of something, especially that gained in a particular profession'.

Subject definition of positive learning experience:

Learning experiences refer to those activities educators seek or develop to ensure that the student meets the desired outcomes as stated in the curriculum (Halstead & Billing, 2014).

Summary

A positive learning experience refers to the constructive clinical learning experiences that ensure that a university student nurse has acquired the desired professional skills upon graduation.

5.2.3.2 Effective clinical education process

Effective clinical instruction is the second identified core concept which has the following related concepts: purposeful supervision, available clinical instructors and effective communication.

Dictionary definition of effective clinical education process:

According to the online Oxford Dictionary (https://en.oxforddictionaries.com), *effective* is defined as 'producing desired or intended result' while *education* is 'the process of giving information or receiving information systematically'. *Process* is defined as 'the series of action taken to achieve an intended goal'.

Subject definition of effective clinical education process:

Effective clinical education is defined as the education of students in the clinical facilities where they have contact with real-life situations for the purpose of acquiring professional skills under the supervision of a competent senior professional in becoming a competent health practitioner (Cantatore, Crane & Wilmoth, 2016).

Summary

Effective clinical education process, as defined in this study, refers to the detailed guidance given by a nurse educator or professional nurse for the purpose of helping nursing students acquire the desired professional skills needed for a successful and safe practise as a professional nurse.

5.2.3.3 Supportive learning environment

Supportive learning environment is the third core concept which has the following two related concepts: adequate learning resources and adequate human resources.

Dictionary definition of supportive learning environment:

Supportive is defined by Cambridge Academic Content Dictionary (www.dictionary.cambridge.org), as 'actively giving help to someone who needs it'. *Learning* is defined as the 'activity of getting knowledge' while *environment* is defined as the 'condition that you live or work in' and it determines the effectiveness of your work.

Subject definition of supportive learning environment:

Supportive learning environment has been identified as a learning environment that has adequate learning resources, which include patients and material resources (Kapucu & Bulut, 2011); professional nurses and nurse educators that are friendly and ready to teach (Kristofferon, Mårtensson, Mamhidir, & Löfmark, 2013), and the inclusion of students in decision-making and patient care (Ali, El Banan & Al Seraty, 2015).

Summary

In the model, supportive learning environment is defined as an environment that is friendly with adequate human and material resources for student clinical learning and one that will enhance the acquisition of professional nursing skills.

5.2.3.4 Capacity building

The fourth core concept is capacity building which has the following related concepts: collaboration, positive attitudes, role models, motivation, acceptance and belonging.

Dictionary definition of capacity building:

According to www.businessdictionary.com, capacity building is defined as 'planned development of knowledge, output rate, management, skills and other capabilities of an organisation through acquisition, incentives, technology and or training'.

Subject definition of capacity building:

Capacity building is defined by Markaki and Lionis (2008:141) as "promoting an environment that increases the potential of individuals, organizations and communities to receive and possess knowledge and skills as well as to become qualified in planning, developing, implementing and sustaining health- related activities to changing or emerging needs".

Summary

In the model, capacity building refers to the development of knowledge, skills and attitudes of nurse educators, professional nurses and students by means of collaboration.

5.2.3.5 Government support

The fifth concept is government support which has the following two related concepts: policies and funding.

Dictionary definition of government support:

According to the Oxford Advanced Learners Dictionary (2015), *Support* can refer to 'the act of holding firm preventing from falling'. While the online Oxford Dictionary (https://en.oxforddictionaries.com) defines *government* as 'a group of people that have the authority to govern a set of people or a system'.

Subject definition of government support:

Government support, according to Fitzgerald, Kantrowitz-Gordon, Katz and Hirsch (2012), refers to the provision of funding and formation of policies that will enhance the education of professional nurses towards a better healthcare system.

Summary

Government support refers to help received from the government in terms of policies and funding, to support clinical facilities and the universities.

5.3 STEP TWO: STATEMENT SYNTHESIS

Statement synthesis refers to the identification of the relationships or interrelationships between two or more concepts (Walker & Avant, 2014) based on the evidence gleaned in step one – concept synthesis. The aim of the process is to formulate statements which lead to

theory synthesis. Understanding the relationships was enhanced by using the survey list by Dickoff et al. (1968). Chinn and Kramer (2015) caution that such statements are not always core to a theory and might have peripheral meaning. It is therefore important to identify the nature of the relationship(s) between concepts which might include concepts that are interrelated in many ways; a single concept which is related to many other concepts; or concepts which are unrelated (Walker & Avant, 2014). Chinn and Kramer (2015) assert that this would result in simple or more complex relational statements. The process of constructing relational statements provides form to a theory or model (Walker & Avant, 2014).

5.3.1 Relational statements of the model

The following relational statements were constructed based on the nature of the relationship, which may in this study describe, explain or provide an understanding of the phenomena:

- Positive learning experience is developed within a supportive learning environment through interaction between educators, students and the professional nurses towards producing competent versatile polyvalent nurses based on an appropriately structured curriculum provided by the university.
- An effective clinical education process will be driven by both nurse educators and professional nurses to ensure that students have a positive learning experience based on their availability to provide purposeful supervision underpinned by effective communication and feedback to students.
- A supportive environment is one that has adequate material and human resources maintained by government support to ensure that students have a positive learning experience.

- Capacity building of nurse educators, professional nurses and students will be attained through collaboration which will increase the sense of acceptance and belonging, increase motivation and result in the development of role models who have a positive attitude towards clinical education and the students.
- The external support, which includes financial support from the government, is fundamental to the existence of the university and the clinical facilities should be underpinned by sound policies regarding income and expenditure on clinical nursing education, including material and human resources. Policies regarding clinical learning of health professionals produced by government departments for effect in the hospitals must provide by ensuring a supportive learning environment.
- A versatile polyvalent nurse is the successful outcome of the collaborative efforts of both the nurse educators in the universities and the professional nurses in the clinical facilities.

5.4 STEP THREE: THEORY SYNTHESIS

Theory synthesis is the process of using empirical research, which has been classified into a system of interrelated ideas− a theory. Often theory synthesis is presented in an expository form, however, a graphic representation of the relationships within and among statements is another accepted form of presenting theory. This is referred to as model development, which is an objective of this study (Walker & Avant, 2014).

5.4.1 Overview of the model

The overview of the model is based on the structure depicted in Figure 5.2. The model of clinical nursing education is patterned to exhibit the processes for clinical nursing education.

The model shows the relationships between universities, clinical learning sites and government towards the production of a polyvalent nurse.

5.4.2 Purpose of the model

The purpose of developing a model is underpinned by the notion that the statements related to the model are embedded within its theoretical structure and is valuable in terms of restoring clinical education in universities in Nigeria (Chinn & Kramer, 2015).

5.4.3 Context of the model

Although the data was collected at the universities and their teaching hospitals in the south-western region of the Nigeria, the researcher intends for the model to be used in all the universities and their teaching hospitals throughout the country. However, Chinn and Kramer (2015) caution that the generalisability of the theory depends on the extent and quality of the evidence, which in this study, refers to the data collected in phase one, on which the theory is based.

5.4.4 Assumption of the model

The model is based on the following assumptions:

i) That the curriculum of the universities in Nigeria will be reviewed to ensure that clinical nursing education is well developed and strategized to bring out the desire outcome in the student nurse.

ii) That the nurse educators and professional nurses will collaborate to bring about the clinical learning experience which will result in the production of a versatile polyvalent nurse.

iii) That the government will provide adequate financial support to the nursing institutions and government-funded hospitals to ensure the effective delivery of clinical education through the availability of adequate human and material resources.

5.4.5 Model structure

As alluded to earlier, a model is a group of concepts and propositions that are brought together and explains the relationship between the concepts thereby providing a deeper understanding about a phenomenon (Fawcett & Ellenbecker, 2015; McKenna, Pajnkihar & Murphy, 2014). According to Chinn and Kramer (2015), in order to identify and show the relationships that exist between concepts they should be illustrated in a structure. The main concepts identified are therefore brought together in diagrammatic form in Figure 5.2 and the relationships between the concepts are illustrated in the model. Figure 5.2 below represents the proposed model of clinical nursing education in Nigeria.

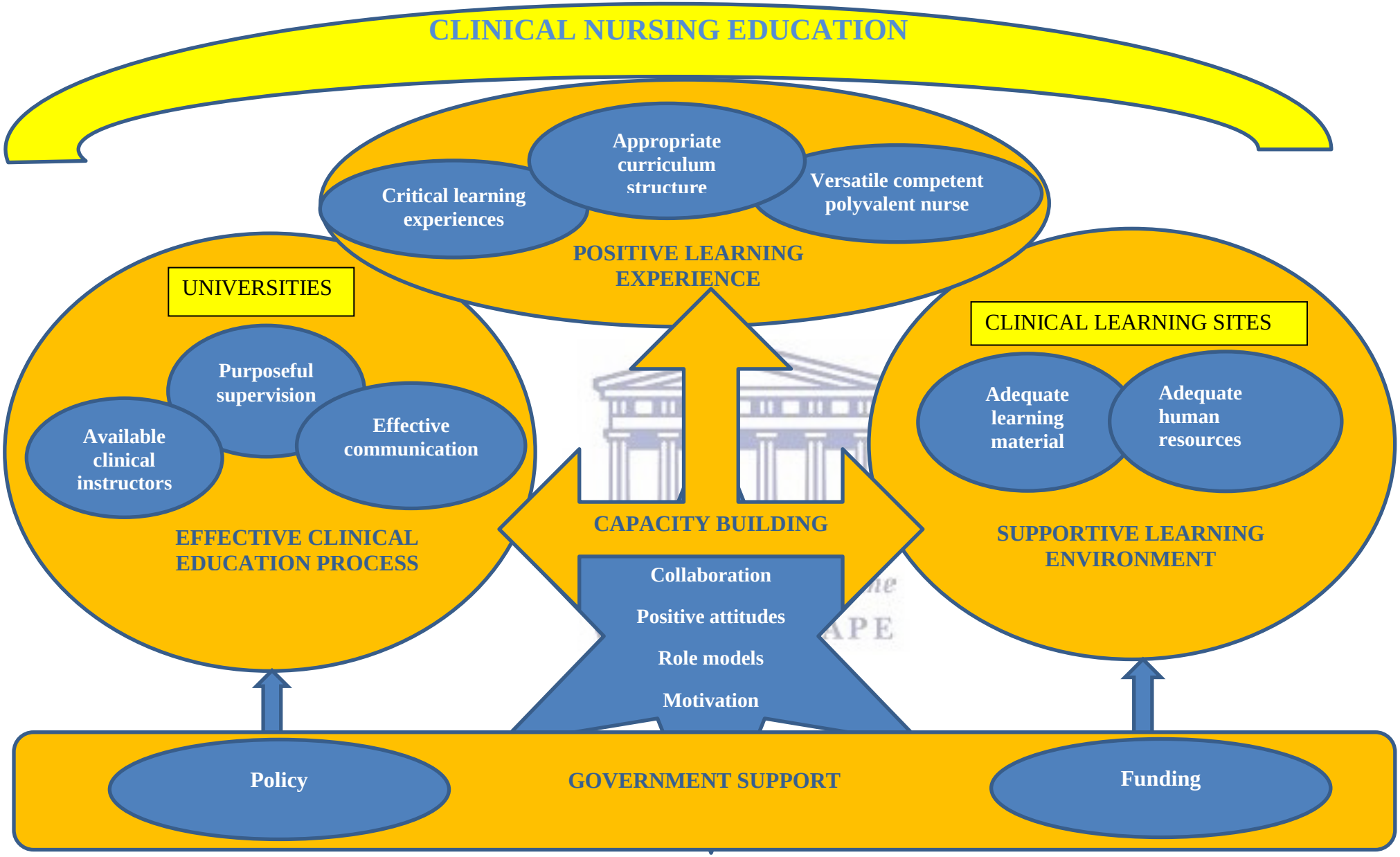


Figure 5-2 Model of clinical nursing education

5.4.6 Description of the concepts in the model

The operational meaning of the five core concepts are provided in relation to the developed model. The operational definitions were definitions identified earlier in 5.2.3 through the synthesis of dictionary meanings and meanings according to nursing literature. These definitions are discussed in relation to the core concepts and related concepts.

A positive learning experience is the first core concept depicted in the model as the top centred yellow oval structure encompassing critical learning experience and appropriate curriculum structure and versatile polyvalent nurse. This refers to the constructive clinical learning experiences that ensure that a student nurse at university has acquired the desired professional skills upon graduation.

According to Halstead and Billings (2014), **critical learning experiences** are learning experiences in the curriculum which a student must successfully complete before graduation.

An appropriate curriculum structure includes planning adequate and quality clinical placements and ensures that they are aligned to the theoretical component. The theoretical classes should not clash with clinical practice timing.

Literature reveals that clinical education is the bedrock of any nursing programme, and in order to ensure good clinical education for student nurses the nurse educators must work together with the professional nurses in the clinical placements sites. Timing is very crucial to the successful implementation of planned learning outcomes in a curriculum (Council of Ontario Universities, 2013; Heidari & Norouzadeh, 2015). Timing of the learning experiences in the curriculum does not only refer to the hours spent in the clinical placement but also to ensure the availability of learning opportunities for the students in order to have a favourable learning outcome.

Effective clinical education process is the second core concept depicted in the model as the yellow oval structure on the left and is defined as the detailed guidance given by a nurse educator or professional nurse for the purpose of helping nursing students acquiring the desired professional skills needed for a successful and safe practice as a professional nurse. The other concepts related to an effective clinical education process are purposeful supervision, available clinical instructors and effective communication. An effective clinical education process cannot be achieved without the related identified concepts. According to Ford, Courtney-Pratt, Marlow, Cooper, Williams and Mason (2016), the supervision and support a student receives during clinical placement are crucial and it defines the learning experience of the student. **Purposeful supervision** of students during clinical placement refers to the nurse educator, inclusive of the clinical instructors, facilitating student learning towards meeting the proposed clinical learning objectives of the curriculum. It is therefore the decisive intervention provided by the qualified expert (nurse educators, clinical instructors, professional nurses) to the student nurse with the aim of developing a competent polyvalent nurse. However, equally important is the **availability of clinical instructors** during clinical placement to identify learning opportunities.

Communication refers to the exchange of information between two or more people. It is the means by which a relationship develops between two or more people (http://www.merriam-webster.com; Bramhall, 2014). **Effective communication** therefore refers to the exchange of intended information between the experts and the student nurse. It includes providing **timely** and **objective feedback** to the student for the purpose of improving skills and bringing out the best learning outcome in the student nurse.

Supportive learning environment is the third core concept depicted in the third yellow oval structure to the right in the model. Related concepts, including adequate learning resources and adequate human resources are situated in the oval. A clinical placement facility can only

be said to be supportive when it has adequate learning resources which include patients and material resources (Kapucu & Bulut, 2011) and professional nurses and nurse educators that are friendly and ready to teach (Kristofferon, Mårtensson, Mamhidir & Löfmark, 2013).

Supportive learning environment is defined as the environment that is friendly with adequate human and material resources for student clinical learning that will enhance acquisition of professional nursing skills. It is linked with the effective clinical education process through **capacity building.**

Capacity building is the fourth core concept depicted in the model as a yellow three-way arrow; and embedded in it are other related concepts in an underlying blue star, which include collaboration, positive attitude, role models, motivation, acceptance and belonging. These related concepts serve, and is referred to as the mortar, which holds the concepts together. It refers to the development of knowledge, skills and attitudes of the nurse educators, professional nurses and students through collaboration with each other. Collaboration, according to www.aiim.com, is when two persons work together to achieve a common goal. According to Aktas and Karabulut (2016), the quality of the clinical placement is directly related to the **academic motivation** of the nursing students and ultimately the achievement of the learning outcomes and acquisition of professional skills. It also refers to the **motivation** provided by the professional nurses and educators towards the building of intrinsic motivation in the student nurse. **Acceptance and belonging** refers to the degree to which the students are made to feel welcome and accepted in to the community of the professional nurses by the professional nurses. It also refers to the extent to which the students perceive themselves as being accepted into the community. This acceptance increases when the professional exhibits a **positive attitude** of friendliness and care towards the students. **Attitude** is defined by the Oxford Dictionary (2015) 'as the way that you behave that shows how you think and feel'. Therefore, the positive attitude exhibited by professional nurses

towards the students and nurse educators, who accompany the students to the clinical facilities, enhances capacity building in both nurse educators and professional nurses, and ultimately leads to the production of versatile polyvalent nurses, as indicated by the arrow of capacity building . Positive attitude also refers to the respect shown to professional nurses by the students and the eagerness and readiness to learn exhibited by the students. In addition, it refers to the mutual respect between nurse educators and professional nurses. The positive attitude exhibited by the professional nurses enhances the students' ability to perceive the professional nurses as their role models and mentors. Students' respect for the professionals and the profession is enhanced when educators and professional nurses exhibit a positive attitude towards each other. This relates to the concept of being a **role model** which is defined by Baldwin, Mills, Birks and Budden (2014) as the behaviour or attitude a person adopts of another person who he or she esteems and holds in high regard. In role modelling, the responsibility lies more with the professional nurses that the students meet every day during their clinical placement. The professional nurses have the obligation to model what is right in the presence of the students when carrying out patient care and during their interaction with their colleagues and students. The nurse educators, as role models, are also obliged to model correct ethical and professional skills.

Government support refers to help received from the government in terms of policies and funding; to support clinical facilities and the universities. In the model, it is depicted as the yellow rectangular base that contains the positive learning experience, the effective clinical education process, supportive learning environment and capacity building.

5.4.7 Guidelines to operationalise the model

The guidelines for putting to use the model of clinical nursing education in Nigeria will be described using the phases of the CIPP model which are Context, Input, Process and Product.

These phases are based on its use in the evaluation of clinical education in Nigeria. Moreover, according to Stufflebeam (2017), the model can be used in the formative stage, in which the Context refers to the goal; the Input refers to the designs and plans; the Process refers to the actions and plans; and the Product refers to the terminus or the outcome. The guideline will be described in the context of the universities and the clinical facilities used for clinical placement.

5.4.7.1 Context evaluation (Goals)

Guideline 1: Nurse educators and professional nurses must work together to develop learning experiences that will ensure that the outcome of developing a versatile polyvalent nurse is achieved.

Strategy:

- Develop learning objectives that are achievable for each clinical placement so as to ensure that supervision of the student is focused and measurable.
- Evaluate the nurse educators learning outcomes whether it is measurable.
- Conduct meetings between educators and clinical facility staff, at least quarterly, to ensure that clinical placements are effective, and if not, to devise improvement plans.
- Invite staff from clinical sites to curriculum meetings to ensure that their views and expertise are considered, which facilitates buy in and ownership of the nursing programme in general and of the clinical education programme in particular.
- Ensure that professional nurses receive and understand the learning objectives of each clinical placement.

Responsibility: Nurse educators, head of department and Clinical Education Committee

- Ensure that students have good exposure to procedures in the clinical skills laboratory before proceeding on a clinical placement. This reduces mistakes on

patients and enhance the transition period of student nurses into clinical environment and can be achieved by:

  - developing sufficient practice times in the clinical skills laboratories; and
  - ensuring that students complete their requirements in the clinical skills laboratories before proceeding on clinical placement.

- Identify/create learning opportunities for students in the clinical facilities.
- Monitor the uptake of clinical learning.
- Monitor the achievement of clinical learning objectives.
- Conduct a background check on the adequacy of the clinical facilities for clinical placements to ensure that students will have learning opportunities that will bring desired outcome before the commencement of the clinical placement. Hospital policies should be in place for equity of allocation of clinical learning opportunities.

Responsibility: Nurse educators, professional nurses, Director of Nursing Services and head of department in the universities

5.4.7.2 Input phase (Actions, Plans and Resources)

Guideline 2: The government, university and clinical placement facilities must demonstrate support towards the nursing programme by ensuring that resources needed for clinical education are available.

Strategy:

- Ensure that there is a budget for appropriate learning materials.
- Conduct benchmarking exercises with institutions who have well-established skills laboratories.

- Ensure that the clinical skills laboratories are adequately resourced with modern technologies and necessary equipment towards the achievement of the learning outcomes.
- Adequacy of resources must be reviewed and updated regularly.
- The university augments the resources in the facilities to ensure that resources are adequate and available.
- Establish norms and standards for clinical supervision. For example. apply the recommended educator to student ratio of 1:10.
- Determine the need for nurse educators and ensure sufficiency at each clinical placement site.
- Strictly adhere to the Nursing and Midwifery Council of Nigeria (NMCN) regulation on the admission quota of 50 students per set to prevent skewed educator to student ratios.

Responsibility: Nurse educators, university administrative committees, Clinical Education Committee and head of departments.

- Ensure that the clinical facility budgets for resources needed for patient care and therefore students' learning
- Adequacy of staff (professional nurses) and material resources at the clinical facilities are reviewed to ensure that professional nurses can fulfil the role in the education and training of nurses
- The professional nurses are kept motivated by timeous payment of their salaries and incentives.

Responsibility: Professional nurses, government, Director of Nursing services.

5.4.7.3 Process (Action Phase)

Guideline 3: Nurse educators and professional nurses must collaborate to ensure that students have a positive learning experience and that they are supported by meaningful supervision in a supportive learning environment.

Strategy:

- Nurse educators and professional nurses must collectively decide on clinical placements to ensure that students have the best learning experience.
- Ensure the alignment of clinical placement with the theoretical component of the curriculum.
- Develop and conduct seminars for professional nurses to prepare then to be relevant preceptors and mentors for students in line with the nursing departments teaching and learning philosophy.
- Students should attend the clinical facility in-service training sessions where relevant.
- Invite professional nurses to graduation and other ceremonies to celebrate students' achievements.
- Motivate student nurses through frequent and open interaction about their progress

Responsibility: Students, nurse educators, professional nurses, Director of Nursing Services, head of departments, Clinical Education Committee

Guideline 4: Students, nurse educators and professional nurses must ensure an effective line of communication.

Strategy:

- Provide guidelines for channels of communication between educators, professional nurses and students.
- Provision of timely formative and summative feedback to the student nurses.

- Circulation of objectives among the student nurses and professionals and what is expected of the students in order to achieve the objectives.
- Conduct regular assessments according to an assessment plan to establish students' level of competence.
- Develop a feedback system which allows professional nurses to provide feedback to the university at the end of each student placement regarding a student's performance.
- Regular consultations with the student nurses and their mentors to discuss their progress and plans. This is especially important for at risk students.

Responsibility: Student nurses, professional nurses and nurse educators.

5.4.7.4 Product phase

Guideline 5: Students' professional skills must be assessed to establish the successful achievement of professional skills, as required by versatile polyvalent nurses.

Strategy:

- Conduct formal assessments on students' clinical skills according to a structured assessment plan.
- Implement a system for students to provide feedback on their experience at the clinical placement.

5.4.8 Evaluation of the model

According to Sousa (2014), validation is a very important part of theory generation which enables the researcher to ascertain that the intended population understands the intended meaning of the theory/model or concepts involve in the model, and the diagram illustrating the model. One of the ways the model of clinical nursing education was evaluated was by

presenting the model to experts in the field of nursing education. The experts included the Head of Department of Medical Surgical Nursing at a university, the Head of Maternal and Child Health Nursing, the chief clinical instructor of a nursing department at a university and a senior lecturer (an expert in curriculum development). The model was also presented to an expert in policy development and a student of nursing education. It was requested of these participants to check for clarity, simplicity, generality, accessibility and the significance of the model. The critical reflection questions related to the evaluation of the theory were obtained from Chinn and Kramer (2015).

5.4.8.1 Clarity

Clarity ensures that the definitions of the concepts in the model are clear and it means what is intended. It also depicts whether the structural description of the model is consistent with the description of the model. The experts gave their positive opinions on the clarity as illustrated by the following statement from one participant on the review panel:

"*The concepts are well described and the arrows are showing the direction of the concepts"- (Head of Department Medical-Surgical Nursing).*

5.4.8.2 Simplicity

Simplicity seeks to establish whether the model is simple and straightforward to understand. The model has only five concepts and it is not crowded. Participants involved in the review of the model acknowledged its simplicity and that it is easy to understand. One of the reasons why the model was sent to an expert in a field other than nursing was to ascertain the simplicity of the model by those who do not necessarily understand nursing. The accurate description of the model by this expert indicated its simplicity. The expert described the model with the statement below:

"I can tell that the universities and the clinical facilities need to work together to produce a versatile nurse and without funding from the government it is almost impossible to ahieve the goal"-(Expert in Policy Making).

5.4.8.3 Generality

This model was tested for its relevance in other fields of nursing. Although the research was conducted in an acute care medical-surgical nursing setting, the expert from the midwifery section understood the concepts and acknowledged its applicability in midwifery education. Although the model was conducted in the south-western region of Nigeria, it is relevant and can be applied to other parts of Nigeria.

5.4.8.4 Accessibility

The goal of the researcher is to present the model to the Nursing and Midwifery Council of Nigeria where it would be recommended that it be adopted across universities in Nigeria.

5.4.8.5 Importance

Clinical nursing education in Nigeria is not currently based on any model. Consequently, the proposed model is important since it will serve as a standard that guides clinical nursing education offered in Nigerian universities.

5.5 SUMMARY

The second objective of this research study was to develop a model for clinical nursing education that will guide clinical nursing education offered in the Nigerian universities. This chapter provided a detailed description of the process of model development. Chapter six presents the conclusion, recommendations and limitations of the study.

CHAPTER 6

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The previous chapter focused on the development of a model to guide clinical nursing education offered at Nigerian universities. This final chapter of the thesis summarizes and draws conclusions on Chapters 1− 5. The limitations of the study and recommendations for nursing education, nursing practice and research based on the findings of the study, are also presented in this chapter.

6.2 SUMMARY AND CONCLUSIONS

The aim of this study was to develop a model to guide clinical nursing education at universities in Nigeria. The first objective was to explore the effectiveness of clinical nursing education in Bachelor of Nursing Science programmes at universities in Nigeria. This objective was divided into four sub-objectives, which were to:

- Explore and describe the context for clinical nursing education offered at universities in Nigeria;
- Explore and describe the resource allocation for clinical nursing education offered at universities in Nigeria;
- Explore and describe the process of delivery of clinical nursing education offered at universities in Nigeria; and
- Explore and describe whether the clinical nursing education offered at universities in Nigeria is effective.

The first phase of the study which was guided by Stufflebeam's CIPP model of evaluation also served as the framework for the study (Stufflebeam, 2007). A document review, semi-

structured interviews and focus group discussions served as data collection methods. The interviews and focus group discussions were conducted among the educators which included nurse educators and clinical instructors employed by the universities involved in the study, students, professional nurses at the clinical facilities, and the alumni of the Bachelor of Nursing Science programme at the universities. An inductive approach was used to generate themes and categories from the data.

In the second phase of the study, concepts were identified from the themes generated in phase one which formed the basis for the development of the clinical nursing education model for Nigerian universities; the second objective of the study. The model development process followed steps outlined by Walker and Avant (2014), Chinn and Kramer (2015) and Dickoff, James and Wiedenbach (1968).

After its development, the model was evaluated and validated through expert review and through the use of critical reflection questions, as proposed by Chinn and Kramer (2015). The guidelines for operationalising the model were then described using the phases of the CIPP model. Successful execution of phases one and two of the study enabled the researcher to meet the purpose and objective of the study.

6.3 LIMITATIONS

The following limitations relate to the study:

- The model developed in this study is intended to serve as the model which would guide clinical nursing education in the universities in Nigeria. However, the research was conducted only in the south-western region of Nigeria. It could be argued that the model is only as good as the data collected in phase one. In addition, only four universities were included in the study even though six universities were offering the nursing programme in the region at the time the research was conducted.

- The developed model was not reviewed by all the participants of the study to ascertain whether the concepts presented in the model represented their perception of clinical nursing education.

6.4 RECOMMENDATIONS FOR NURSING EDUCATION, NURSING PRACTICE, RESEARCH AND POLICY DEVELOPMENT

The following recommendations are based on the research findings:

6.4.1 Recommendations for nursing education

- An orientation session should be arranged by nurse educators before the commencement of clinical placement to ensure that professional nurses are familiar with the learning outcomes of the clinical programme.
- Thereafter, regular stakeholder meetings and seminars should be scheduled between nurse educators and professional nurses to discuss issues pertaining to clinical nursing education and the students' development in clinical practice.
- The Bachelor of Nursing Science curriculum should be restructured in such a way that the theoretical and clinical practice components are aligned.
- More nurse educators should be employed to ensure a manageable student-educator ratio for clinical accompaniment.
- The university should establish a programme to train preceptors and mentors in the clinical facilities who would support student nurses during their clinical placement. This would augment the role of the clinical instructors.
- Nurse educators /head of nursing departments should prepare and submit adequate budgets to the University for the Procurement of resources pertaining to the clinical education programme.

- An internship programme should be established and introduced at the end of the nursing programme. During this period the new graduate nurse can master his/her skills under the supervision of a more senior professional nurse.

6.4.2 Recommendations for nursing practice

- Professional nurses should be encouraged to act as role models for both new graduates and student nurses.
- Open and honest communication should be encouraged between professional nurses and educators regarding student matters.
- Professional nurses should be encouraged to provide constructive feedback to the educators regarding the clinical education programme and students' progress.
- Professional nurses should attend seminars planned by nurse educators to ensure that they keep abreast of developments in nursing education; and likewise they should use the platform to update nurse educators on developments in clinical practice.
- Professional nurses and nurse educators should be encouraged to participate in the development of policies pertaining to nursing education and training.

6.4.3 Recommendations for nursing research

- Research should be conducted on factors that contribute to the negative attitudes of professional nurses towards university students and university graduate nurses.
- An evaluation of the developed clinical nursing education model after successful implementation will assist in the refinement of the model.
- The model can be implemented and evaluated in other university settings within Nigeria.

6.4.4 Recommendations for clinical nursing education policy development

- After testing and refining the developed model, the guidelines for implementation may require adjustment.
- The tested model, guidelines and the related strategies may then be used to formulate policy for clinical nursing education.
- A formal policy development process should be followed.

6.5 CONCLUSION

Clinical nursing education at universities has been a challenge that is not limited to nursing education in Nigeria. The lack of a model that guides clinical nursing education was the precursor to the challenges which students, nurse educators and professional nurses experienced while trying to support students to become versatile, polyvalent nurses. This study closes this gap by exploring the effectiveness of the clinical education programme as it is currently offered by universities in Nigeria. Several challenges were uncovered through this research which assisted in shaping the development of a clinical nursing education model, which it is hoped will have some impact by reducing these existing challenges.

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Appendix: 1

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

09 March 2015

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Mrs R Anokwuru (School of Nursing)

Research Project:	Development of a clinical nursing education model for Nigerian Universities.
Registration no:	14/10/32

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

Appendix: 2

BABCOCK UNIVERSITY
HEALTH RESEARCH ETHICS COMMITTEE

Our Ref. NHREC/17/12/2013 **Your Ref.** BUHREC 069/15 **Date:** March 25, 2015

NAME OF PRINCIPAL INVESTIGATOR: RAFIAT AJOKE ANOKWURU

TITLE OF STUDY: DEVELOPMENT OF MODEL FOR THE DELIVERY OF CLINICAL NURSING EDUCATION IN SOME SELECTED SOUTH-WEST NIGERIAN UNIVERSITIES

RESEARCH LOCATION: SOME SELECTED SOUTH-WEST NIGERIAN UNIVERSITIES

NOTIFICATION FOR ETHICAL APPROVAL

Babcock University Health Research Ethics Committee has approved your research proposal and other related materials after the necessary reviews and corrections.

The National code for Health Research Ethics requires that you comply with all institutional guidelines, rules and regulations. All forms and questionnaire must carry the assigned BUHREC number. No changes are permitted in the research without prior approval by the committee.

Please, note that the committee will monitor the research study. You are expected to give a progress report of the investigation and submit a final copy of the research to the committee.

Thank you.

BABCOCK UNIVERSITY HEALTH RESEARCH ETHICS COMMITTEE
Sign
Date 25/3/15

Professor D.O. Akinbeye

ILISHAN-REMO, NIGERIA.
buhrec@babcock.edu.ng buhrec@gmail.com

Appendix: 3

ETHICS AND RESEARCH COMMITTEE (ERC)
OBAFEMI AWOLOWO UNIVERSITY TEACHING HOSPITAL S COMPLEX
Tel +2348152092751 +2348152092755 +2348152092999
E-mail oauthc ethicalcommittee@yahoo.com

CHAIRMAN: Prof. (Mrs.) E.A. Adejuyigbe MBChB(IFE)FMC Paed.

REGISTRATION NUMBERS:
INTERNATIONAL: IRB/IEC/0004553 NATIONAL: NHREC/27/02/2009a

CLEARANCE CERTIFICATE

PROTOCOL NUMBER: ERC/2015/06/15

PROJECT TITLE: DEVELOPMENT OF CLINICAL NURSING EDUCATION FOR NIGERIA UNIVERSITY

INVESTIGATOR: MRS RAFIAT AJOKE ANOKWURU

DEPARTMENT /INSTITUTION: SCHOOL OF NURING, UNIVERSITY OF WESTERN CAPE, BELLEVILLE SOUTH AFRICA

DATE OF RECEIPT OF VALID APPLICATION 08/04/2015

DATE WHEN FINAL DETERMINATION ON ETHICAL APPROVAL WAS MADE: 02/07/2015

DURATION OF APPROVAL Seven (7) Months

This is to inform you that the research described in the submitted protocol, the informed consent forms and other participant information materials have been reviewed and given full approval by the **OAUTHC Ethics and Research Committee.**

The approval is from **15/07/2015** to **15/02/2016**. You are to inform the Committee the commencement date of the research and if there is any delay in starting the research, please inform the Committee so that the date of approval can be adjusted accordingly. All informed consent forms used in the study must carry the **OAUTHC/ERC** protocol number and duration of approval of the study. In multi-year research you are to submit an annual report in order to obtain renewal of approval.

The National Code of Health Research Ethics required that you comply with all institutional guidelines, rules and regulations including ensuring that all adverse events are reported promptly to the **OAUTHC/ERC**. No changes are permitted in the research without prior approval by the **OAUTHC/ERC.** The **OAUTHC/ERC** reserves the right to conduct compliance visit to your research site without previous notification.

Prof. (Mrs.) E.A. Adejuyigbe,
Chairman, OAUTHC/ERC.

Appendix: 4

INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)
COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN. IBADAN, NIGERIA.
Director: Prof. A. Ogunniyi, B.Sc(Hons), MBChB, FMCP, FWACP, FRCP (Edin), FRCP (Lond)
Tel: 08023038583, 08038094173
E-mail: aogunniyi@comui.edu.ng

UI/UCH EC Registration Number: **NHREC/0/01/2008a**

NOTICE OF EXPEDITED REVIEW AND APPROVAL

Re: Development of a Clinical Nursing Education Model at Nigerian Universities

UI/UCH Ethics Committee assigned number: UI/EC/15/0084

Name of Principal Investigator: **Raflat Ajoke Anokwuru**

Address of Principal Investigator: School of Nursing,
University of Western Cape,
Belleville, South Africa.

Date of receipt of valid application: 11/03/2015

Date of meeting when final determination on ethical approval was made: **N/A**

This is to inform you that the research described in the submitted protocol and other participant information materials have been reviewed and *given expedited approval by the UI/UCH Ethics Committee.*

This approval dates from 17/03/2015 to 16/03/2016. If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the* UI/UCH EC *assigned number and duration of* UI/UCH EC *approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. *No changes are permitted in the research without prior approval by the* UI/UCH EC *except in circumstances outlined in the Code. The* UI/UCH EC *reserves the right to conduct compliance visit to your research site without previous notification.*

UI/UCH EC
17 MAR 2015
APPROVED
COLLEGE OF MEDICINE, U.I.

Dr. O. M. Bolaji
Ag. Director, IAMRAT
Chairman, UI/UCH Ethics Committee
E-mail: uiuchirc@yahoo.com

Appendix: 5

ETHICAL COMMITTEE

LADOKE AKINTOLA UNIVERSITY OF TECHNOLOGY TEACHING HOSPITAL

OGBOMOSO, OYO STATE, NIGERIA

Address: [illegible] **Phone:** [illegible] **E-Mail:** [illegible]

Our Ref: LTH/OGB/EC/2015/070 Your Ref: ____ Date: 20TH MARCH, 2015

Mrs Anokwuru R.A,
School of Nursing,
University of Western Cape,
Belleville, South Africa.

Dear Sir,

ACKNOWLEDGEMENT OF RESEARCH PROPOSAL

Reference to your letter dated 19th March, 2015, I write to inform you that your application for ethical approval on your research proposal titled ***"Development of a clinical Nursing education model for Nigerian Universities."*** has been received by the Ethical Review Office.

Your proposal therefore is under due process and we will get back to you as soon as it is ready.

Thanks for your cooperation

Yours Faithfully,

Sadare M.O
For;Secretary, Ethical Review Committee

Appendix: 6

2 April 2015

TO WHOM IT MAY CONCERN

This is to certify that GAVA KASSIEM edited the thesis titled

DEVELOPMENT OF A MODEL TO GUIDE CLINICAL NURSING EDUCATION OFFERED AT NIGERIAN UNIVERSITIES by RAFIAT AJOKE ANOKWURU.

The onus is however on the author to make the changes suggested and to attend to queries. Kindly note that formatting and reference checking were not requested.

Sincerely

02/04/15

Gava Kassiem

Independent Language Consultant/Academic Editor

MA (Language Practice)

Associate Member of Professional Editors' Guild

Email: gkassiem@gmail.com

Mobile: +27(0)82 4467400

Skype ID: gavakassiem.2

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville, 7535, South Africa

Tel: +27 21-959 2271;, Fax: 27 21-959 2274

E-mail: kjooste@uwc.ac.za

CONSENT FORM

Title of Research Project: Development of a Clinical Nursing Education Model for Nigerian Universities.

The study has been described to me in 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.

Participant's name……..

Participant's signature……

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: Rafiat Ajoke Anokwuru
School of Nursing
University of Western Cape
+27715488425; +2348034622760
rafiat12@gmail.com or 3280992@myuwc.ac.za

Supervisor: Professor F Daniels
University of the Western Cape
Private Bag X17, Belville 7535
Telephone: (021) 959-2443
Fax: (021) 959-2679
Email: fdaniels@uwc.ac.za

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville, 7535, South Africa

Tel: +27 21-959 2271;, Fax: 27 21-959 2274

E-mail: kjooste@uwc.ac.za

INFORMATION SHEET

Project: Development of a Clinical Nursing Education Model for Nigerian Universities

What is this study about?

This is a research project being conducted by Rafiat Ajoke Anokwuru at the University of the Western Cape. We are inviting you to participate in this research because you will be able to share your view on clinical education in Nigeria and what clinical education entails. The main purpose of the research study is to explore university clinical nursing education in Bachelor of Nursing Science programmes in Nigeria and to develop a clinical nursing education model to guide the clinical nursing education and will be a basis to measure clinical nursing education in the future.

What will I be asked to do if I agree to participate?

You will be asked to come to a quiet office in the ward where you will share your view with others during group discussion. The researcher will moderate all the discussion and the period will not exceed an hour.

Would my participation in this study be kept confidential?

Your information will be kept confidential. To help protect your confidentiality, Codes will be used instead of name on any of the documents during data collection and participants will be interviews in a quiet place within the hospital and school premises to ensure privacy. All tapes and instruments used during the study will be under lock and key and will be accessible only to the researcher. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate authorities information that comes to our attention concerning neglect or potential harm to you or others.

What are the risks of this research?

There will be no known risks involved in the study. However, arrangements will be made to offer you support in the event that you should experience distress during your participation in the study.

What are the benefits of this research?

There are no direct benefits to participants. However, your participation in the research will help to bring out the challenges involve in clinical education and what quality clinical education. Thereby helping to develop a model that will be a standard to assess and monitor a quality clinical education in nursing education in Nigeria.

Do I have to be in this research and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?
Yes, the researcher will refer you to available employee or student assistance / support programmes if you are negatively affected by this study.

What if I have questions?
This research is being conducted by Rafiat Ajoke Anokwuru of the School of Nursing the University of the Western Cape. If you have any questions about the research study itself, please contact:
Rafiat Ajoke Anokwuru
School of Nursing
University of Western Cape
+27715488425,+2348034622760
rafiat12@gmail.com or 3280992@myuwc.ac.za

Should you have any questions regarding 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 K Jooste

University of the Western Cape

Private Bag X17

Bellville 7535

Telephone: **021-959 2274**

E-mail: **kjooste@uwc.ac.za**

Dean of the Faculty of Community and Health Sciences: Prof J Frantz

University of the Western Cape

Private Bag X17

Bellville 7535

Telephone: **021-959 2631**/2746

Fax: +27 (0) 21 959 2755
E-mail: **jfrantz@uwc.ac.za**

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

Appendix: 9

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville, 7535, South Africa

Tel: +27 21-959 2271;, Fax: 27 21-959 2274

E-mail: kjooste@uwc.ac.za

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: Development of a Clinical Nursing Education Model for Nigerian Universities

The study has been described to me in 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 agree to be audio-taped during my participation in the study. I also agree not to disclose any information that was discussed during the group discussion.

Participant's name……..

Participant's signature……..

Date……

Appendix: 10

INTERVIEW GUIDE FOR STUDENTS

These are just the themes to be highlighted in the interview but specifics probes will be elicited as the discussions evolve.

1. What is clinical nursing education
2. What is an ideal clinical nursing education
3. Tell me your experience during clinical experience
4. Tell me the process of the supervision you received from the clinical instructors
5. What are your suggestions to improve clinical nursing education

Appendix: 11

INTERVIEW GUIDE FOR EDUCATORS

These are just the themes to be highlighted in the interview but specifics probes will be elicited as the discussions evolve.

1. What is clinical nursing education
2. What is an ideal clinical nursing education
3. Tell about the philosophy behind the clinical nursing education offered
4. Tell me your experience of clinical experience during your school days
5. What is your perception of clinical experience of student nurses today
6. Tell me about the resources available for clinical education
7. Tell me the process of the supervision
8. How do you monitor students' progress
9. Tell me the reports you get from employers about your graduates
10. What are your suggestions to improve clinical nursing education

Appendix: 12

INTERVIEW GUIDE FOR PROFESSIONAL NURSES

These are just the themes to be highlighted in the interview but specifics probes will be elicited as the discussions evolve.

1. What is clinical nursing education
2. What is an ideal clinical nursing education
3. Tell me your experience with the students during their clinical experience
4. Tell me your experiences working with graduates from the universities
5. What are your suggestions to improve clinical nursing education

Appendix: 13

INTERVIEW GUIDE FOR ALUMNI

These are just the themes to be highlighted in the interview but specifics probes will be elicited as the discussions evolve.

1. What is clinical nursing education
2. What is an ideal clinical nursing education
3. Tell me your experience of clinical experience during your school days
4. Tell me the process of the supervision you received from the clinical instructors
5. What are your suggestions to improve clinical nursing education

Appendix: 14

EXAMPLE OF TRANSCRIPT: FOCUS GROUP DISCUSSION WITH STUDENT

Researcher- what is clinical education to you

TEMILOLU- to me i feel clinical education is like a practical aspect of nursing, like all what you have gone through in class and theoretical aspect in class you go to the ward and practice it because the going saying theory without practice is blind and practice without theory is blind. When you have the theory, you go to the ward and practice it on the human being because here we use mannequins or babies that does not respond to stimulus, so then we practice it and know how it is, that is my own definition of clinical education is.

Researcher- Any other definition on what clinical education is to you

IFE- clinical education is a place where i praticalize what i have done and learnt in theory, the things that are not clear in theory during the practical it i will be more clear to me and i will understand it more, those questions i have in mind during the theoretical class then i will have to practice it and have a better view of things because when you practice something, it, at times during the practical aspect you have to some things, are like you have to cram it, it is not really care, when you don't see the actual thing, the way it is in a patient. But on the ward you see a lot of cases, where and they say that pictures tends to stick in the brain more than theoretical thing so when you see a picture of it on patient you will be able to understand it more

CONFID- It is just about acquiring some formal skills of that thing you are studying in class, and when you talk about it, it is just about basically serving a patient, having direct observation with the patient and just as she said earlier we deal with mannequins here that can respond to stimuli, but in the clinic you have access, to observe a patient very closely and quietly and get the responses from patient and we know that even in nursing, the care is always individualized, so it gives you more opportunities to learn a lot of things to learn the way different sets of individual behave or respond to a particular clinical situation.

Researcher- Where do we go for clinical?

Chorus answer- All the hospital affiliated to the university college hospital, ADeoyo, igboora

Researcher- what wards

OPEUI- medical ward, surgical wards, gynaecological ward, special wards, psychiatry, theatre, paediatric work, geriatric, community ward

Researcher- I understand that you are the lowest group in the clinical for now that means you have just been exposed to the clinical when you first of all got to the ward tell your experience, your feelings.

JUDE- Our first encounter i think that was during the medical doctors strike, at the time UCH was quite scanty and i for one had this reservation, because i have this mentality that the school of nursing student are more accepted than we are, so i was having this, i am not sure i like been shouted right when i am not doing something right, i am not use to not doing something right. I was quite skeptical about working on the ward newly and people assuming you should know how to do everything, once they see you have you been taught this or they tell you to do something and you say that i don't know how to do this and there is scornful look like why won't you know how to do this, so it was, because UCH was quite scanty it was not really obvious and we were not learning much or i was not learning much at a time because there were no patients, so there was like, it was quite not easily, but ultimately we started the actual posting when everyone was around, nurses and medical doctors were back, so that one was easier, and the ward i worked on the first time the nurses were quite welcoming and they were actually making efforts to teach you while on the job, so they made it clear that you are actually here to learn at some point.

CHIKA- Actually the first experience we had was when the doctors were on strike and later the nurses were on strike so we couldn't go to posting, But when the doctors were on strike we worked and we did not learn anything we just seat down all day long without learning anything, but now that everyone is around nurses, and doctors, the zeal i was taking to the clinic was i want to learn everything i have been taught theoretically i want to put it into practice but when you get to the clinic, a lot of things you encounter, maybe, one of those things you learn here the procedures we learn here in the classroom or is VERY, VERY different, is contrary to what we meet, see, experience on the ward, for instance i think i was

to do wound dressing and i was trying to accumulate, pack the instruments and the likes and the nurse came to me and was talking to me anyhow, is that how you do it, is this, i was so embarrassed, and one of those things that i don't like i will like to be changed when we go to the clinical education is the way the nurses relate, the trained nurses relate with the student nurses, it is always, discouraging and disheartening, when you are been shouted out and someone will just yell at you and this and that and even the patient won't trust you, they will feel that is this nurse coming here does not know anything so my life is been endangered i think does things need to be changed and one of those things we also experience is that they want you to have known everything and a lot of times when we ask questions they will be like you should Google it out and we check but we did not get the fact and i think one of the experiences i also had with a particular nurse, a particular diagnosis, we have not been taught here, it was a very new diagnosis we met on the ward, i was like excuse me ma, i don't know how to go about it and she said if you don't know about it that is where you will sleep. I was trying to Google it but it was very annoying, i think that is one of those things.

Researcher- You know when we first go to school we will be very anxious, your level of anxiety will be very high so tell me your first time in the ward, your level of anxiety, and the nurses.

ROSE- In fact not my first time in the ward, when i was told to get my uniform from the tailor, i was very happy that i was going to be a nurse and work on the ward, and put on my uniform, you know i see my other friend and i am so proud to say that i am a student nurse, i had this high anxiety and this happiness taking to the ward, But when i got there i met something totally discouraging, because on our first day there we were not welcomed, and we were like what level are you, that was the questions they put to me and i said 200 level no in fact i did not answer myself someone else answer and said they are 200 level, they can't even know anything it is only vital signs, so i had to manage and because i even went to the ward i asked other seniors that have been there, some will give me and because i have seniors in nursing tell me it depends on the way you relate to those nurses, they we take you the way you are, but some told me that even though you are very nice to them they will still treat you like trash, so i had these two different views about, i tried to study their behaviour and just try and stay calm, but at the first instance i was very happy i was going to the ward.

SHAYO- i was very anxious going to the ward, but when i got to the ward with the experiences i had there i think i was like no, if i am to come into nursing for real i will change

a lot of things because the way things are been done there, there are things that i look at myself and i know that this is out-rightly wrong and if somebody is trying to teach me what is wrong and yet you are trying to tell them that this is wrong you will be seen as "I too Know" so you will be treated somehow, but i think with my zeal, one thing i am just going there to just acquire some little skills and one thing i am focusing on looking for ways to improve things and when i become a trained nurse eventually, i will try everything in my own capacity to change things.

DAPO- Lets consider the medical profession when they lecture their other medical students the consultants, registrars, they lecture as if they are passing a legacy, i think the problem with nursing is that they don't have this act of passing them a legacy to the in-coming nurses, if they can have that at the back of their mind they will teach and lecture with passion they will do everything with passion and zeal. I think that is one of the major issues

OPEUI- The other thing is that is like the work load is too much and they have been stressed out, they have a lot of wound dressing to do and you are telling them you have to put these, they will just pack everything and just go and do whatever they want to do and just get of there, so that is one of those things, the workload is just too much for them.

JUDE- I think sometimes it is always because (1). Understaffed, (2) Not well equipped, that is the hospital itself is not equipped, so they always have to improvise and improvise, such that it they have gotten uses to the improvisation and we tend to somehow forget what the actual thing is or what the ideal thing is and then we, they improvise to make it faster and just get the job done.

Researcher- What do you mean improvising?

JUDE- Like say for example, here we are taught that, i remember the first time we went to the ward and we had to do vital signs, here we are taught that vital signs is a tray procedure, right, there we just see a nurse will just go with , in UCH patients have their own thermometer by their side. The Nurse will just pick up the sphygmomanometer and stethoscope and then she is set for vital signs. I remember one time the Assistant director of nursing came into the ward and so me doing the same things, she said a lot of terrible to me that day, of course i cold not respond, after she left, i went to the senior nursing officer on the ward, that this is what happened and this is what we met on the ward. I know we were taught

differently in UI but this is what we met them doing here and i have never seen any nurse with the proper procedure, she told me to just shun the ADNS, and said is it that the ADNS, does not know that we don't have enough instruments on the ward. SO it's more of they just try to use, bed-making, sometimes we are taught here that it is a two man procedure, sometimes they will just say you go and make this bed. And there was a day recently like two weeks ago, i was making the patient with another trained nurse and i was trying to Fan-fold, Mitre the corner rather and she was saying what do you think you are doing, that if you want to do beautification, you should, she said i should go to the side room get a bed and mattress and during my break- time and she does not have time for that. I was like what on earth is this, even the bed linen does not even allow you to mitre the corner, it is so short or cut already, or torn or just. So some are just very i don't know very scanty and all that

JUDE- they are not always available. For the fact that the right thing is not available. It tends to just improvise, if there was a good bed-linen now maybe one that is long enough, they will be willing to mitre the corner, maybe even explain, ask you if you know how to do it, because we were taught mitring the corner makes your bed looks nice.

IFE- You know when they use to pay, now ADNS only, take teaching allowance, the junior staffs they don't pay them teaching allowance, so most of them don't even want to teach you they will say that they are not been paid, that UCH is not paying and federal government is not paying so why should i take my time to teach you. Income is a one of the challenges problem. Before when they pay them teaching allowance they know that it is there duty, responsibility. Like Doctors now they get teaching allowance a consultant get teaching allowance from UCH and federal government and the ADNS are just administrative staff they don't teach us. They are supervisors

Researcher- What do you mean that they are supervisors

IFE- Yes they just supervises the nurses, do you have this and that

JUDE- Have this been charted and they go round

IRELOLUWA- And even if they have much hands, once they see students nurses, they will not do anything, they rest their legs, put their legs up and leave the students, they will start directing us go and do this and that, go and do this and that.

TEMILOLU - what i see the ADNS do is that, they don't even supervise the wards, they just come to pick out faults. Normally when you see things that are done the way, that is not good, you correct. It is only the fault, why did you, why did you not

CHIKA - I have three things that i think it is contributing to that, we have personal issues, that is each nurses the way, i think when we were talking about the way you attend to your patient, as in you should give your patient that respect and you should treat them with care. A lot of them they are not happy the way they are there and when you are nursing them, you need to put that into consideration and make them feel at home. I think i was talking to a particular nurse, she was just shouting, yelling at me and patient and i went to another nurse and ask why she is behaving like that and she answered that that is how the nurse behaves whenever she has issues with her husband, or she does not have money. So nurses have personal issues. The other one i have here is just about creating a universal knowledge about our procedures, you see when school of nursing students perform this, when their educators are training them and teaching them, when we come student nurse UI, BNSC nurses if you want to do this procedure what do you get and we tell them this is how we are taught and they will say this is not how it is they will do another thing. Those things are kind of complicated. They should be a universal way, procedure, a standard of performing a particular procedure and the other ones is lack of, the ADNS, they need to be updated on some things, most of them are not updated so those procedures they have learnt since about ten years ago, that is what they still bring and keep doing. I think that is one of the things bringing us back in nursing. When other professions are looking for ways to get things better and move forward nurses are always like this is what we have been doing in ancient time and this is how it must go

Researcher- What are you trying to say about evidence based

CHIKA- Doctors read every day, they update themselves, and nurses should also do that. Nursing is routine already, they should look for how to make it better and challenging, they can teach because they don't have anything to teach.

IREOLUWA- Nursing is too hierarchical instead of moving forward

CHIKA- I don't know but i feel if you have something here(brain), you will be able to deliver

Researcher- Tell me in direct way what you are trying to say

IFE- They need to acquire more skills so as to be able to know what they are doing, they need to acquire more knowledge, you know maybe before it used to be using the gloves to do something and you know that this can cause cross infection and infect patients, so you need to look for ways to make it better.

TEMILOLU -They should not only based on practical, it should be both practical and theory, they don't even know how to speak fluent English and they just carry themselves anyhow. Look at the medical doctors the way they speak fluently and carry themselves; they believe the bnsc students are proud

Researcher- Tell me about your clinical experience, with your clinical instructors

JUDE - we have 3 clinical instructors and our objectives are always based on what we have been taught in class. For instance the memo that was sent to UCH, they said our log books should be filled based on the objectives of what we taught on the ward. It is basically what we did on medical-surgical nursing for the year, and that is what will be the emphasis, just like our seniors they went to Neuro-psychiatry hospital in Aro that is because they did mental health in the past year, so the emphasis should be psychiatry.

Researcher- Tell me about your supervision from the school in the ward,

TEMILOLU - It is just the first day that we are going to the ward that we are going to the ward that they will orientate us about what to do. SO after then let me say like five weeks we are still on the ward we are working, imagine we are on the ward, orthopaedic ward, neurology and stuff, there we have skin traction, we have skeletal traction, we have everything nobody will come and tell you that these are types of fracture, or skeletal traction, so we don't know all we go there to do is vital sign, emptying of urine bag, serving of bedpan, and administration of IV fluid, so by ourselves and our own we get drug booklet to read what drugs are used for, like warfin, morphine and ask people that can educate us about it, so our clinical instructor, like even most things that we are not met to be done, they will just tell us go and start bringing out the files, and charts and go and make tea for Mrs x, Go and feed Mrs Y. I will be like this thing should be in light of what we are been taught, can i put in my log sheet making of tea for patient. So when the supervisors now come that is our educators, they

just come once to the ward, like since we have started and when she enters the ward, she will just say this patient what is her diagnosis, what is she on, what are her medications, what date was she admitted and these things are not our faults, let me tell you when we resume by 8- 2 we don't even have time to seat down to study the case note. Even when we carry the case note to study, the nurses shout nursing students what are you doing there? So it is not our fault that we are not learning anything.

FATHIA- the clinical instructors they are not really working as they ought to, at least that is what they are meant to do, clinical instructions, they should instruct us and to monitor us when we are in clinical, at least once in two weeks, they should come to the ward and to observe us and even to teach us some of the things we do in the ward, but i think during our clinical this things it is only once they showed face and i think that is not good enough.

OPEUI- Like the school of nursing students their clinical instructors come to the ward, to check how they are carrying out their procedures, are you doing this thing right. There was a time that there was a girl doing vital signs and she did not take her tray, her clinical instructor just met her like that, she had to write three memos that she will submit one why she was doing the procedure wrongly and was on punishment. But we, we do whatever we like when you don't have anybody to tell you why are you doing this, so you just do what you like and another thing, there are sometimes you don't even know some things and the nurses, are, you can't even ask them, they are even too busy, it is not a matter of some nurses might like to shout at you, even when you look at them they are already stress out already and say let me tell you this thing, but when your clinical instructor come they will let you know, this is what is happening to this patient and you will even rub your mind together, but i did not even see them at all.

CHIKA- The first thing is that what their duty is. Their duty has it been specified, do they even know what they have to do. Do we even know what their responsibilities are, and how they are responsible to us and how we are responsible to them? I personally i just know that this is what, since i have come to UI, maybe the first day you are going they will give some sets of instructions, be diligent, be hardworking, wear your breast watch, be good and the likes. We don't know, i don't even know that they are even meant to come to the ward to come and supervise what we are doing to come and instruct us on certain things and one thing i notice, though on my ward, i think we have had, our clinical instructors have visited us about three times, during this course of five weeks training, three times, three times during

this course of training. One of the instructors came and gave me some instructions and passed information to me and to us at that time.

Researcher- Tell your experience in your clinical learning environment

CONFID- i want you to be more specific is it in terms of availability of patients, new patients or what. OK in terms of availability of patient seeing new condition, medical diagnosis, UCH is the tertiary institution, which is the peak that is where you see what you cannot see in other institution. In terms of that it is a very good learning environment, very supportive. But in terms of those things that will now facilitate learning, i will say i will rate it like 40% (chorus) 0%, Yes because if you go to special ward you will see those things that will facilitate learning there, but in terms of the surgical ward or medical ward, you may not really find those things that will facilitate learning. But if you go to special wards like Scan unit, endoscopy, etc., you will want to practice nursing and you will want to learn. But in term of availability of patients you will see a lot

Researcher- In terms of the nurses-

IREOLUWA- I will say it is zero because they are not supportive, there was a day, let me start with this scenario, there was a day i was going for night duty, it is really paining me up to today. I went for a night duty, you now i use my money to take transport to that place, on getting to the front of UCH, i had an accident which is very bad, i limped to the ward, i was actually limping, immediately i got to the ward, the nurses there were like what happened, they took me to Accident and emergency, i was attended to, so they gave me treatment, before they could give that treatment they said i will pay, i said really, working for UCH, people, i will have to pay. I had to use my money, which i am managing for treatment. What i wanted to say is that one of them, the clinical tutor knew what happened, the way she asked that question about what happened, she said, how is your leg sarcastically, just for me to answer, she just turned back and left, i was like what, you know with this same accident my leg was in cast, and i was on crutches nobody called me from the department, i was angry and they knew what happened. So i am not happy about that. Even when i now came back to the ward, i said OK since the cast have been removed let me exercise my leg at least i have missed two good weeks, and i am not gaining anything OK let me just go and exercise, the leg. I was been placed on night again that same ward. I went without complaining and those people in the ward knew and they said don't were shoes were sandal i said OK, So once i am

tired i will ask that can i seat, they told me to go and sit down so i sat down and one Chief nursing officer just came from nowhere an told those nurses and said that student nurse is just sitting, instead of you to order her around, i said really, they should order me around, i am not a baby. Immediately i stood up, i did not want to respond, the way that chief nursing officer was talking to them, in my presence maybe they don't want to do anything. Immediately i don't know where the courage came from, i just said excuse ma i have been respecting you since all these days, i don't know you from anywhere and i am not a baby and i am a trained nurse, you should not talk to me anyhow, i explained that i had an accident, she said it is none of my business, if you know you are not fit for this job, you leave it and go. I said see the job that i am not been paid and yet they are shouting on me. So i said OK what can i do so that she can be afraid of me, immediately i went to the sluice room, i started incantation, before i finished the nurse has left. I said to myself that is good. Even those train nurses they even clapped and supported me that yes you really tried. I love the way you dealt with her.

IFE- My experiences with nurses in UCH i was forced to go and type on Google on the very thing why nurses eat their young and a lady was talking about nurses there. It was just like when it comes to trained nurses in UCH it is not conducive at all. They will just insult you. When it comes to professional, they should be professional, rather the way nurses pride themselves, in fact all other health workers.

TEMILOLU - Imagine a senor nurses saying of i slap you will become dizzy immediately but there is this particular nurse that is so nice she is very nice, because she makes us feel the reason why we are here, she talks nicely and gently. She drills us and even when you make mistakes she is gentle with you. The way she explains things to us. Even when you don't ask her questions she will explain to you.

JUDE- One of the nurses, she is very nice; she made me realize the fact that we are here to learn. She did not out-rightly say it. All she was doing is that i am here to learn not to work for free. Like somewhere along the line, i almost forget i am actually receiving training here because it just happens that thank God here, allocation, there is not part of work, like come let me explain to you. She is always anytime i am privilege to work with her and she is always explaining, and she will explain the drug use of a patient, with the drug chart. She teaches all the time, she does not yell at people, she corrects you lovingly when you make mistakes, and she is very assertive. And she is up to date, she is very versatile, her charisma makes daughter to like her. She is in fact very adorable and she knows what she is doing, and she is very

hardworking. She is also very supportive, she is not lazy like most nurses, and she does not seat down somewhere, she teaches and gives you your due respect.

Researcher- Let me quickly ask you about the process of delivery during clinical teaching

Chorus answer- I feel there is no mode of delivery most of them don't know how to pass the message

CONFID- I think there is no mode of delivery. For example when you get to the ward, they just allocate you to patient, they don't want to know whether you are doing it well or not, there is no mode of delivery to tell you that do it this way or not

JUDE- I think they need to be trained and be aware of their responsibility, that beyond been a nurse that you are a trainer and you need to impart this training to younger nurses.

IFE- For you to be working in a teaching hospital that means that you are there to impart your knowledge to other people but i don't think they know this, they see us as helpers and workers like them.

CHIKA- I think in BNSC nursing we go to the education department to learn how to teach people, so i think i don't know how far, if it is so in all other schools of nursing. Beside i was working with a particular Principal nursing officer (PNO) because if she ask me to do the procedure, i will just do it, maybe because of shortage of resources, i will just improvise and improvise, there was a day she did the exact same thing and i was acting as if the procedure was new to me, she was just yelling and shouting at me. I was like her mode of delivery is so poor. In fact there is no mode of delivery at all

Researcher- In terms of resources

ROSE- In terms of resources i will say 0% because there was a day i wanted to do tepid sponge, Flannels that can easily be gotten i asked for face flannels they told me i should go and use my money to buy the face flannels since i want to do the standard thing and i have enough money. There was a day i wanted to do dressing i had to use spirit to clean the trolley. They bring just two dressing packs for the ward. No galli- pots, no kidney dishes

Researcher- Tell me about how you are been assessed during your clinical expereince

OPEUI- Personally on my own ward, i think it is only during the examinations that my clinical instructors evaluate

JUDE- there is practically no feedback, it is almost like giving you, giving you, there is no way for me to find out if i am doing well or not, there is no way for me to find if i have met the objectives, IS this atmosphere conducive, there is basically no feedback, they are just passing out information. And then when they are trying to find out is actually when they are trying to view you, like make you feel terrible for not knowing it.

CHIKA - I feel a meeting should be done after our clinical posting so we pour out our mind after our clinical posting, there is supposed to be a discussion like this, with our clinical instructor after the clinical posting, so we pour out our mind about things we see on the ward, things that we feel are not right and all that

IFE- Another thing is that if we pour out our mind will they listen, because when we talk to them they are always looking at it from one perspective as if we complain a lot

TEMILOLU - they look at from one side of the coin, most of the decision is just to favour those in the clinic, they don't really feel our pains, they see us as if we are lazy and we are trying to shy our from responsibilities. They don't really put into consideration our feels

FATHIA- But our Adns (Assistant director of nursing service) always assess us. She will chose specific guide and she will bring out the guide that was sent from the school and the objectives that was sent, she was calling out the objectives one by one and was asking us questions and was orientating us, telling us more about the objectives. That is from my ward and at the end of the discussion, she told us our weaknesses and how we should work towards it to improve our weaknesses.

Researcher- I want to ask each person now so we can close. Give me suggestion on what to do on clinical education to improve the clinical education

CHIKA- I think one on clinical education, we need resources, the ministry of our country should at least do something and provide instruments so that we can learn and they should be taught how to teach students. Nurses should be orientated on how to deal with nursing students and they should be taught not to put their personal issues, they should put their personal at home and come to the clinic to deliver what they ought to deliver

IRELOLUWA- they should try to upgrade this profession, the issue of changing uniform is not the best, before we will see this one, today they will were pink, tomorrow it is ASH colour nursing is not about uniform

IFE- they should go organize seminars for training nurses, they should update themselves.

CHIKA- They should calm and collected when they are teaching, they should learn from medical students on how they teach their students.

CONFID- They should stop putting hierarchy on their ends

JUDE- the clinical instructors should have their own eyes there. Like one that is almost speaking for them, a replica of them in ward, that is aware of all that we should know, they should choose somebody on ground that is aware of all they taught us and all that at the end of this posting you should have known.

ROSE - Even when they are telling us things that we are not to do, they can be cautioned that these students are not for that

DAPO- there should create mutual respect between one another on the ward, the he CNO, NO and all that. Each person should do their work, the work they assigned for, they should do it faithfully. They should encourage the nurse consultancy program, it was very helpful.

Appendix: 15

EXAMPLE OF TRANSCRIPT: INTERVIEW WITH EDUCATORS

NOTE – NAME IS A PSEUDO NAME

Researcher- Good morning sir, what is clinical education to you sir,

Mr ROM- Clinical education is the rudiments of expectation in terms of learning and exposure and acquisition of skills that a nursing student or a health professional student that has passed through the expected theoretical concepts and now at the area of delivery to actually show how much of that learning exposure he has gotten. He or she is able to actually use to impact based on the needs of patients to make for quick convalescence in the process of adopting quality care.

Researcher- In your time sir, i just want you to compare the clinical education in your time as a student and now that you are a lecturer that is impacting the knowledge.

MR ROM- Good, in my time my own experience could not be a direct jacket of a straight course of a student who is taken from the street after the secondary school certificate and now there to pass through university education combining it with. Because i pass through the basic school and having to come through the basic school the concept of nursing is well defined there. Whereby you develop your interest to come into nursing and you are always there to actually acquire the skill in doing almost, in carrying out every procedure but when you compare that with liberal act of education which university stands for. University has both the vertical and the horizontal and everything moving within a very short time. Whereas using the basic school concept, there are two parallel issues, you have time to actually develop yourself in the acquisition of the required skill whereas in the university because of the specified hours attached to each performance or activity students are limited that's one thing. The second thing is in the clinical setting itself the people that are there on ground because of some other factors like envy and petty jealousy they don't have commensurate qualification to be on ground to be able to tutor these group of students but they see them as nurses in the air, which means the responsibility of having to actually take this people through should be the within the core of their educators meaning that educators, academic educator in professional nursing education in the university should be clinically specialized which will make that individual to come into class give the theoretical concept and at the same time carry them

along to tutor them in the clinical setting and assist them in the concept of manipulative of the individual using the scenario of the standard required through personal demonstration by that qualified academic clinical instructor. But when the programme started in this department then university of Ife almost all the lecturer present in this department then was not only academically qualified but they were specialized individuals which have sufficient skills and exposure within and outside Nigeria to be able to carry the students and manipulate them to make sure they acquire the necessary skills. This is lacking now because people saw university education as a leeway out to move out of clinical. The understanding of handling of patients is gradually going down; it is depreciating even with academics. While the ones in the hospital are not as qualified to manipulate them to make sure they acquire the skill. In view of this because of the influence of the Nigeria National University commission a concept was brought in that why not have in between lecturer and students, the in between lecturer and student is referred to as clinical instructor. That clinical instructor who must be a graduate of the same concept of polyvalent training who would have acquired sufficient clinical exposure to be able to handle and help these students in the manipulation of the patient expectation through their own acquired skill. There is a problem around the line there. It would have been easier for that lecturer to be both clinically and as well as academically qualified to be able to say for example dressing what are the objectives of the dressing and take that student along with the clinical instructor after the actual theoretical lecture while the clinical instructor assist him and they are doing that demonstration with the student in the clinical lab but getting to the hospital that lecturer takes it over to actually take the demonstration and show the dressing technique to the students while the clinical instructor now takes over with confidence which is not also there. There are some new concepts in terms of having electronics and digitalis approach to it. Yes it is good when you have recorded programs been displayed for students. If that recorded programme is not been handled by an experienced somebody how could actually depict that practically for student it may be difficult for student. These are the limitations that we have gotten. The university education been different from the then apprenticeship approach which makes you to be there all the time and working through and continuous exposure and continuous manipulation will make you to acquire the skill.

Researcher- I have seen that you have been able to outline some challenges, you have talked about the opportunities and challenges that are embedded in this present clinical education. I want to ask the curriculum been built now, how does it accommodate for these challenges. I

understand that you are one of the people that built the curriculum and you contributed a lot to this present curriculum. How has it accommodated these challenges?

MR ROM- Good it has accommodated a lot of the challenges but the actual, there are three issues we have to look at , the curriculum is an entity, comprehensively prepared with both theoretical and clinical expectation while the applicability of that curriculum is an issue in relation to who actually takes over, what is the experience of that person, what is the understanding of that person and at the same time what is the clinical competent of that person that is from the lecturer and academic point of view. When that person is short in any of the two of the three dimensions, It is one thing to understand the rudiments of the curriculum itself and the experience is not there or the understanding, i gave you an example of what was happening at the other end when that university was started. The three private universities approved opened almost the same day; you see one of the problems of academics environment today is quality staffing. When you don't have somebody with the commensurate qualification, experience and understanding of the curriculum it may be difficult to manage and managing it maybe in error, looking at it from this perspective. I have a BSc even though tagged nursing i say i have specialization in administration, education. Now you are now into a programme that is not really talking of education or administration specific it is talking of the totality, comprehensive totality of nursing be it in the clinical setting, or in the public environment, or industry, or in the mental health institution and it is a polyvalent sort of thing and you have no exposure of that. the number one problem you will get is what is the meaning of this polyvalent nursing, what exactly do they mean if you are there because a professional programme must first of all have comprehensive package for a start not fractionalizing or specializing in anything it is the comprehensive totality that you must have so that if at the second level you now have a specialization, you have a reference to the background, just as when they say Mbbs it is a totality, but if such a certificate with specialization in education or whatever makes you to go further, you move to administration, or education you have M Ed and PHD education and you are now back to nursing with a generic curriculum what exactly will be your

Researcher- Are you trying to say there is a problem with the curriculum

MR ROM- No, the curriculum is not the problem, the curriculum is there, it is the quality staffing that is affecting it, the person with commensurate qualification, if you have general nursing put together, and then master in special something, by the time you come into the

generic programme you have a good understanding of the programme, But when you have already strayed away and you are back but you are the only one people are counting on, shortage of quality staff, is the number one problem to curriculum implementation, because people will not understand the philosophy. The philosophy of nursing, when you look at the baccalaureate curriculum is wedge into the philosophy of nursing, what society feel about nursing. When somebody is sick be it a mental deprivation or a maternity demand a general issue, yes he is there, they don't know whether you have that training that is why a general nurse has a better concept but when you say you come into the degree you say you specialize something, but when you have the comprehensive, you will have a good understanding and that will meet the philosophy of the society, when they get to you they feel happy after going back. That conflicting concept of philosophy of what the society feel about nursing and the implementation of programmes that produce some people the outcome which is product of a programme may not be germane to a programme they have no experience of. That is one aspect that is talking of the staff. Talking of facilities, is another one not only in the hospital when you are talking of clinical within the institution where the theoretical knowledge is been imparted if you don't have the commensurate facilities that will enable the students to appreciate what they will be seeing in the clinical setting, we may be going into error. Quality staffing yes, but in terms of not only educational preparation, but clinical specialization. Then facilities and other resources available the demonstration of the clinical setting in the department how adequate is it. Then how do you relate that curriculum to that demonstration as you are moving out of one system, you go straight into the practice if you are following that student will be able to appreciate the relationship theoretical perspective and the practical expectation and how do you do it, if you are a specialize person you get out of the class, you want to teach vital signs, you have taught vital signs giving the rudiments of objectives, rationale sequence of explanation as vital signs as response, physiological response measure of patients and other individuals in order to interpret changes in the system. If that is done and you get into the setting Students are broken into groups and they are handled by that person that has clinical specialization along with the clinical instructor. By the time they take the blood pressure what is blood pressure supposed to be doing, what are the component of equipment that you have to put together get to understand all these stages. What factors will affect Blood pressure, if i have just walk from somewhere to somewhere how is that going to affect my cardiac output, my peripheral resistance, viscosity and by the time you put all these things elasticity and whatever you are seeing these things practically along with the students it sticks by the time they now get to the clinical setting, they are seeing sphygmomanometer

they are seeing the other equipment, they will have confident in moving straight to the patient and doing the right thing. When you come around and you ask what is the rationale for this actin they will be able to tell you. This is where quality staffing comes in. THEN WHEN YOU LOOK AT THE ISSUE OF DEPARTMENT TODAY i have really contributed to the synthesis of saying we should have more department of nursing but i was doing it consciously because of the manpower availability and at the same time we are not promoting capacity building, how why did i say that when you come in as an academic even though you have been to a department in error, you have got all sort of qualification sitting together with people that have the commensurate clinical as well as professional academic training and working together and collaborative approach would have gone a long way to synthesize you and modify your situation,

Researcher- So you are talking about training of the personnel even though you have the wrong time

MR ROM- Yes collaborative approach will bring some changes, knowledge is not static it continues to evolve and by the time you are moving on and you are interacting you have not done clinical research you are now working with people that are doing clinical research, you have not been adequate when it comes to clinical expectation, as to really demonstrating for students but you are working with someone that is active in doing it. I did a lot of that when i was in Babcock because i looked at the department people were short. It is not registered nurse or midwife is the issue. I remember when i said look every Wednesday we will have to be in the lab. I will be part of the demonstration along with the people appointed as clinical instructor. You understand, so that if you allow interaction to improve your knowledge it will go a long way. Another thing is to utilize every little opportunity to upgrade your knowledge, seminar, conferences, by the time you come back you won't be the same thing. You have to really understand all these things. Then you are talking of the curriculum, curriculum today i will say it is fairly overloaded, we thinking that almost every idea should come into the curriculum. You see you cannot put every little idea into the curriculum, i have always one people. Today there is health informatics, health economic, etc., at the end of the day you will be overloading the students and overloading the students will affect their performance and could cause disinterest, pressure work load stress these are things that will come out of that. You may now be having people reporting sick most of the time because of pressure because polyvalent programme puts you in the jacket of having to work with other health professional

as students. Once you finish your white house, physics, chemistry, biology and you come into the department, You are not only doing nursing programme, you are doing requirement for the faculty which are anatomy, physiology biochemistry and others, is that not true. In addition to that while medicine is only looking at anatomy, physiology and biochemistry. You are doing other courses within your department and outside your department, philosophy, this and that by the time you are doing that other people are concentrating reading b. This is still an area that i am seriously concerned. because of civilization now we now see some other things we have to put at the end of the day the maximum unit should be 24, you have seen nursing student carrying 24 almost all the time and when they are supposed to go to clinic lectures are going on somewhere some of them may decide to be deviant that is not attending clinical and the cost of training now have gone up. SO MANY people are interested in nursing but they cannot afford the course of training. Parents do not understand the different between nursing and medicine some parents do not, you continue to work, and you have concentrated clinical during the holidays you rarely go home that is an aspect of a student. Students could now become disinterested a sort of work load stress.

MR ROM- you see that i have told you that there are new trend and new dimensions that have come in to clinical training in terms of electronic and digital and whatever so many things are there now. Even you can copy some things on your system on your laptop if you are interested. OK if you decide i want to get something on dressing, you will get. The only thing is if you really have not gotten the actual background to develop on, it may be difficult. There was a time i got some CDs and other things, problem-oriented medical records and so on something for students. When you look at these and you don't have somebody that is better than your own understanding in doing it yes and the other aspect of what you are saying are the students interested in it themselves, Interest matters when it comes to clinical acquisition.

Researcher- How do we make them interested?

MR ROM- Good, you see the first thing to do is allow only people that are interested in your profession to come into it. We are having too much of influence from parent now because they want their child to graduate immediately and get out of Nigeria to go and make money. That child we struggle to graduate but it is not really his interest. So many are in possession of it now in error today. Interest matters, whatever your interest is if you are facing any challenges you will cope but if you don't have an interest in a thing, however good that thing

maybe it will just nauseate you. Because in our days in the basic schools, we are happy even when we are supposed to be off-duty there is a bell immediately you here that bell in the hospital there is an emergency serious emergency that they want people to quickly assist. Today if you are doing it people with Bachelor of Nursing Science degree education who are students will not even do it. Even basic school today, because they are now paying, they will not show interest. Policy is another dimension to it, our policy should be with human face.

Researcher- Sir, I understand that we are supposed to have objectives for each clinical posting, how is it that the students and the nurses on the ward know each objective what is expected of them at each clinical placement

MR ROM- Good that is why even today the clinical instructors prepares the objectives along with the academic person and you look at whatever against the background of theoretical learning, what they have done, this is the limitation of this student, you let them know so as not to have a conflict. I hope you are getting what i am saying and working together like that will make the all thing, the scenario to come together. Objectives are always set, if you don't set objectives based on the competency levels of the students and also initiating continuing education with people in the clinic because they live in the past they are not modern and not bothered. It is you who will propagate through continuing education. That is why through the nursing council when I was the chairman of the education committee we brought in this mandatory development programme in Nursing. But the implementation matters, that is why i say it is a product of who is implementing, his own experience, and his own interest in it and at the same time what is available. The other aspect of it is the facility and whatever which is a product of the funding

Researcher- What are the sources of funding for this department

MR ROM- The University is in charge through the federal government. There is no external funding, except if we are going around. It is unlike your university which is a private university and Seventh Day is given so much attention and they have worldwide sort of investment. What the federal government would have really initiated is to make people accountable. Like we go to hospital and all these things if we are appointed consultant we will have interest in some things and in the process we will be able to bring in a lot as an additional fund to the department. This department if not for the part-time programme that is generating some amount to the university pocket.

Researcher- Do we use the money specifically for clinical education

MR ROM- We have specific allocation for clinical supervision, and moderation. And facilities are coming from that programme because money is allocated to ensure those students are having commensurate expectation. Funding is a vital issue when it comes to any programme.

Researcher- Tell me about the clinical learning environment

MR ROM- we can't see it is conducive i am sorry. One, in terms of facility, how adequate is the facility itself in terms of space, and other factors such as aeration and lighting and so on. And in terms of needs that are supposed to be there to make you a functional person. In effort to achieve quality assurance so many things have to be in place. Within when you are talking of the learning units itself, clinical learning unit as it is not as wholesome for the patient it is also not wholesome for the staff even worse when students are now added. Some of the spaces are not as adequate and there is over-pressure on the little that is available. If a teaching hospital has no water most of the time, how do you ensure standard in terms of infection control and safety communicable issues, safe environment. So many factors can make the environment not to be safe, the arrangement of bedding, which is one aspect of it. When you get to an environment, there are situational factors the odour and whatever, the people that are supposed to be doing one thing or another are not there. It is now strike every minute. For one year the teaching hospital was closed down because doctors will go on strike, nurses will go on strike, and other health workers too. Good that does not make for good continuity for learning experience and acquisition of skills; In addition to that as we are talking of funds here we are also having problems of funds there too. The government is in charge, the money that is meant for each whatever, i don't know what they do to it. Priority is not set straight; the other aspect of it that is embarrassing is the inter-distant relationship among workers. We don't really see ourselves as a team. In fighting all the time, so that if i see you everybody should be my student it is no longer like that. We started with a good philosophy before team spirit, that was the philosophy of this college but today it is not there everything has become partially separated and the issue of politics and policy, the will the goodwill to be there for everybody is no longer there.

Researcher- In your words sir, you know students are supposed to be in the community of experts in the ward, can you say that the students are among the community of experts

MR ROM- To some extents, yes i will say so. It is not really an issue of 60% No, because one i say the type of training and the concept and even manpower recruitment now is a product of so many things, when you say you are recruiting somebody, you have an expectation to achieve how well is that person achieving it and what will make that person achieve the expectation is a product of several political issues. Students have their lecturers, clinical instructors, these and that but when you get to some issues, clinical instructing is not as it should be. That is why i am saying when academic professionals who are specialized take over the clinical teaching of their students it is better.

Researcher- So you are saying the nurses are not necessarily helping in the teaching

MR ROM- Their helping process is not as adequate because they don't have the commensurate level of education and at the same time we allow in fighting to divide us the more. I rest my case

Researcher- How do you assess your students in the clinical

MR ROM- there is on-going assessment and we call it continuous assessment not only within the theoretical but also in the clinical because as we are going on. Every semester we have a sort of clinical examinations there are always there and when you come around there are always, when we are there in the ward setting, one of the easiest way to know whether your students are really moving is through interaction when we do clinical round. Each student is allocated patient, you present your patient and people ask questions to you to know how updated you are in terms of managing the patient. You have your care-plan that you follow and this is evaluated and we look at it. You have assignments about your patients' situation that you have to bring to seminar.

Researcher- Are you saying you have post clinical seminar

MR ROM- Yes we have pre and post clinical conference that is the procedure with us here because we have experience in managing polyvalent programme. In some of the universities it is not there because people that when you have people that are not with commensurate qualification even though they are registered nurses and midwife and degree in another thing apart from nursing but at the end of the day they don't appreciate when you even assert some of those things. That is why i have stopped going as nursing council examiner because i end

up been clinical Instructor because i don't feel happy because if you are not really consistent in teaching these students handling of procedures and patients they will not be skilled in anything.

Researcher- In your word, What are the things you will see in a clinical education to be able to call it standard?

MR ROM- The student would have been taught rightly, exposed to those clinical skills under the supervision of a specialist who has the understanding of what it takes to take patients round and carrying out procedures. You see before you can say somebody is safe in the hands of somebody a necessary procedure should have been achieved and that type of thing i can tell you what negates some of these things today is the type of concepts and the type of educational pattern that we have. Almost every university is into strike and whatever, which actually severs hours of clinical requirement from students. For almost one year the teaching hospital was not open. There are some that are within the limit of those operating the curriculum and there are some beyond their limits

MR ROM- There is always a logbook and not only do they have logbook they have what we call anecdotal notes which keeps you on as to your interaction within the clinical setting, the pre and post clinical conference, then day to day seminars, clinical seminars, you have presentations on patients the one that are unique within the hospital settings and once they are doing that and you make them to ensure that they comply with attendance to the clinical settings, because there is no relationship that you are going to have when you don't have commensurate attendance you should be there where you will learn because once you miss, I was counselling someone here yesterday because here when you miss a day clinical you pay with three days and once it passes three days you will lose a whole session because clinical experience is not textbook you can read, it is a thing that you have to be there it is not an ordinary share that you can purchase in the market but it is what you have to accumulate out of a period of exposure OK. Thank you

Appendix: 16

EXAMPLE OF TRANSCRIPT: FOCUS GROUP DISCUSSION WITH PROFESSIONAL NURSES

NOTE – NAME IS A PSEUDO NAME

NURSES ON THE WARD

Researcher- Good morning everybody, I am very grateful for this focus group. In your opinion what is clinical nursing education

MRS AGBAJE- Clinical nursing education is integration of students nurses to the clinical settings not necessarily having their training within the hospital, it could be in the university, but you integrate them into the hospital system to know what they are expected to do in the clinics in the wards, concerning the patients, that is just clinical education

Researcher- Any other opinion, i will be very grateful if we can all participate in the discussion

Researcher- What is an ideal clinical learning environment to us. We said it is the process of integrating the students into the hospital setting, so what is an ideal clinical learning environment to us

MRS YUSUF- an ideal clinical environment is comprised those things that are needed for the students to make use to carry out their activities in a way that it will be of benefit to the patient.

MRS AGBAJE- to buttress what she has said i think that and ideal clinical nursing education, apart from been in the university, it should also involve teaching in the clinical setting, so that it is not everything, even though they have been thought in the school, they should also be thought within the hospital, after the theory, the lecturing, the practical session should be adapted, to be brought to the hospital environment so that the educator that will teach them will come to the ward with them to conduct a ward round with them, so as to make them better. Because if you keep them to the university alone, it won't be sufficient to them, because our job is an art and is also a science, the art of it is within the hospital setting. So you bring them to the ward let them see those things in reality. You have taught them with mannequins, but let them now come and interact with human beings to face the real cases in

the hospital. SO the clinical instructors and educators should also come to the hospital setting to come and teach them, so that they will have all the basic knowledge. Those things are there in their imagination, let them come and see the reality on the ward.

MISS LATIFA: The atmosphere should be friendly, that is from the nurses on the ward, and they should be friendly to the students and be readily available to the students to impart knowledge in the students

MRS SHONAIKE- And the habit of learning, they should inculcate and habit of learning, because some just come to the ward to show face that i am present, but some come to learn what they have done in the class, they want to know, maybe for instance they have learnt about the medical - surgical of eclammpsia, when they see a patient with eclampitic fit, they will be able to say this is what we have learnt, the patient is having eclampsia, they should develop the habit of learning. Some will come very late to the ward, and it is your job, you are paid to do it and if at all they are not there, won't i do my job. So some come to the ward with that impression that i am a student

Researcher - there must be motivation from the students and there must be a friendly atmosphere. Now i want us to talk in -depth about the resources

MRS SHONAIKE- we improvise a lot, in an ideal setting there should not be an improvisation everything should be made available, but here even the patient, the logistics are not there even when they told that you need this and that, even the investigation, they don' have money for the investigation, talk less of what you will use to care for them.

Researcher- So that leads me to the next question, what is the actual learning environment that these students come into here in UCH

MRS THOMAS- For human resources i will rate that one has good, but for the material resources let me just say fair, just, just fair because most of the time we improvise so these students, the ideal resources that they supposed to use are not available so they have to improvise most of the time.

Researcher- I will like us to avoid just good or summary, i will like us to be in-depth in our discussion.

MRS AGBAJE-What she is trying to say in short is that those things we are actually need, like you want to do a bed-bath you need a two face towel, the top flannel and the bottom flannel, do you understand, you are making use of the patient, at times it can even the blouse of the patient or the pillow case how do you want the student to learn the ideal situation or procedure without you having all the resources that you need. So that is what she is trying to say that it is just fair, at times you will have material to use at times you wouldn't have so it is not consistent, so that is what is she meant by that, the supplies are not consistent. You want to give injection now, in the past there used to be injection pack and so on and so forth, but these days you make use of what you can see, so the students will not be able to learn the ideal situation, in this present situation, so if you want them to learn you provide all that is needed to teach them the way it should be. SO the material should be made available in the hospital so that you can teach them the right thing, Instead of them learning improvisation all the time. During examination it is what they have been doing that will be in their brain and they will tend to make mistakes.

Researcher- What about the human resources-

MRS AGBAJE We cannot say it is adequate, we still need more but it is better than in the past. But we still need more hands, do you understand now. Because these patients now are aware of their rights, they want everything to be done for them. They have paid for the services and we are human begin you can over work or stretch yourself, so if we have more hands we will be able to work more efficiently, so we cannot say we are there, we are moving towards perfection we are not there already, so we need more hands, we can say we are about 75 % but the remaining 25% is still worth it.

Researcher-Tell me about your experience with the students on clinical

MRS AGBAJE- It has been cordial, we teach them, like myself i love to teach, so i teach them, but at times some of them are not ready to learn., some will tell you they are going to follow up their thesis, their research supervisor ask them to come and see them. The two should not collide, if they are on clinical posting they should be, not that when they are on clinical posting they will tell you by 12pm that they have lecture in the school and the school is in UI not in the hospital, so the time frame for you to teach them is limited. Because you must have time for your patient, that is not your primary assignment, you will have to do your

procedure before you attend to them; you have to attend to your patients before you attend to them

MRS SHOANIKE I don't know maybe the orientation has changed we all want to do paper work, we don't, must of them don't believe in clinical set- up. All they want is read, download. They will even tell you 75% of them will tell you that i am not coming to the clinical setting, God forbid i will never work in UCH. That orientation has already limited them. Most of them are not interested to learn anything in the clinical setting. Even when you are trying to force them you have to know this as a nurse, even let's remove the financial aspect of it, for your family, home and relatives, there are things that are basic that you should now. All they want to know is that i want to go and lecture and do this, everybody is running away. I wouldn't know if that is the orientation now. If you ask them little, little things you expect them to know, they are not ready, all they want to know is to go on net, during exams download it and that is affecting nursing.

Researcher- Any other opinion on that

MRS AGBAJE- I want to say that i agree with her but it is not totally the fault of the students. During our own time our clinical instructors from the school will follow-us up, she will come from the school to check on us, she will tell you to take her on ward round, and you must know your patient, the name of your patient, the drugs she is using, the reason why she is using the drug and all that. You will even have a booklet to write the patients' names and diagnosis and drugs. But these days they don't come and around and when they do come they will say matron i came to see the students and will chit-chat and go, but it should not be like that. She should ask what they have learnt while on the ward, they should be able to tell you what they have learnt on their ward. Because when they come out and get out of school they will be in the labour market and if we don't train them well they are going to mar the profession. Let me give you an example. i have worked with someone that have masters in nursing, she finished her bnsc and went in straight for her masters. She is now a senior nursing officer, she passed a catheter one day and the patient started to bleed, in fact as soon as she finished, passing the catheter, the patient started to shout that she is in pain. I asked her OK let us go to the patient, screen the patient and we went to check, and lo and behold she ballooned the urethra, the blood was already tripping out of the catheter. At that level you will expect that she wouldn't make any mistake with catheterization but because most of the time when you are even doing it some of them will be doing something else, interacting with

their phone or laptop and because you are not their primary lecturer, they don't fear you, Even if you call them and want to reproof them, they don't care because it does not have impart on their GPA. So let the clinical instructors be around. So if you are a clinical instructor and they are not around in the class room, you should be in the ward were they are and be teaching them, following them up, all those procedures you teach them, ask us questions about them. SO it is not totally the fault of the students

Researcher- You mentioned something and i want us to discuss more about that thing that you mentioned, You said the primary responsibility is your job on the ward and not necessarily the student, when do they have the opportunity to learn? How long do they have to observe the procedure before they actually have the hands-on?

MRS LAKAS - For instance if they are to resume 8 am, some will come 9 am and will start with i want to go and sign, and all that. IF they are around and you want to do your procedure as nurse, they observe today and tomorrow , you can ask them if they can do it tomorrow, since they have observe today. Even if she did not get it right today, tomorrow she will get it right after trying again. But since they are not around how do you force them to learn.

MISS LATIFA-part of our job is to teach the students, nursing students, medical students and etc., it is part of our job description and you can't teach them in isolation, we teach them while doing the act, the smart will ask can i do this, then for the weak one, or shy or whatever, you just tell them try it yourselves and they do it. But for the lazy ones, if you push, push and they decide not to do, you let them be.

MRS LAKAS- Yesterday a colleague of mine was dressing patient's wound, we have allocated patients, so i was just looking and i saw these nurses behind the screen. Maybe they were scared, or have never seen such before, it was osteomyelitis it was smelling, must of them were doing like this, so i had to force them. How would you know what she is doing, so i said go under the screen and that is what most of them doing. If you ask them OK we are handing over, when you hand over a patient you will know more about the patient, they will tell you it is time for us to go. Our bus is ready to go. They wouldn't come on time to the ward but they are ready to go on time. So how would they know how to carry out this procedure? But in the act i personally teach them, in fact on my ward, they teach them they create time for the students to do that because there are some nurses assigned to them. When

you ask them questions on little things that you expect them to know and it is a routine. They don't do it

Researcher- How do we create motivation in the students for learning to take place

MRS PETERS-The motivation should be from the school. We should get it into the students that clinical experience is not a time to rest. It is time for school work. Let us stress it that what you can do clinically is the power that you have. If we don't so that, they will just say this is the time for me to do whatever i want to do. And when they are supposed to be there, let the clinical instructors be around. SO they would at least respect her to some extent better than we because they know that you cant really do much to them,

MRS AGBAJE- It borders on attitudinal change, they should come to the clinical setting with the right mind, clinical setting is not a place of pleasure but a place to work, so they should come with the right attitude, it is not a time for them for loiter around that i want to visit my colleague. Of course i wouldn't force any student, you learn at your pace, at your will, because you don't know who the parents or Godfather of the students is and you want to guide your job and will want to face it, if there is any problem you are the one to face it even if they are final year students and phd students they are students and you are the one that will answer for the patients, so they should come, tell them to come with the right attitude to learn, to put even if you are a boss somewhere, you come with humility, to that trained nurse to teach you , you are the one that need something from her, so it is you that will bring down your pride and get whatever you want to get. There are instances where the seniors on the wards will learn from the junior bur when you know it, you can lord it over her. But the students want to come and behave some how, you will push them aside, some will ask questions and you can actually teach them.

MRS ORIYOMI- the attitudinal change should be imbibed from the school. Like there are some things that i learnt while i was a student. I finished from the school of nursing in 1994, there are some condition as at that time that i see , that i may not have read or exam but because of the care of the patient on the ward i was able to write the exams. So they should see that the time on the ward is learning time. When you go for clinical practice, you are there for clinical activities, you are there for business, not there for loitering or extra-curricula activities, you should tell them from the school. Like when we started, the discipline they imbibe in us is what er have, there are some students that will not greet you even when they

see you on the corridor, i switch off my phone because if it rings on my ward, so you are in trouble

Researcher- I am interested in the clinical learning environment, not the school, how do we help the students to learn in our various ward.

MRS ODEYEMI- We do patient allocation, we allocate patients to them, like my own ward we have male and female side, so if they are three in number we allocate like five patient to each one of them, so they will be under a staff nurse to monitor them, e.g if they are doing vital sign , you ask them to report to you the measurements they have taken and tell you the normal range and diagnose the patient. Sometimes we do ward teaching after the whole procedures, overlapping periods. The ACNO will teach them, like the particular disease that is paramount in that ward and the instruments because it is different from other wards, I work on ENT ward

MRS SHONAIKE- Honestly i will need to be sincere, some of them don't come with the spirit of learning, they only come to come and see and when they see, they interested in that theoretical aspect of it. I think what the issues should be now is that from the university, their lecturers should tell them that these clinical stuff is part of their assessment. I think when they put 30% of their mark, maybe they will put more effort. Because at the end of the day when you have taught them a procedure and you tell them to repeat it they cant do it. For instance one could not even read the thermometer, some time you get frustrated and ask are they really teaching them in the school. They should put in more time in the practical. I stand to be corrected the school that went to the school of nursing are far better than those in the university

MRS SHONAIKE- Everything is on this fact that theory, theory, school of nursing is both theory and practical, they know that the theory and practical is important for them to pass to the next level

MISS LATIFA- The university process is per semester, school of nursing is the whole year, school of nursing is from year one to the third year but university is per semester. And in the school of nursing they taught them morals, unfortunately the bnsc, the morals is not part of their curriculum, because if it is part of the curriculum you will see it in them. Because in the university, they think that they are the one paying them not the one paying the student

MRS YUSUF- On my unit emergency, when are our students are on the ward, they will not go for break they will be there till they close but these bnsc students will tell you i want to go and see my supervisor

MRS TEMIDOPE- i love this forum, i have been longing for something like this to open my mind. When i work on the ward i give the students on the ward orientation, I use to tell them if you are on duty, if your name appears on the duty roaster, you have a responsibility to the patient. Before coming into nursing, the person my dad took me to asked me, are you been forced or you have it at heart because you must touch the person that you have on the ward. What i observe is that after vital signs most of them bring out their laptops and start browsing, they see themselves as different breed. Now i am in In-service, there are a lot of things they do that is not acceptable in UCH my boss as seized a lot of earrings and complained on their hairdo. I believe that there are some things that should be in common when they are coming for clinical

MRS TEMIDOPE- One thing i see the clinical nursing are doing, we have nurses on the ward who we believe are good in the practical, they are now in the school of nursing, they are part of the clinical but they are in the school of nursing, after the theory they are the ones that will teach the practicals. My senior colleagues took part in the last examinations and she told me that the students were too good , so to me that means that the clinical instructors did a good job.

MRS ODEYEMI- Like the school of nursing students, the clinical instructors came and was their till the end,We did our part like i said earlier, on my ward we have those assigned already, after we finished the teaching,she took over, the clinical instructor asked the student what she taught you, tell me what you have gained and she tried to blend everything together and that is what my boss is trying to say.

Researcher-What i am getting now is that from the university setting, the clinical instructors don't necessarily see themselves as part of the structure of the nurse on the ward

MRS ODEYEMI- They just come, greet occasionally and face their students

Researcher-Tell me about your relationship with the clinical instructors from the university setting

MRS ODEYEMI- Like on my ward i told you my boss is very strict, if you miss day you will payback and if you are late you will payback. Once the clinical instructor is here my boss will carry the roaster to report each student. The students don't like her, but he thing is just that we have different nature and temperament and it is not all of us that can go that far, considering the fact that the workload over there is much too, when someone tells you i want to see my clinical instructor, i have this exam, one of them told me that when i finish this exam this week, i have another one next week and they are still coming for clinical. You will see that the whole thing is muddled up truly but you will see that right within them they are not ready for clinical

MRS YUSUF- we know our own part, it should start from the school, anytime they come to the clinical setting, they should be there because when you allocate them that is when they are going for something.

MRS AGBAJE- They should resume to time, when they are on clinical posting they should be their on clinical posting and should not mix it with another thing and so that they wouldn't have excuse to run over. They should handover and takeover with us, they don't because they don't come on time and this is part of nursing, how will they know the line of continuity in the treatment of patient. They will come by 9 in the morning that they were waiting for school-bus, by 12 they are leaving and saying they have group discussion in the school. Within those three hours even though they are observing, they still need time to ask questions but by the time you are ready to face them they are on their way going.

Researcher- When do they have their hands-on

MRS AGBAJE - they do the procedures together like when you are laying bed the do it with you, you are turning patient, but delicate procedures you cannot leave it to them, like s student is gasping for breath or is aspirating you can’t ask them to do it, when you have finish doing it then you can ask them question, after handing over, during the overlapping period we teach them, we have nurses allocated to student nurses and staff training, we call it adhoc duty apart from your primary duty, we have nurses allocated to that duty, we have done that for this year now on my ward, some will do ward teaching, monitor roaster etc, but they don't wait until that time, the overlapping period

MRS TEMIDOPE- One thing we should find out the period they have their practical is that, the period they have their practicals is too short. What is the duration of those in the school of nursing compared to the ones in the university? I am just thinking aloud, maybe that is what we should look into. Because it is not all of them that wouldn't be dedicated to do nursing, even though i know that there are some that wanted to do medicine, or pharmacy and other courses. Like there is one that changed from biochemistry to nursing recently maybe she was not doing well and she then change to nursing but nursing is not easy to. So i think we should look into the number of hours spent in the clinical and if they need collaboration with those on the wards they should come and let us know because presently i don't think there is anything like that. Let us be sincere to ourselves there are some leaders that can't take their behaviors and some will actually tell you that if they are there they are on their own, due to some of the behavior they have seen, some will come at nine, and some will not come at all saying since the bus is not available. It looks as if there is no commitment, some will actually pay there way to the hospital. Some will come but not serious, they will come at 9 take one hour break before you know it they will say that the bus is available and they are off.

MRS AGBAJE- where do they spend those ours

MISS LATIFA- On a serious not i think each ward in UCH is relatively busy and when they come in 9 we have to attend to the patient first, yes we teach as we go on, for instance if i have two- three burns patient i have to dress and we are just four, and for each burns patient you need minimum of three nurses to make it first, and you spend one and half hours or two. As i am dressing this patient, i will be teaching them yes, that this is the way to do it, but i will also want to get this job done on time, that is also behind my brain, so after i had finished the work, the major problem is that when i have time to settle down with them to download that is when they take off- that is when they say they are going, when i am writing my report, nursing process. i will call those working with me, pick the nursing process, we want to write tell me what we have done today, usually i don't like them writing, i will just ask them to tell me, some of them will just be looking at you, we gather together and brainstorm together, and ask them to bring the case-note for discussion, some of them will wait, while some will be grumbling. One of my boss was teaching them one day, and one student said ma, we are tired we want to go and she said OK you can go, can you imagine two of them left. SO it is when we really have time with them to help them that they will take off. But the people here, the

school of nursing will stay, maybe because they are closer, some of them will come at their leisure time.

MISS LATIFA- We discuss together even though they don't write it.

Researcher- But how would you know that they know how to write, how would they know their weak point when they don't have opportunity to do.

MISS LATIFA- they admit patients and in UCH we admit with nursing process and they do that, like if you are working with me, if you want to write, if you look at what they write, they just say so, like when they are admitting a patient, i will ask have you gotten their history, what do you want to write, after telling me i will correct her in the right way to write it. But my daily report i write and sign on my own, of course i will countersign what she has written in the nursing report because if they are to write alone they can use three booklets.

Researcher- Do they have the opportunity to make mistakes and have them corrected. When can they do the real thing, do they have to reach a particular level before they can write

MISS LATIFA- the last level i worked with the 200 level i did not allow them to write it. But this particular lady, i allowed her set, i think she finished from here but when she was in 300 level i allow them to write.

MRS AGBAJE- i don't give report to the students to write i am accountable for the patients,because once the students are gone, they are gone, they can even be gone for life. That nursing process can be called for at any time, how can i account for what i did not write. There is a session for the student on the nursing process booklet.

Researcher- Do they have any book from the school for them to write and it can be corrected

Chorus-No they don't

Researcher- Have you ever work with a nurse that finished from the degree setting, you will tell me your experience with that person

MRS SHOANIKE- like you rightly said for them not to kill us, like i work with one of them on my ward, she was to give abidec to a baby, when she went through the case-note, she saw 0.6 ml she went ahead to measure 6 ml to the patient, thank God the baby was not on NG

tube, so she served it into the cup that the mother should be giving it with cup and spoon. She came to tell me she has served it the drug, so i said were did you put it and she said i poured it into the cup and i was like what, i went to the mother and i told the patient that the child does not need this much, we are not to give it, i poured it back into the bottle, so i gave the drop. I called the nurse that if you have known these is either you give 0.3 or 0.6 ml, we don't give these much. Even if a doctor should write that mistake you should correct the doctor.

MRS AGBAJE- Presently i have two graduate on my ward, one masters and one degree, It is the one that i said passed catheter wrongly and i had to re-pass the catheter in her presence and i called her aside, you are a senior nursing officer, and you are a masters holder how can you say that you don't know how to pass catheter in the presence of your students, she said she does not know what went wrong, i had to tell her go and read it up again, nobody is to big to learn, you can even ask a staff nurse to re-check for you, you should not be ashamed to ask, I still ask the staff nurses questions because they are just coming from school so they will know the new trend. But one is a staff nurse, i can say she is actually picking up and f she does not know anything, immediately she will ask you, even when you are handing over, she hears a terminology, she does not know, she will say boss tell me what this means and we will trash it out

Researcher- In your opinion the clinical level she has received did she get the minimal level of competency

MRS AGBAJE- Yes

Researcher- Each one of us should say what we want in a clinical nursing education that will make it to be quality, that will make it to be standard, so that these our nurses that are coming will not kill us when they are on the ward. You should tell us what should be in the clinical education

MRS OLUGBEMI- the clinical instructors should make themselves available, they should come to the clinical area to teach the students, whatever they tell the students from the school, they should raise their motivation that they are going to the clinical area to work and not to focus on the theoretical aspect alone

MRS ODEYEMI- What i will say is this, you said globally now, school of nursing is going into extinction, but you know that there are some procedure that we do in this school of nursing everyday, if there are some practical room in that setting, do we have them in the university

MRS TEMIDOPE- From there lets pass it across that they are coming to learn, not that they are superior, because they see themselves as superiors we know better than them, what do they know, just to carry bed-pan, maybe that is what is making them not to, because you see my boss that are going to the degree when they come to your ward to learn, they say please my younger one can you teach me this, since this is a specialty ward, they will tell you please don't call me your boss now i am a student. But you see theses students there are shoulders are high up there maybe because their parents are whoever, so lets re-orientate them

MRS TEMIDOPE- we need to be united as we are coming in and we see the diplomats and degree coming in, we need to see ourselves as one, the on coming from the university should be humble enough to work on the ward. Actually when you work on the ward, some are very humble, and so me are very high up there. Even the students, the ones from the school of nursing and the degree students they don't mix, they seat separately, they don't mingle and they will come and work on the same ward and by the time they are coming in, if we see ourselves as one, the ward leader should be able to carry but the ones from the university and the school of nursing, but on the ward some don't even want to have anything to do at ll with them not because of anything but because of attitude. Like it i told you the last time i had some of them around, i call them you give them proper orientation, but let me tell you one thing, if your name appear on this roaster you have a responsibility to the patient you are nursing, you must do one thing or the other to the patient. Every ward leader also have a responsibility to do, not for today but for future, we need to see ourselves as one, because it is still coming, every single nurse will be a graduate nurse, we too we are praying that this place and every other school should be close down so that we see ourselves as one and primarily as a nurse

Appendix: 17

EXAMPLE OF TRANSCRIPT INTERVIEW WITH ALUMNI

NOTE – NAME IS A PSEUDO NAME

Researcher: Good evening

Ife. T: Good evening ma

Researcher: I am very grateful for this opportunity and for taking time out from your busy schedule to talk with me. In your opinion, what is Clinical Nursing Education?

Ife.T: Wow. I will say it is the healthiest based practice of a thing. It is beyond what you have. It is expressing the theoretical knowledge that you have and putting it into practice. I can say it is knowledge at work.

Researcher: Tell me where you think Clinical Nursing Education takes place.

Ife.T : Basically it takes place at the clinics in the hospital. Although It starts right from the school and moves to the clinics in the hospital setting.

Researcher: What are the resources that are available for you in your school in terms of adequacy and opportunity that are being open to you in terms of the clinical learning experience?

Ife.T: At Obafemi Awolowo University (OAU), I will say that that we have a lot of opportunities. Looking at the facts that nursing has started for a while. The nursing department in OAU has been around for a very long time. The labs for instance are equipped with human models that are used in practical. This facility provides us the experience to learn more about nursing. I will also add that we have a lot of clinical instructors who provide one-on-one learning experience for the students. Also we are divided into different learning groups and this avail us the opportunity to really have a first-hand learning experience in using the human like models in the laboratory. To enable us to ask questions and learn more. We have about ten or twelve models and with different groups you are free to ask questions. Unlike other schools where there are not enough models to work with, they have two models for students. And that is not good enough. I'd say this is not the case at OAU. The demonstration classes we had were very good and I can say that they really helped us.

Researcher: Talking about the human resources, how many instructors were available to you as at that time?

Ife.T: As at that time I will say we have 4 clinical instructors. Although some were teaching the senior classes, the 500 and 400-level students of the institution while some where taking the 200 and 300-level students of the school. But we had four at our disposals.

Researcher: What about the students?

Ife.T: For example my set 2011 sets we were just 49 students. With 4 clinical instructors to our small class, the educator to student ratio is really good for us. In terms of human resources I will say it was good.

Researcher: Tell me what an ideal clinical learning environment is to you.

Ife.T: An ideal clinical learning environment to me I must let us know that the world is evolving and technology is also advancing and our ability to incorporate technology into the clinical learning process. I think there is something they called telemedicine people have started to use it and it even here in Nigeria. That unfortunately is one aspect that we are still lacking in this part of the world. At times when we get to the clinic we see some advance technology and we are not really exposed to the use of those things. I believe and ideal environment to learn will be good if we incorporate all these things to it. I believe we can do better in that aspect. Much more than that, the infrastructures that are needed beyond models are still lacking. It goes beyond the Mr or Mrs Jones human model that we still use in the labs. I believe that we being able to get better will also enhance Much more can be improved in that regards as well.

Researcher: Okay. You have talked about clinical demonstrations in the skills lab. You also said it takes place in the hospital. What do you think an ideal clinical learning environment in the hospital wards should look like?

Ife.T: An ideal clinical learning environment in the ward I believe it should be of something of Here, we are dealing with the patients directly these are not models, I believe that to create an ideal or therapeutic environment for learning So I believed that everybody must be carried along on what their actions and roles should be. The patients, the students, the nurses, and the clinical instructors everyone must understand. I will give you an instance of a patient that refused to cooperate with the students during the examinations because he has not been

properly introduced to them beforehand and he does not understand. So I believe everyone should be carried along this should not be the case and it is something that ought to have been done long before the students came to the wards. Added to this is the availability of the instructors at the hospital clinics. I believed they should be around in the wards and not just leave the students alone with the matrons. Yes students are in the hands of the matrons but the clinical instructors should be around to monitor the students if they are getting what they are been taught. And the students should be teachable as well. Their presence is still needed to supervise and coordinate the students. An ideal learning environment also entails bringing the theory knowledge into work environment because it is one thing to know theory it is another to practice. at the hospital clinics is incomplete without students bringing in the theoretical learning from the classrooms and using them in the wards. For instance, there was a situation when a patient had the case of meningitis in as much as we understand the pathological and theoretical process, when the actual treatment of the patient started we were lost. This will not have been the case if the instructors were there because they will have explained the whole process to the students and even possibly grade their performances right on spot. And not wait to when the examination comes the grading system should be every day. For instance in our chemistry class in 100-level, you are graded from every practical class. There is no exam for the chemistry class each practical class is your exams and everyone is serious about it because you don't want to fail the examination so everyone attends the practical class because they don't want to fail since each practical class is exam and it is your average score over all the practical class is your score. SO I believe we should start from there. It is not until when the exam comes. An ideal clinical learning environment should start from there it should be everyday learning activity and you see everybody participating.

Researcher: What was the actual learning environment that you find yourself as a student?

Ife.T: The actual learning environment I found myself was not the ideal one.

Researcher: Tell me the experiences you had.

Ife.T: It was not ideal setting because it was from there I could deduce what and ideal setting should be like. In as much as it was a good one, there are still many areas lacking that can be improved on. I found myself in the environment. From my personal experience and that of my colleagues, I came to realise that we were not exposed to quite a number of things that could have help our learning. There is a common say that bnsc nurses don't know anything

We were usually called the 'Theory Nurses' because most people think we only know the theoretical aspect of our discipline but little of the practical. Many think we were not exposed enough to the practical aspect of the nursing profession. And we have given them that priviledge to name us like that because they have seen us on the ward on the clinical settings and they believe we are not well exposed. For example we started going for clinicals when we were in 200 level going to 300 level and as at then Then the instructors were not really coming with us to the wards. They were majorly in class. What they did was to hand us over to the matrons who were of little help. All the matrons did was to assign duties to the students and whether it is done or not is not their problem. As far as things were moving on in the ward and because we were not really learning that way, we had to talk to some of our senior colleagues to help put us through. They said you must humble yourself and learn when the doctors were around. For most of the students, it was more of a personal effort for us. And we were looking at it that since it is not OAU that will set the councils examinations and since you must do well in the praticals for you to be licensed as a nurse so we had to put in a lot of personal efforts. And of course any little mistake you make you are in trouble because they will be singing bnsc nurses and you know in a way we have to shun those things and move ahead as much as possible. I recollect the first time I was to administer an injection on a patient at a clinic in the teaching hospital. The problem is that our instructors were not around on the ward if they were there it will help us a lot to curb all these trouble I was in 300-level then. In the teaching hospital, they have given it in my presence before and I was to give it subcutaneous As I about to administer the injection, the matron at the ward right there in front of the patient called on me to do you know how to give it, 'take it easy' with the patient. The patient already knows that, this was my first time maybe I am using here for practice. She allowed me to give her but she was acting as if it was painful. This action had an adverse psychological effect on me as well as the patient. Though the patient allowed me to carry out the process, but she was left with the impression that I was using her for 'practical' as that was my first time of doing that. I felt so Bad and at times you are not just encourage to do some other things I believe that by the time I started working it became a lot of things I had to learn on the job. Most of what I ought to have learnt in school, I had to learn on the job.

Researcher: What was your relationship with the nurses? How did they view you?

Ife.T: I think I have mentioned some of our experiences. Any time we go for clinical posting, we meet a lot of nurses. Those doing their postings. Some that are also in school of nurses Some few graduate nurses and so on. They are not many but majority are RN and

RM. Sincerely speaking especially The young ones have some negative competitive spirits which affect our relationships with them. I think they believe because they lack the opportunities we have, they tend to be envious of us. Anything we do they tend to flare up,I have to admit that they know more of the clinical works than us based on their trainings. As a result of this, they are not always willing to teach us except for those that you have personal and cordial relationship with that you know beyond work, just few of them and few people that are also good enough that they don't really count all these things they are there and they put us through. I cannot also dismiss the fact that some bnsc nurses can be overdoing thing, overbearing too with bad attitudes.like we are not in the same category and we can not rule that out. Some people tend to behave like that, like what do you know that I don't know if not for the practical. Despite the rivalry, there is still a common ground at which we all meet. That we are all nurses, in as much as I am bringing out the problems we should look beyond the minors and look at it that we are there for the patients and not ourselves. We should try as much as possible to put our differences aside and work for the collective good of the profession.

Researcher: So your relationship was not that….

Ife.T: (Cuts in)..it wasn't that cordial.

Researcher: How do you know what you were expected to do when you go for each clinical posting?

Ife.T: Most times before we leave, we would have been adequately briefed in the classrooms.

Researcher: Briefed? How do you mean?

Ife.T: Normally we are usually told that we are going there to learn and given handbills that aid us.That within this period you must have learnt this like the target. But most times, like I said they ought to score us like are you able to meet the target. But there are more to that. There's no feedback while on the field from us to the clinical instructor and the clinical instructor to us. So there is no way to know if the student has achieved the objective of going or not. They are not even there to monitor us, I can tell you that all they care for is that if you don't go for the clinical posting you will be punished with night duty but it is not all about that because I can go for the night duty and go to sleep, they don't care if I am learning or not, they are not aware. SO I think they missed point in this.

Researcher: When you started working, what do you think your clinical learning in school should have prepared you for but didn't?

Ife. T: My first job ever was immediately after leaving school in Ibadan. That was before going for my NYSC I remembered the man I worked with telling me that most of the graduate nurses he has met are not always good in clinical works but that he was ready to help and put me through especially being a male. Soon I discovered I was really lacking in the practical aspect, the clinical education I received was good to an extent but for practical work, it was not good. The fact that I trained in the teaching hospital there were so many rules that will deprive the nurses of so many procedures, for instance nurses don't set line but in a private hospital it is different all together. To my employer all those things were minor and he was expecting that I should be able to do all these but to me it was major because I couldn't learn it while I was in school. I had to start learning on the job. The clinical education just exposed us a bit. I remembered that in one of our demonstration classes we used foam to learn suturing, it was good but when you get to the skin it is a different ball game entirely. It was challenging for me and you know I had to take a lot of insults that we don't know anything and you tend to ask yourself that you spent five years in the university how come you are not good at it but then you tell yourself that you graduated with a second class upper and that you tried your best about the whole things. This thing did not affect only me because I have met a lot of people that have similar problem. Some solutions should be propounded like clinical instructors been around getting feedback from us and helping us through or challenges during the clinical.

Researcher: Away from the challenges, were there any benefits or strengths your trainings afforded or prepared you for?

Ife.T: Yes there is strength in it like I said it has the pros and cons. If I am to dwell on it has a lot of pros. Sincerely speaking in the university some may say you don't know the clinical work but I believe that it starts from the theory and if I am good at the theory and I improve that on practical whao you will be 100%. My mummy is a good nurse and knows al the drugs but she did not study nursing but the different between her and me is that I know the pharmacology behind the drugs. I know how to maintain aseptic procedure, I know why I am doing it, I know the pathophysiology and I know why the organs are functioning well or not and I can easily tell when something is going wrong. And as a BNSC nurse you are actively involved in the treatment of your patient. That makes me different from an auxiliary nurse.

So that is a major advantage in, my training. In as much as the cons are there, I will say going to the university and learning the theoretical aspect of my profession prepared me for the job. The learning process starts from understanding the theoretical part of nursing. I believed that if I am good at the theory and I work hard at the clinical I will be perfect. I understand the pathology and why some things are functioning properly or not.

Researcher: Considering your training and 4 years work experience, how will you rate yourself?

Ife. T: I will say I have really developed myself over this period. I have grown well in this aspect and I can say I know much better than I did previously. If I am to be critical about myself I will say that I Have grown to a reasonable extent. There were so many work related things I was unable to do before but which I can do very well right now. I was talking about suturing and setting of line I had worked in smaller private settings than these and most of them leave you to do the work especially if you are a bnsc nurses they believe in you and they entrust a lot of things into your care and they wouldn't even supervise you and they will just ask you the result and they have come to trust you and I think that is major advantage in my training. Although there is still room for improvement, I will say I have fare well so far. Now my superiors entrusts more into my care now and expect me to deliver accordingly and do not disappoint them. My theoretical knowledge has also helped me to adapt better in my clinical judgement and help me grow faster. There are things I don't have to go and read I know them and I can easily say o, even when Ebola came it is not that I have to read afresh, the knowledge was there, I was taught already though they did not go deep because it was not in epidemic that time but I had a knowledge of it so all I needed to do is just to refresh my brain, it is not that they will ask you and you don't know, people wants answers from you in as much as you are in the health team and I believe that the theory knowledge has helped me to grow faster than I should and that is a strength.

Researcher: How will you rate the clinical judgement of diploma nurses and degree nurses? How will you rate your different background.

Ife.T: If I am to be sincere about that when it comes to the clinical judgement I will say degree nurses have demonstrated superior clinical judgement compare to diploma nurses. In terms of accuracy, efficiency, promptness, I will say we have an edge over them. Most times they come to us to ask some certain things and that has also gingered them to go back to also

get the knowledge that we have so that as much as possible we can all move and be at the same level.

Researcher: What do you think is the problem with your clinical exposure?

Ife.T: To start with, I'd say exposure to the clinical setting early enough is a factor. We were not exposed early enough. For instance, we were made to undergo courses that were inconsequential to my discipline. This is unlike diploma nurses that were taught what they should know. Secondly, they spend longer hours at the hospital than we do. At times they use, they stop their theory for long and use longer period at the hospital for clinical. Thirdly, Availability of our instructors, our instructors should be more readily available to us rather than delegating the responsibility to the matron. Like I said the all thing starts from the class but they should not stop there they should follow us to the hospital, because in the hospital we are dealing with human beigns and not models and that is when we really need their expertise to help us through. When they even come they are not coming to know whether we have learnt or not they are coming to see whether we come so that they will know who will be punished. They are not interested in those that have come if they are meeting the objectives that were set for the clinicals. Are they interested in what we are doing or are they just setting objectives for setting sake? They were not efficient enough to the level of monitoring whether we are learning or not. This affected our training a great deal. We spent three years in clinicals and this should have been enough if the clinicals were monitored properly the way it should be. They should monitor closely what we do.

Researcher: if you were given a chance to change anything, let's say the curriculum, what will it be?

Ife.T: I will modify the curriculum in such a way that will ensure that the clinical instructors are more readily available to the students when they are in the ward as much as possible I believe that alone will solve a lot of problem for the BNSC nurses. Another thing is incorporating technology into our learning process. I think it will help us a lot. For instance I was never posted to accident and emergency unit when I was I school, so I don't know some instruments that are been used until I finished and started to work.

Researcher: How were they able to bridge the gap between the theory and practical?

Ife.T: They were able to do that through demonstration of what we were taught.

Researcher: How did you incorporate the theory into the practical in reality?

Ife. T: It was more of a personal development process because or instructors were not available, they will just post you there and ask you to report there. You are always on your own. As students at our leisure time we go to the ward and interact with senior colleagues. On my own, I created time to read and research and interact with my senior colleague.

Researcher: My final question. Did you have any specific challenge with your senior colleague when you started to work? How were you able to interact with your senior colleague and how did they help you integrate into the working sector?

Ife.T: I believe that will really have to do more with personalities. This varies on personalities because personalities differ. I may be a person withdrawn so I don't like to interact to people. Irrespective of the qualifications, your relationships and interactions with people will go a long way in other people accepting you. Also what you meet on ground in your working place can also affect how you will be integrated into the system. If you meet rivalry you were have problems but if you meet love you will be welcomed with love.