UNIVERSITY OF THE WESTERN CAPE

Faculty of Community and Health Science

School of Nursing

CREATING A CARING PRAXIS IN NURSING EDUCATION AND TRAINING: THE EXPERIENCES OF THE CLINICAL SUPERVISORS

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Faculty of Community Health Sciences,
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ABSTRACT

Background: The integration of theory, research, and practice as caring praxis was revealed in the everyday work and practice of caring within nursing. “Praxis is a coherent structure of the nurse's work that integrates guiding values, specific actions consistent within the social mission of the profession, knowledge construction, community awareness, and the realization that within a profession lies the process of bringing about some human good”, and that nursing as a “practice-based profession and its training requires the embedment of theoretical and clinical learning” along with national and provincial guidelines and treatment regimens to ensure that nurses are trained according to required standards of the nursing regulatory body in South Africa. It was therefore deemed relevant to examine the caring praxis in the nursing education and training of undergraduate nursing students.

Aim: The purpose of this study was to understand the experiences of clinical supervisors in creating a caring praxis in nursing education and training. The theoretical framework of this study is aimed to link the five comportments prescribed in the model of practical skills performance to clinical teaching to create a caring praxis in nursing education and training.

Design and method: This study employed a qualitative study method and a qualitative explorative contextual design to meet the two objectives of the study, which were: to explore and describe the experiences of the clinical supervisors doing clinical teaching in hospitals and clinics; and to identify the needs of the clinical supervisors to ensure a caring praxis in nursing education and training.

Ethical considerations: The proposal was submitted to the Humanities and Social Science Research Ethics Committee for approval. Permission was obtained from the Head of Department at the School of Nursing and the supervisor coordinator provided access to obtain information from potential participants. Informed consent was obtained from all participants, and they had the right to withdraw at any time should they wish to do so. The researcher aimed to guarantee the well-being of the participants and to minimize harm and discomfort. Anonymity was strictly maintained to protect the participants and ensure confidentiality.

Conclusion: Five main themes emerged from the analysis: during clinical supervision the clinical supervisors must ensure that they educate the nursing student to care for their patients holistically and to meet the patient’s needs regarding comfort and safety; the clinical supervisors integrate teaching and learning tools to breech the gap between theory and practice, integrating their experiences to add meaning to clinical teaching and learning; students’

participation and involvement during skills development allowed the clinical supervisors to assess and manage risk during patient engagement; during clinical teaching and learning the clinical supervisors has to ensure the skills are within the scope and guidelines of the clinical facilities; and the clinical supervisors takes on many roles to advocate and facilitate the caring praxis in nursing.

KEYWORDS

Praxis

Clinical supervisor

Clinical supervision

Clinical accompaniment

Caring praxis

Undergraduate nursing programme

LIST OF ABBREVIATIONS

CS	Clinical supervisor/s
HEI	Higher education institution
HSSREC	Humanities and Social Sciences Research Ethics Committee
OSCE	Objective Structured Clinical Examination
PN	Professional Nurse
SANC	South African Nursing Council
SON	School of Nursing
UWC	University of the Western Cape
WHO	World Health Organization
WIL	Work-integrated learning

DECLARATION

I, Beverdene, Christine Syme, student number 2828761, declare that:

This thesis is my own work and all the sources used, are indicated and acknowledged in the accompanying references. The study was approved by the Humanities and Social Science Ethics Committee of the University of the Western Cape, in terms of its methodology and ethics considerations, and therefore complies with the research and ethical standards of the University of the Western Cape.

Name: Beverdene Christine Syme

Date: December 2022

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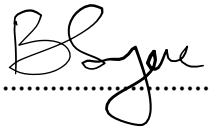

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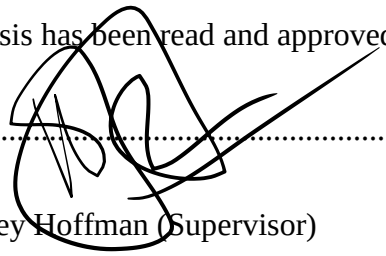

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To my two beautiful daughters, Taytum Leigh Baugaard and Madison Isabella Syme, the two of you were my biggest motivation to get my thesis done – thank you for your love towards me.

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To my friends, I would like to say thank you for the support, words of encouragement and prayers throughout this journey; your love and support means so much to me.

Dedication

Proverbs 3:5-6

"Trust in the Lord with all your heart and lean not on your own understanding; In all your ways acknowledge Him, and He shall direct your path."

This study is dedicated to my daughters whom I love dearly and my grandparents who are no longer with me; their memories are forever engraved in my heart:

To my daughters, Taytum Leigh Baugaard & Madison Isabella Syme,

my late Grandfather, Christy Baugaard

and late Grandmother, Helen Kalakoda

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CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 Outline of the chapter

In this chapter, the researcher sets the context and provides relevant information for a general overview of this current study. This chapter contains the orientation and background of the study, the problem statement, research question, aim of the study, objectives, significance of the study, operational definitions, and an overview of the research process that was followed, concluding with a summary of the first chapter.

1.2 Orientation to the study

The study intends to contribute to the understanding of the caring praxis that exists within nursing education and training. The art of nursing is reported to be grounded in the praxis and philosophy where the theory complements the practical element of nursing. The goal of this philosophy is to instil a humanistic value in nursing practise (Devi, Pradhan, Giri, & Lepcha, 2022).

Nursing is a "practice-based profession and its training requires the embedment of theoretical and clinical learning" along with national and provincial guidelines and treatment regimens to ensure that nurses are trained according to required standards of the nursing regulatory body in South Africa (Farzi et al., 2018, p. 45). This alludes to the inherent nature of nursing, that consists of a praxis: "Praxis is therefore a coherent structure of the nurse's work that integrates guiding values, specific actions consistent within the social mission of the profession, knowledge construction, community awareness, and the realization that within a profession lies the process of bringing about some human good" (Hagedorn, 2004, p. 12). Praxis allows for the integration of theory, research, and practice as it is revealed in the everyday work and caring

within nursing practice (Enzman Hines & Gaughan, 2017). Embedded within the practice of nursing is knowledge related to human health that enforces practices based on scientific foundations and it includes the ability to demonstrate an attitude or conviction towards the profession and its social obligation towards society (Al-Hussein, 2022). Further Sari, Prihatiningsih & Lusmilasa. (2021) postulate that health system competency, professional values, nursing care, professional development, and basic care competency remain central to uphold professional values of nursing practice.

These competencies that are embedded in the values of nursing practice require knowledge related to human health, which refers to theoretical learning and clinical learning. Theoretical learning is important since it serve as an opportunity to instil the important scientific principles and foundation of nursing practice in undergraduate programmes; in contrast, clinical learning is learning that is focused on the acquisition of skills and application of theoretical concepts and principles in clinical practice (Farzi et al., 2018). In nursing education, theory and clinical learning cannot function independently, and it is therefore important for the nurse educator to integrate the two components to illuminate a caring praxis in nursing education. Therefore, to enrich our understanding of creating a praxis of caring when executing the academic agenda of nursing education, this study aims to understand the experiences of clinical supervisors (CS) when creating a caring praxis in nursing education and training undergraduates to enhance the acquisition of clinical skills.

1.3 Recent developments in nursing education and training

The South African Nursing Council (SANC), the professional regulatory body of the nursing profession, is clear in terms of its standards to align nursing education, training, and practice to address high-quality care in rapidly changing environments (SANC, 2014). In 2018 the SANC allowed higher education institutions (HEIs) to implement Regulation 174 (R174) to

replace the previous Regulation 425 (R425) for registration as a professional nurse (PN) with SANC. This regulation is characterized by a reduced total of clinical hours needed to qualify for registration as a PN (SANC, 2014). According to the nursing education training standards of SANC, R174 is prescriptive in terms of the clinical requirements of the clinical education and training programme (SANC, 2014). SANC expressed their commitment to improve clinical education and training through provision of a range of activities to engage the student, and clinical learning areas and learning outcomes that are defined for the purpose of undergraduate training. Curriculum advisors in South Africa through FUNDISA proposed that the curriculum is designed in such a way that theory should comprise 30% and practical 70%, while clinical practice for learning comprises 30% and clinical practice for role-taking 40% in total. Clinical practice for simulation forms 20% of the clinical learning (Nursing Summit Organising Committee and the Ministerial Task Team, 2012). However, the distribution between clinical hours for learning 60% and clinical hours for role taking 20% and work integrated learning 20% were finalised by SANC for the new bachelors of nursing (SANC, 2014). This means that in practice more time is spent on clinical supervision and clinical teaching than on theory. Moreover, simulation in skills laboratories is only a small percentage of the total clinical component. In line with the new curriculum, training hours are now seen as notional and 183 credits for the clinical training component is equal to 1830 hours of clinical experience (SANC, 2014). It is therefore fundamentally important for the nurse educator to understand that clinical teaching and learning at an HEI must adhere to and comply with the regulations stipulated by the SANC.

1.4 The role of the clinical supervisor

In HEIs the CS are primarily responsible for clinical learning through skills development, clinical accompaniment, and clinical supervision in healthcare facilities. Previously with R425

the requirement for the position of a CS did not require an additional qualification to facilitate clinical learning in nursing education. However, the R174 curriculum requires all CS to have nursing education as a postgraduate qualification and they must be registered with the SANC as assessors and moderators (SANC, 2014). Multiple studies and research have been conducted among CS and clinical facilitators to understand their role and how they manage themselves in this role (Magerman, 2016 Farzi et al., 2018; Donough & Van der Heever, 2018; Hoffman & Daniels, 2020). It is not clear whether they are able to integrate the complexities and requirements to ensure that a caring praxis is maintained during the act of clinical supervision. It is therefore the intention of this study to understand how CS create a caring praxis within work-related activities when engaged with the learning process. The World Health Organization (WHO) focuses on eight core competencies that describe the role of the nurse educator. In general, these relate to the cognitive, affective, and psychomotor learning domains. Core competency three is "nurse educators maintain current knowledge and skills in theory and practice, based on the best available evidence" (WHO, 2016).

The SANC has provided seven domains that are aligned to the competencies of the WHO and that describe the role of the nurse educator. The fifth domain prescribed by the SANC is that the personal development of the nurse educator should demonstrate a commitment to life-long learning and participation in professional development opportunities that increase their effectiveness (SANC, 2014).

1.5 Strategies in nursing education and training to create a caring praxis

The following strategies are facilitators of praxis in nursing education and training: clinical accompaniment, clinical supervision, clinical skills laboratory, clinical practice for learning and role taking, simulation technology, skills lab methodology, reflective practices, integrating technology, peer learning and group work. Simulation technology is simulation training, which

might bridge the gap between theory and practice, heightening the confidence and abilities of nursing students.

1.5.1 Clinical accompaniment

Student nurse clinical accompaniment forms an important part of the nurse's practical training, as nursing is a practice-based profession. During their training student nurses are required to spend 60% of their time in the clinical setting to attain proficiency in the prescribed nursing skills, in order to meet the clinical requirements as prescribed by the SANC (Bruce, Klopper, Mellish, 2011). Clinical accompaniment therefore implies a type of role-modelling which might facilitate appropriate professional socialization of student nurses into the exemplary role of a PN which displays nursing values which include human dignity, integrity, autonomy, altruism, and social justice (Mathe, Downing, & Kearns, 2021).

1.5.2 Clinical supervision

Clinical supervision is essential in practice preparation in clinical settings. It develops the professional values, identity, and competency of emerging clinicians while also offering professional development opportunities (King, Edlington, & Williams, 2020).

1.5.3 Clinical skills laboratory training

Skills laboratory training is used as a teaching strategy to assist nursing students in developing clinical skills. This educational intervention assists nursing students to develop expertise in clinical skills to ensure the safe care of patients (Mothiba, Bopape, & Mbombi, 2020).

1.5.4 Clinical practice for learning and role taking

Clinical practice is a model of practice that involves practical activities with and on behalf of patients that are carried out by students to enhance the clinical learning experience that nurses require to function in a healthcare environment to care for patients (Abazie, Okwuikpo, Adetunji, & Nweke, 2021). Clinical learning and role taking provide nursing students with opportunities to transform their theoretical knowledge into various skills such as mental, psychological, and motor skills, all which are a necessity for patient care (Bo, Madangi, Ralaitafika, Ersdal, & Tjoflat, 2022).

1.5.5 Clinical simulation

Clinical simulation is a teaching method used to replace real patients with artificial or virtual standardized patients or technologies and methods; these can be used to reproduce clinical scenarios to enable a realistic feel to clinical learning for nursing students, which is both therapeutic and educational (Fuglsang, Bloch, & Selberg, 2022).

1.5.6 Reflective practices

Reflective practice is a tool used in clinical teaching that allows the nursing student to recognize their own strengths and weaknesses and use it as a guide in their ongoing clinical learning to enhance the praxis. Therefore, self-directed learning is encouraged in students as a means of motivation to improve the quality of the care provided (Froneman, Du Plessis, & van Graan, 2022).

1.5.7 Challenges experienced with clinical learning

Effective and efficient clinical accompaniment can be regarded as the means of achieving the aim of integrating theory and practice in nursing education (Beukes & Nolte, 2013). However, numerous challenges have been noted in recent studies regarding the quality and preparedness

of CS (Magerman, 2016, Donough & van der Heever 2018, Hoffman & Daniels, 2020). These challenges can be described as factors that disturb the praxis in clinical skills learning. Donough and Van der Heever (2018) discovered in their research that students reported negative experiences when engaging their CS in the clinical field. Literature also alludes to CS not being punctual and observation of apparent incompetence (Hoffman & Daniels, 2020; Donough & Van der Heever, 2018). Further nursing students also reported that discrepancies exist between supervisors when demonstrating clinical procedures, both in a simulated environment or in clinical practice (Donough & Van der Heever, 2018).

1.6 Problem statement

CS are given complex tasks to provide clinical accompaniment and clinical supervision and to promote the development of undergraduate nursing students in the clinical skills laboratory and clinical practice settings. As a corps it is their responsibility to integrate theory with practice that is relevant to skills. However, when tasked with the development of clinical skills, the expectation exists to create a praxis between theory and clinical learning outcomes when working with patients in clinical practice. This serves as a measure to ensure that undergraduate nursing students are socialised into the role of a PN from the onset of their nursing. The creation of a caring praxis in nursing education requires a relationship between the CS and the students, which is highlighted in the literature as crucial to maintain training and professional standards (Hagedorn, 2004). This relationship has been the focus of numerous research endeavours (Hoffman & Daniels, 2020; Donough & Van der Heever, 2018). The mentioned research indicated that various factors influence skills development and training negatively and listed the following as of concern: the CS are not readily prepared during clinical teaching, and discrepancies were identified by nursing students during their skills development.

The new nursing qualification as per Government Notice No. R174 of 8 March 2013, Regulation 174 that is currently in its implementation phase, embeds a strong focus on the development of skill through prescriptive requirements in terms of the clinical component, which is structured as follows: 60% of the clinical practice for learning, 20% of the clinical practice for role taking, and 20% for work-integrated learning (WIL) to ensure that a caring praxis exists between theory and practice within nursing education. Despite ongoing research on preparedness and readiness for the role and the experiences of CS employed in HEIs, literature and research on the experiences of CS while providing clinical supervision within the clinical environment is limited, and there is a strong focus on the personal and professional attributes of the CS. This study therefore seeks to expand on the current body of knowledge to understand the experiences of CS providing teaching and learning opportunities within the clinical setting through a framework of creating a caring praxis.

1.7 Aim of the research

The aim of the research is to understand the experiences of CS in creating a caring praxis in nursing education and training.

1.8 Research question

The following research questions will guide the intention of the research:

- How do clinical supervisors create a caring praxis in nursing education and training?
- What are the needs of the clinical supervisors to ensure a praxis in clinical supervision?

1.9 Research objectives

Based on the research questions, the two objectives of the research study are as follows:

- **Objective one**: To explore and describe the experiences of clinical supervisors regarding their ability to create a caring praxis in nursing education and training.
- **Objective two**: To identify the needs of clinical supervisors to create a caring praxis in nursing education and training.

1.10 Research methodology

This section comprises a brief introduction to the research methods that will be used in this study. A detailed description of the research methodology will be presented in Chapter Three.

1.10.1 Research approach and design

This study uses a qualitative research approach. Qualitative research can be defined as primarily non-numerical, social science research to interpret underlying meanings, opinions, and reasons (Korstjens & Moser, 2022). An exploratory, contextual design will be applied. Exploratory research designs facilitate research about a problem where there are few or no earlier studies to refer to or rely upon to predict an outcome, while contextual design is a structured, well-defined user-centred design process that provides methods to collect data in a structured way (Ntaro, Owokuhaisa, Isunju, Mulogo, & Ssempebwa, 2022). This study wants to explore and contextualise the experiences of CS in creating a caring praxis and their needs in education and training.

1.10.2 Research setting

The setting is a university in the Western Cape that offers a full qualification in nursing that leads to registration as a PN with the SANC. Two nursing programmes are currently offered at this university, namely the R425 and R174. The R425 programme grants the nursing student a

bachelor's degree in general nursing, community nursing, psychiatry and midwifery. The R425 programme is a four-year qualification and the expected outcome for the undergraduate nursing student is to have worked 4000 clinical hours. This programme is referred to as the legacy programme and is phasing out as a new curriculum is developed for undergraduate nurses. As of 2018 the R425 programme had its last intake, and it will phase out over the next four years. The new programme will be implemented in 2019. The R174 programme is the new curriculum being offered at this nursing school, and is a four-year programme that will qualify the nursing student in general nursing, which is primary health focused as well as midwifery, with 1830 clinical hours to be completed.

1.10.3 Research target population

The population in a research study refers to the entire group of people which meets the criteria that the researcher is interested in studying (Nieswiadomy & Bailey, 2018). The target population of this study will be the CS of the undergraduate nursing programme at a School of Nursing (SON) at a university in the Western Cape. The school has 40 CS, which includes 4 CS managers. Currently the CS provide clinical accompaniment and supervision across the two programmes being offered at the institution.

1.10.4 Research sample and sampling

Sampling is the selection of people from the target population, who meet the criteria that will enable the researcher to meet the requirements of their study (Nieswiadomy & Bailey, 2018). The researcher will make use of purposive sampling to select 10 to 12 participants or until data saturation is reached (Nieswiadomy & Bailey, 2018). This is a specific type of sampling that purposely relies on data collection from population members who are accessibly available to

participate in a study. It is a type of sampling where the first available primary data source will be used for the research without additional requirements.

1.10.4.1 Inclusion and exclusion criteria

Inclusion criteria are those characteristics that the participant has, that the researcher has identified as allowing them to be included in the study. Exclusion criteria are the opposite and indicate characteristics which disallow participation in the study (Nieswiadomy & Bailey, 2018). All supervisors who are currently employed at an SON at a university in the Western Cape will be included in the sample.

Exclusion criterion: this study will exclude CS who have less than one year of experience in the field of clinical supervision. This is to ensure that the selected supervisors have enough relevant experience to elaborate on.

1.10.5 Data collection

In-depth data will be collected through individual semi-structured interviews conducted by the researcher at a place convenient for the participants; during the COVID-19 pandemic a virtual platform was chosen to ensure the safety of both the researcher and participants (Boswell, Ashcraft, Long, Cannon, Divito-Thomas, & Delaney, 2020). A semi-structured interview is a qualitative method that combines a pre-determined set of open questions which provides the interviewer with the opportunity to explore themes or responses further (Ruslin, Mashuri, Rasak, Alhabayi, & Syam, 2022).

A semi-structured interview guide will be used. (Addendum C), consisting of five questions that were developed and derived from applying the theoretical framework of the study, which will be explained in Chapter Two. The researcher will audio-record the interviews, which will be transcribed verbatim. Qualitative research is adaptable in the sense that it provides the

researcher and the participant with the prospect of conducting an interview in a very natural environment that is quiet and conducive to clear recording for approximately 45–60 minutes.

1.10.6 Data analysis

This study will analyse the collected data according to Braun and Clarke's (2021) six phases of thematic analysis. Thematic analysis is a process that consists of identifying, analysing, and reporting qualitative data. The researcher engages with the transcribed data to attain a comprehensive understanding of the content. There are six phases that forms part of data analysis: step 1 – becoming familiar with the data and engaging with transcribed data; step 2 – creating meaningful codes; step 3 – creating the link between codes and emerging themes; step 4 – reviewing themes and creating a thematic map; step 5 – defining the themes; and step 6 – writing up the report (Sale, 2022). The software that will be used to facilitate the data analysis is ATLAS.ti version 2022 that facilitates analysis of qualitative data for qualitative research, quantitative research and mixed-methods research.

1.11 Paradigmatic perspectives

The paradigmatic perspective refers to *"... an essential belief system that guides the researcher, not only in their choices of a method but also ontologically and epistemologically in fundamental ways*." Guba and Lincoln (1994, p. 105). It was therefore regard as essential to address the paradigmatic perspective in this, due to scope and nature of this study.

1.11.1 Methodological assumptions

The methodological assumptions refer to the systematic way of gathering knowledge based on a particular research philosophy adhering to a prescribe set of believes about how knowledge is gathered and processed into a meaningful unit. Further a methodology can represent the interconnective relationship between the ontological and epistemological beliefs which will be

discussed in the subsequent paragraphs, but is more practical than the epistemology (Slevitch, 2011). This research follows a qualitative approach and is based on the subjective reality of the experiences of the clinical supervisors in terms of managing their daily performance of providing clinical supervision. Further qualitative research in its classic tradition involves collecting and analyzing non-numerical data (e.g., text, video, or audio) to understand concepts, opinions, or experiences. It can be used to gather in-depth insights into a problem or generate new ideas for research. It can therefore be concluded that the tradition applied to this study is based on constructivism and it promotes an inductive approach to translate reality.

1.11.2 Ontological assumptions

The ontological assumptions of this study refer to the examination of the reality of the clinical supervisors as they define or elaborate on the meaning of their daily interaction. It is therefore focussing on the reality as embedded into the experiences of the clinical supervisor. Slevitch (2011) corroborate this in her definition of ontology as the study of reality which positions to describe what entities exist or can be said to exist and also what relationships exists with the experiences of the clinical supervisor towards the maintenance of a caring praxis.

1.11.3 Epistemological assumptions

Epistemological assumptions are concerned with theory of knowledge and is concerned with the nature and scope of knowledge (Slevitch, 2011). This gives impetus to the development of the research questions and research objectives on page 8 of this chapter. In return this guided the researcher towards choosing a methodology that is fitting and relevant to the achieve the research objectives whilst providing answer to the research question.

1.12 Research ethics

The relevant research ethics will be adhered to throughout this current study. The proposal was submitted to the Humanities and Social Sciences Research Ethics Committee (HSSREC)

at the University of the Western Cape (UWC) for screening and clearance. This was followed by obtaining permission from the Registrar of the HEI. The head of department at the SON where the study was conducted, and the postgraduate coordinator provided the researcher with access to the information on the potential participants for recruitment into the study. Participation in the study was voluntary and consensual, and the ethical principles of anonymity and confidentiality were maintained throughout. A detailed discussion will be provided in Chapter Three.

1.13 Trustworthiness

Trustworthiness aims to ensure that the study reflects the truth of the phenomena at hand and that all the findings and information are reflective of the procedures followed in this study to ensure the truthfulness. In this study the following elements were ensured: credibility, confirmability, transferability, and dependability. A detailed discussion will be provided in Chapter Three.

1.14 Significance of the study

This study seeks to expand on the current body of knowledge to ensure that the praxis is maintained by ensuring quality nursing education. This study seeks to ensure that the educational needs of CS are developed in creating a caring praxis. To maintain the caring praxis, relevant and updated clinical skills need to be taught that are in line with practice guidelines.

1.15 Operational definitions

Praxis: "Is a coherent structure in a field of discipline that integrates guiding values, specific actions consistent within the social mission of the profession, knowledge construction,

community awareness, and the realization that within a profession lies the process of bringing about some human good" (Hagedorn, 2004, p. 12).

Clinical supervisor: Is a PN that is required to provide clinical teaching and support to nursing students in order to socialise them into the role of a PN. The CS who are employed are primarily responsible for clinical learning through skills development, by integrating theory with practical experiences, clinical accompaniment, and clinical supervision in healthcare facilities (SANC, 2014).

Clinical supervision: Clinical supervision is support provided for students and one of the standards set out by the SANC to ensure that praxis needs of clinical learning are scheduled and structured according to the learning needs of the student and outcomes required at the relevant level of training (SANC, 2013).

Caring praxis: Refers to the integration of theory, research, and practice as caring praxis is revealed in the everyday work and caring within nursing practice (Enzman Hines & Gaughan, 2017).

Undergraduate nursing programme: A four-year programme that provides support and training opportunities in the clinical setting to undergraduate nursing students (Hagedorn, 2004).

1.16 Outline of the study

The thesis consists of six chapters, which are briefly described below to orientate the reader.

Chapter One: In this chapter, the researcher orientates the reader by providing the relevant information for a general overview of the study. Additionally, this chapter contains a description of the research process followed in this thesis.

Chapter Two: This chapter consists of a literature review, in which the researcher considers the international as well as local contexts relating to creating a caring praxis in nursing education and training.

Chapter Three: In this chapter, the researcher discusses the qualitative research methodology that was employed in the study. It includes an overview of the research approach and design, the research setting, population, sampling method, data collection process, the pilot study, research ethics, and data analysis process, as well as the trustworthiness of the study.

Chapter Four: The researcher presents the results of the analysis of the data, which includes direct quotations from participants' transcripts which are used to describe the results and overall experiences of the CS in creating a caring praxis in nursing education and training.

Chapter Five: In this chapter, the researcher presents a refined analysis of the initial analysis, which is compared with international and national literature. The themes and categories are interrelated and discussed in detail.

Chapter Six: This chapter presents a summary of the findings and the limitations of the study, followed by recommendations based on the findings.

1.17 Summary

This chapter comprised an overview of the study to orientate the reader through providing an introduction and background to the study. The chapter also highlighted the key components of the research process, namely the problem statement, research question, aim of the study, objectives, methodology, significance of the study, and operational definitions, and it provides an outline of the study. The following chapter comprises the literature review and the guiding framework for the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter comprises a literature review, which is a systematic process used to retrieve information that provides an overview of the existing knowledge regarding the research topic of interest. The researcher searched sources such as Google Scholar, EBSCOhost search, and the UWC library, using the keywords caring praxis, nursing education, clinical training, experiences of clinical supervisors and higher educational institution to retrieve information from the available international and national publications. In this chapter, the researcher defines caring praxis within the context of HEIs and nursing education and training. In addition, the experiences of CS are explored in clinical teaching in the health facilities, along with all the guidelines and SANC regulations.

A preliminary review of the literature was conducted on educational strategies in nursing education to create a caring praxis in nursing. This review yielded the following strategies: clinical supervision for support and accompaniment of students that is employed by HEIs to create and maintain a caring praxis, the integration of clinical supervision as a teaching and learning activity, work-integrated learning (WIL), simulated learning, and skills laboratory methods. These are explored, and the review concludes with positive and negative experiences regarding the strategies identified.

2.2 Learning and teaching strategies to enhance a caring praxis

Learning that leads to conscious actions requires capturing the dialectic between theory and practice. WIL is related to the social sciences and the humanities and focuses on the relationship

between working life and learning, such as how knowledge and learning are constructed and understood through activities and relationships. WIL also integrates theoretical and practical knowledge and experiences (Dahlborg, 2022). Creating a learning process involves discovering what needs to be learned and incorporating this knowledge into a conscious learning process that results in more conscious actions (Dahlborg, 2022). To enable learning from both theoretical knowledge (episteme) and practical skills (poiesis), educators need a deliberate strategy that will facilitate a student's praxis. To use case methods is well suited to both individual and collective construction of knowledge or learning. Students' own experiences from their internships can be used to construct cases, an approach that adds authenticity to the learning. Narration and storytelling form the foundation of all learning and can lead to dialogue. Both narration and dialogue are important parts of the case method. In everyday life we construct ourselves by 'talking' about events and situations, making the unknown meaningful in a state of constant change (Dahlborg, 2022). Learning and teaching connects praxis to reflection or phronesis (practical understanding, sound judgement) a two-part construction directed at transformation, especially with respect to one's critical awareness of one's own condition enmeshed in power relations. Hence, because students have prior knowledge and beliefs about both health and human conditions, theoretical content should not be so abstract that it is incomprehensible. That is, nurse educators need to help students to use phronesis and link their own lifeworld, as learning always extends beyond the classroom (Dahlborg, 2022).

2.2.1 Clinical supervision for support and accompaniment

Clinical supervision as support for students is one of the standards set out by the SANC to ensure that praxis needs of clinical learning are scheduled and structured according to the learning needs and outcomes of students at the relevant level of training (SANC, 2013). It forms a compulsory and essential requirement in undergraduate nurse training, to socialize the undergraduate student nurses into the role of the PN. Clinical learning can be regarded as the

acquisition and achievement of clinical skills and competencies (Motsaanaka , Makhene, & Ally, 2020). Exposure to clinical practice in practice settings and the development of clinical skills prepare student nurses to become safe and independent PNs on graduation. SANC refers to this kind of learning as experiential learning, which therefore regards clinical placement as a learning and teaching activity.

2.2.2 Work-integrated learning

As a means of addressing concerns around student development and graduate attributes, there has been interest in fostering university learning that is less didactic and more situated, participative, and 'real world' oriented. This kind of learning is termed work-integrated learning or WIL. WIL is used as an umbrella term to describe curricular, pedagogic and assessment practices across a range of academic disciplines that integrate formal learning and workplace concerns (Council on Higher Education, 2011). The integration of theory and practice in student learning can occur through a range of WIL approaches, apart from formal or informal work placements (Council on Higher Education, 2011). By integrating theory and practice, WIL will have more substance, because it will prepare the undergraduate nursing student to integrate their knowledge into practice, thus creating a caring praxis.

2.2.3 Clinical supervision as teaching and learning activity

To facilitate this kind of learning, CS are entrusted with the responsibility to facilitate clinical learning and to accompany students, ensuring safe, competent practice (Pollock Campbell, Deery, Fleming, Rankin, Sloan, & Cheyne, 2017). CS are employed for their clinical expertise and understanding of specific clinical contexts; they are expected to understand experiential learning, and how it informs the undergraduate curriculum, and to be able to support the development of student nurses as they learn to apply theoretical concepts to the increasingly complex realm of patient care (Malouf & Campbell, 2014). This was corroborated in research

conducted by Magerman (2016) and Russell (2017), who indicated that CS should provide support and guidance to the undergraduate nursing student during clinical placement, and be able to provide effective supervised care to enable student nurses to acquire the essential knowledge, skills and attitudes required to practice in the profession.

Even though the CS is the expert on clinical teaching, they need to be upskilled and up to date with current practices, and they should be knowledgeable of the current guidelines that support clinical practice. However, as the literature attests, there is still a lack of updated skills among the CS (Magerman, 2016, Donough & van der Heever, 2018, Hoffman & Daniels, 2020).

2.2.4 Simulated learning methodology

Simulation methodology presents opportunities to reproduce both rare and frequent clinical events in a realistic manner as often as needed (Lavoie & Clarke, 2017). Jeffries, Glew, Karhani, McNally & Ramjan, (2021) defined simulated learning as activities that reflect the reality of the clinic environment and are designed to demonstrate procedures, appropriate organization of students in the simulation activity, decision making, and critical thinking through techniques such as role-playing.

2.2.5 Skills laboratory methodology

The skills laboratory methodology is used in the training of undergraduate nursing students to prepare them or give them an idea of the skill set they need to function in the clinical facilities. The clinical skill is demonstrated to the student once or twice; they can then carry out the skill themselves by guided practice with the CS. The CS uses this time to guide and assist the student to be able to physically do the skill that they need to for patient care in the facility. However, in a real-life situation the approach that is used to teach a skill in a skills laboratory does not necessary unfold in the way that it was taught. Is this method enough to create a caring praxis? Praxis in nursing education is a process which aligns to experiential learning, requiring the

student to take the knowledge of theory and merge that with practice by doing and perfecting skills development in clinical practice (Langhout, Kohfeldt, Chamberlain, Cruz, Rock, & Emmert, 2013).

2.3 Positive and negative experiences associated with clinical supervision

Both positive and negative experiences were reported with the use of clinical supervision. In a recent study by an HEI in Jordan, positive experiences included that clinical supervision is a vital component of nursing education that ensures the accomplishment of clinical course objectives (Mahasneh, Shoqirat, Al Hadid, Alja`lafreh, & Shosha, 2020). Clinical supervision influences the student nurses' professional development and socialization into the culture and reality of the nursing profession, including their choices of the area of specialization and preferences (Mahasneh et al., 2020). It was found in their study that supervision had an outcome of a positive nature (Mahasneh et al., 2020). Another research study that focused on the experiences of undergraduate nursing students regarding clinical supervision reported that differences exist among CS pertaining to the demonstration and assessment of clinical procedures (Donough & Van der Heever, 2018). Undergraduate nursing students stated that various supervisors demonstrated the same clinical procedures differently. These differences tend to negatively affect how well the student learns as well as performance in their final examination (Donough & Van der Heever, 2018).

2.4 Identifying a theoretical framework

A theoretical framework can be described as an abstract or logical structure of meaning that permits the researcher to conduct the study and provides a tangible support system to embed and link findings to scientific knowledge (Rocco, Plakhotnik, & Silberman, 2022). It further facilitates the dialogue between the literature and the study and provides the opportunity for objective interpretation in qualitative research (Van Graan & Williams, 2017).

The researcher explored the literature to identify concepts and models to be adopted as theoretical frameworks to organize the study. Firstly, Kolb's cycle of experiential learning was considered and explored. The experiential cycle focuses on four main concepts. The first concept refers to concrete experience; it speaks of doing or having their own experiences to learn from. From concrete experience it flows into the second concept, which is reflective observation. This concept focuses on reflective practice – how the learner reviews or reflects on their learning experience. Following this is the third concept, which is abstract conceptualization or how the learner draws conclusions from their learned experiences. Lastly, the active experimentation of learning focuses on planning or trying out what you have learned (Fromm, Radianti, Wehking, Stieglitz, Majchrzak, & vom Brocke, 2021). The researcher established that Kolb's experiential learning cycle does not meet the requirements of the proposed study as it lacks the depth needed to understand different dimensions of praxis in caring.

The model of practical skills performance was then considered, as it allows for understanding the complexities which exist within clinical skills development (Nielsen, Sommer, Larsen, Bjork, 2013). The model consists of five mutually dependent categories: substance and sequence, accuracy, fluency, integration, and the caring comportment that encapsules all the categories (Nielsen et al., 2013). To ensure quality in patient care, healthcare personnel must be qualified in practical procedure performance. Research indicates that newly qualified nurses experience the nursing demands as complex and overwhelming and require a higher level of competence in concrete situations and better knowledge about procedures they are expected to master (Gregersen, Hansen, Brynhildsen, Grondahl, & Leonardsen, 2021). This model would therefore provide a comprehensive approach to examine the phenomenon of praxis in nursing education and training, allowing the researcher to understand the dynamics involved with the

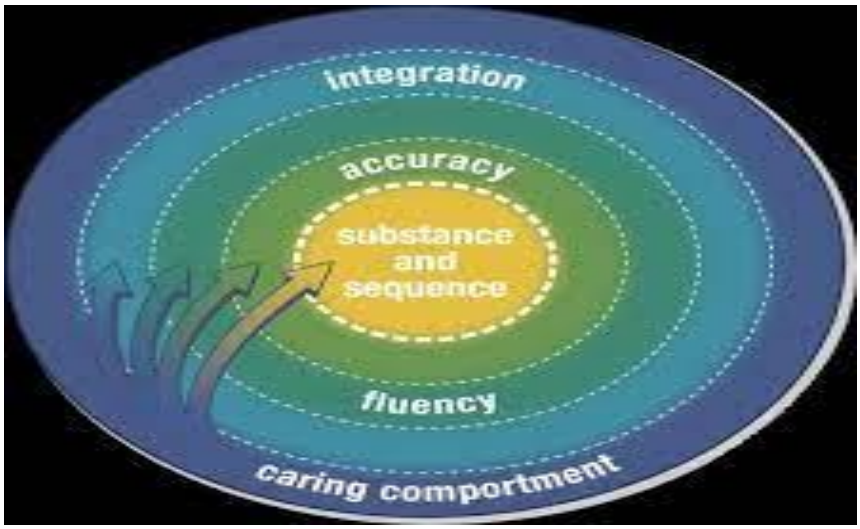
CS. This theoretical framework was therefore selected to illustrate the complex dimensions of a caring praxis as concepts to explore the following objectives:

1. To explore and describe the experiences of clinical supervisors regarding their ability to create a caring praxis in nursing education and training.

2. To identify what clinical supervisors need to create a caring praxis in nursing education and training.

The framework therefore relates to the essence of praxis required to socialize the student nurse into the caring role. The model of practical skill performance is therefore deemed appropriate to be used as a tool to guide the researcher to reach the objectives of this study and have a positive outcome.

Figure 2.1: Model of practical skills performance



2.5 Model of practical skills performance

The different categories of the model of practical skills performance are described and discussed below, in terms of how they fit with this study.

2.5.1 Caring comportment

Caring comportment means to create an atmosphere of caring and to uphold the client's dignity and a holistic patient-centred approach to conduct clinical supervision. Application of the caring comportment encapsulates all required steps or comportments (list steps) to ensure that a caring atmosphere is created during clinical supervision (Sommer, Larsen, Nielsen, Bjork, 2020). This caring comportment is applied in the current study by illustrating the caring values; for example, how the professional and ethical denominators influence patient interaction during clinical supervision while maintaining a caring praxis. During clinical teaching the CS should follow a holistic approach when engaging the patient during clinical teaching with the undergraduate nursing students in order to maintain the caring praxis throughout their teachings.

2.5.2 Integration

Integration refers to navigating the way to praxis through conscious application of educational modalities. Therefore, in this study a practical skill should be applied and adjusted to give a holistic approach to patient care. The holistic approach refers to the CS being able to integrate knowledge, skills, and a confident attitude that ensures that practices are aligned to the caring environment (Sommer et al., 2020). The application of this comportment to this study is clear as the researcher wants to know how the CS integrates knowledge, practice guidelines and research during clinical supervision. It gives attention to how CS adopt creative ways to develop clinical skills in students to enhance and facilitate praxis; therefore, students should be able to breech the gap between theory and practice.

2.5.3 Accuracy

In this study accuracy refers to developing skilfulness to achieve praxis standards, and it is important to ascertain the security of the patient and the nursing environment. In this step the

CS should be able to secure the safety of the client they used when working with the student during clinical supervision and accompaniment. This requires the CS to consider risks associated with providing care (Sommer et al., 2020). It is applied in this study when the researcher wants to determine how the CS manages risk associated with a practical skill during clinical supervision. In this study, to ensure that the caring praxis is maintained, the nursing students execute clinical procedures within their scope of practice, which is the framework provided by the SANC (SANC, 2014).

2.5.4 Substance and sequence

This refers to the nature and essence of skills development and it is the core aspect of all clinical skills. This details the process and structured guidelines available to be followed to contribute to a meaningful caring praxis. Also, this should adhere to policies available within practice (Sommer et al., 2020). This comportment speaks to the relationship between the CS and the nursing student. It is applied by determining how important substance and sequence is when the CS engages the nursing students. During clinical skills development CS teach relevant and up-to-date clinical skills, and the procedures they teach follow a step-by-step approach for the students to fully grasp the context.

2.5.5 Fluency

In this study fluency refers to the state of being mindful to contextual factors. CS ensure that practical skills should have a rhythm and a tempo and should be adjusted to the patient needs during clinical teaching. The patients' needs should be considered when creating a caring praxis. This means that the CS should be mindful of the condition that derives from the needs of the client (Sommer et al., 2020). In this study, the CS must have a process they follow to ensure that the client's needs are satisfied. The role of the PN and their attitude towards the

nursing students influences their training in the praxis. This is a factor that influences student learning that can hinder the caring praxis.

2.6 Summary

This chapter comprised a review of relevant literature to define a caring praxis and explore the experiences of CS in creating a caring praxis. In this chapter the researcher also examined the teaching strategies that are needed in clinical teaching during clinical supervision, and how they influence the caring praxis. Chapter Three includes an in-depth overview of the research methodology and the research design used in this current study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

In this chapter the researcher discusses the research methods used to conduct this current study. Firstly, an overview of the research approach and design is presented, followed by the research setting, population, sampling method, data collection method, the pilot study, research ethics, and data analysis, as well as the trustworthiness of this current study.

3.2 Research approach and design

A qualitative research approach was adopted to achieve the aim of this current study, which was to understand the experience of CS involved in creating a caring praxis in nursing education and training in the undergraduate nursing programme at an HEI in the Western Cape. Qualitative research is defined as a systematic process in which the researcher explores the experiences of the participants, to provide meaning as well as to generate a deeper understanding of their experiences (Brink, Back-Pettersson, & Sernert, 2012). An exploratory, contextual design was selected to examine the objectives of this current study.

3.2.1 Exploratory design

An exploratory design was considered to conduct the study due to its flexible nature, and it was used to gain an understanding of the experiences of the CS when creating a praxis during clinical learning (De Vos, De Hauw, & van der Heijden, 2011). This design was selected since literature on the topic of creating a praxis in clinical learning was scant, and therefore this study was primarily inductively approached to explore the areas of interest (Rendle, Abramson, Garrett, Halley, & Dohan, 2019).

3.2.2 Contextual design

Contextual designs are used to develop an understanding of the specific situation in which the participant operates (Grove, Burns, & Gray, 2012). In this study the context of the different areas where clinical learning occurred was considered important to understand the experiences of the CS when creating a caring praxis in nursing education and training. The context of the study varies from the clinical skills laboratory to the practical setting to achieve the objectives of the study.

3.3 Research setting

The research setting refers to the place where the research study is conducted. In qualitative research it is common practice to collect data in the real-world or rather naturalistic setting (Brink et al., 2012). This current study was conducted at a SON, located in the Faculty of Community Health Sciences at an HEI in the Western Cape. The SON is currently offering two undergraduate nursing programmes which are running concurrently:

- The R425 nursing programme is the legacy programme that is phasing out. This programme qualifies the nursing student in general nursing, midwifery, community nursing, and psychiatry. The remaining cohort of students is 120 students in their third year of the programme and 276 students in the fourth year, after which phasing out will be achieved.
- The new programme, which is in the implementation phase, is the R174. This programme is run over a four-year period and will qualify the nursing student for registration with the SANC in general nursing and midwifery. There is a total of 364 students across year levels one and two in the R174 programme.

3.4 Research population

The research population is defined as a group of people that embody the characteristics of the topic of interest (Brink et al., 2012). The study population of this study were the CS of the undergraduate nursing programme at a university in the Western Cape. The population consisted of 40 CS, which included 4 CS managers; thus 36 of the CS were responsible for clinical supervision.

3.5 Sampling and sample

A convenience sampling method was applied in this study. Convenience sampling is where participants are selected for inclusion because they are easy for the researcher to access (Jeong, Zhang, Morgan, ross, Osman, Baynton, & Brewer, 2019). Sampling refers to the actual selection of a representative group of individuals from the entire population, who embody the characteristics of the topic of interest which the researcher intends to study (Brink et al., 2012). Qualitative research may include from five to more than 50 participants (Speziale, Streubert, & Carpenter, 2011). However, in this study the researcher collected data until saturation was reached (Nieswiadomy & Bailey, 2018).

3.5.1 Sampling criteria

The sampling criteria refer to the characteristics that were considered crucial for participants in the study (Brink et al., 2012), which allow them to either be included in (inclusion criteria) or excluded (exclusion criteria) from the study.

The inclusion criteria were the characteristics that the potential participants were required to have in order to be included in the study:

- All CS who facilitate clinical supervision among undergraduate nursing students in the Bachelor of Nursing programme according to the R425 and R174.

The exclusion criterion in this study was CS with less than one year of experience in the field of clinical supervision. They were excluded, since they would not have enough relevant experience to garner research findings from.

3.6 Data collection

Data collection in qualitative research is a systematic process, essentially utilized to collect information from the participants in the study that answers the research question of the research topic under examination. The accuracy of the data collection method is of fundamental importance to reflect the true essence of the data (Tiedemann, Chamberlin, Kosmowski, Ayalew, Sida, & Hijmans, 2022). The quality of the data collection method should translate into credibility and justification of the research question of the study (Tiedemann et al., 2022).

3.6.1 Data collection method

Data was collected through in-depth, individual semi-structured interviews conducted at a place convenient to the participants. Due to the COVID-19 pandemic a virtual platform was chosen, to ensure the safety of both the researcher and the participants (Boswell et al., 2020). Permission was obtained to audio-record the interviews, and this was later used to transcribe the interviews verbatim. Qualitative research is adaptative since it provided the researcher and the participant with the opportunity to conduct the interview in a natural environment that is quiet and conducive to create a clear recording. The duration of each individual interview was approximately 45–60 minutes. The data was collected over a 12-week period between March 2022 and May 2022. Data analysis took place from June 2022 until August 2022. Data collection involves several choices which refer to the type of design that is used (Aguinis, Hill, & Bailey, 2021).

3.6.2 Data collection instrument

The data collection instrument used to achieve the objectives consisted of five interview questions that were developed based on the model of practical skills performance from the theoretical framework of this study (Sommer et al., 2020). In Chapter Two the framework was discussed in detail, and it entrenches five comportments that translate the following application and understanding within the context of this study (Appendix C):

- Comportment 1: This ***caring comportment*** was applied in this study by determining how the client's dignity is kept intact during clinical supervision while creating a caring praxis. The application of the caring comportment to this study is in that the researcher wants to know how the CS maintain the dignity of the patient during clinical engagement.
- Comportment 2: ***Integration*** was applied to this study by determining how the CS integrate their knowledge of theory into clinical teaching. The researcher wants to know how CS integrate knowledge, practice guidelines, and research during clinical supervision.
- Comportment 3: ***Accuracy*** was applied in this study, with the researcher wanting to determine how the CS manage risk associated with practical skills during clinical supervision. The researcher wants to know how the CS manages risk associated with practical skill performance.
- Comportment 4: ***Sequence and substance*** was applied to this study by determining how important these are when the CS engages the nursing students. The researcher wants to determine how important sequence and substance are during clinical engagement.
- Comportment 5: In terms of ***fluency,*** in this study the researcher wants to determine what process the CS follows to ensure that the needs of the patient are satisfied. The

CS needed to know how to ensure that the needs of the patient are satisfied during clinical engagement.

3.6.3 Data collection process

After obtaining ethical permission from UWC's HSSREC on 22 December 2021 (Appendix E), the data collection process was commenced. The researcher sent out email communication to invite various CS to recruit participants for the study. The email contained the information sheet (Appendix A) that was developed as part of the research proposal, with relevant information regarding this current study, such as what the study entails, the data collection method, as well as explanations of important ethical considerations. The researcher then followed up with an agreement to be signed by the participant, known as the informed consent form (Appendix B). The participants had to submit the completed informed consent form prior to the interviews being conducted. Due to COVID-19 this was done electronically via email. Termination of the interview was in agreement with the participant once they had no further comments or questions to offer (Naicker & Van Rensburg, 2018).

3.6.4 The pilot interview

The researcher conducted a pilot interview to examine the interview instrument and assess whether the interview questions were designed to examine the topic of interest. The pilot also facilitated the assessment of the design structure of each question and was to determine if the participant could respond, engage with and answer the questions (Appendix C). The pilot study also facilitated the timeframe needed to conduct and refine the interviewing skills of the researcher (Naicker & Van Rensburg, 2018).

3.7 Data analysis

This study analysed data according to Braun and Clarke's (2021) six steps of thematic analysis. Thematic analysis is a process that consists of identifying, analysing, and reporting qualitative data. The researcher engaged with the transcribed data to obtain a comprehensive understanding of the content.

The steps that facilitated the data analysed consist of becoming familiar with the data; engaging with transcribed data; generating and creating meaningful codes; searching for themes: creating a link between codes and emerging themes; reviewing themes and creating a thematic map; defining themes, which requires refinement of the themes; and writing up an interpretive report. Once the emerged themes were interpreted, the researcher can developed a rich and detailed report regarding the experiences of the CS who carry out clinical teaching in hospitals and clinics as part of the undergraduate nursing programme. These are further detailed below.

Step 1: Becoming familiar with the data. To enhance the credibility of the findings the pilot interview that were conducted using a semi-structured interview were not included in the data analysis process. In addition, field notes were used to record any non-verbal communication cues during the interviews. The researcher replayed the audio recordings of the interviews that were done, in order to understand the information that was given. This was welcomed as a positive step towards a deeper understanding of the data set (Lochmiller, 2021).

Step 2: Engaging with transcribed data. The researcher read with meaning in order to understand the data set and to reflect on the interview with the participant. The data was acquired from CS at an SON at a university in the Western Cape, and nine transcripts were engaged with. This format worked especially well in thematic analysis, as the structure of the conversation lends itself to more easily grouping ideas, concepts, or issues (Lochmiller, 2021).

Step 3: Generating codes. These step captures the following: creating meaningful codes, searching for themes, creating a link between codes and emerging themes. The researcher engaged with the data set and then generated codes through this process, in order to give meaning to what was transcribed. These structures also allows the researcher to compare responses across participant perspectives (Lochmiller, 2021). Creating meaningful codes is when there were engaged with the data several times to create understanding. Using the software ATLASti version 2022 the researcher grouped codes with the same meaning together. From the codes generated the researcher finds meaning within them that will lead up to the story that will unfold. An important consideration in the setup phase is whether to establish all of the codes before they are analysed (Lochmiller, 2021). In the search for themes, the researcher will use the framework of this study as a guide to create them. Thematic analysis does not assume that the analyst fully develops his or her coding scheme. In my own practice, I tend to make this decision based on the theoretical or conceptual assumptions that guide the study as well as the complexity of the dataset (Lochmiller, 2021). Creating a link between codes and emerging themes, the researcher will use the experiences of the participants and form codes through the identified themes and attach labels to them (Lochmiller, 2021).

Step 4: Reviewing themes (creating a thematic map). The researcher conducted repeated review of the participants' relations in the coded data and the entire dataset. This is done for the researcher to see if the themes have meaningful interpretations (Braun & Clarke, 2021). Creating a thematic map gives the researcher a clear reflection of the participants' desires and actions. It provides the reader with an image of how the story will unfold of the CS creating a caring praxis in nursing education and training.

Step 5: Defining themes required refinement of themes. Themes consisted of categories and codes were printed as a report, which was incorporated into a table format in Microsoft Word, which was reviewed by a supervisor, after which the researcher sought to refine and interpret

the provisional themes, categories, and codes into more identifiable themes, categories, and codes. Later, the assigned codes were reviewed and refined again, to identify any further similarities and patterns, to validate the existing categories and themes.

Step 6: Writing up the report. Once the themes, categories, and codes were clear, the researcher captured the findings and discussion through providing an account of the experiences of the CS in creating a caring praxis in nursing education and training. In terms of creating an interpretive report, once the researcher has written up the report the next step is to ensure that it contains the correct statements, gathered from the data, that provide the findings on CS creating a caring praxis in nursing education and training.

3.8 Research ethics

Academic research demands the consideration of ethical principles pertaining to the research endeavour that is undertaken. These ethical considerations should be maintained throughout the entire research process (Brink et al., 2012). The following ethical principles which were applied in this study are discussed; permission to conduct the study, respect for the person and informed consent, the right to freedom of choice and withdrawal, beneficence, data protection, justice, privacy and confidentiality, and protection of personal information.

The researcher only started to collect data once ethical clearance had been received, granting the researcher written permission to collect data. Once the institution had granted the researcher permission, the proposal was submitted to the HSSREC for ethical clearance and screening. This was followed by obtaining permission from the Registrar of the institution. The head of department at the SON and postgraduate coordinator provided the researcher with access to the required information of the potential participants in the study.

All participants were given a written consent form accompanied by a letter which explained what the research is all about and the inclusion criteria to participate in the study. The potential participants had the right to choose whether he/she would like to participate in the study or not (Boswell et al., 2020). All participants had the right to autonomy and the right to self-determination and could choose to participate or withdraw at any time without penalty (Boswell et al., 2020).

The researcher aimed to guarantee the well-being of participants by minimizing harm and discomfort throughout the study (Boswell et al., 2020). Should a participant experience any discomfort, the researcher will refer them for a debriefing session with a suitable professional.

The information collected from the participants will be kept confidential and stored in a secured location. Data will only be accessible to the researcher and those involved in the study (Naicker & Van Rensburg, 2018). According to the institution's policy, all data will be kept for at least five years after the results have been published (Naicker & Van Rensburg, 2018).

The participants will remain anonymous, and their information will be kept confidential. In addition, only the researcher will be able to link any information to the participant. All sensitive information will be protected to ensure that the identities of the participants are kept anonymous in the final report (Naicker & Van Rensburg, 2018).

In terms of the requirements of the Protection of Personal Information Act 4 of 2013 (POPIA), the respondents were informed that their personal information will be collected and processed: No personal information other than informed consent will be required to participate in this study. Your participation will be kept confidential during the study, and it will not be disclosed to any other person except the researchers of the study. No information will be shared with any person outside the university. Your participation will be anonymous, and the interview

transcript will be kept for a period of five (5) years by the institution. No information that is personal will be disclosed in the thesis or any publication.

3.9 Trustworthiness

Trustworthiness is the term used to ensure that a study reflects the truth regarding the phenomena at hand (Woo, 2017). The findings of this study are reported to be credible, confirmable, transferable, and dependable. The participants in this study were allowed to review the transcribed documents, to ensure that the data collected was a true and accurate reflection of their experiences, and not of the researcher's convictions.

Credibility refers to the truth and interpretation of the data (Woo, 2017). In this study the researcher followed the interview guidelines with every participant to ensure consistency. To enhance and confirm the credibility, a pilot study was conducted to determine if the questions on the interview guide were understandable and appropriate for the intent of this study. Dependability refers to the stability of the study over time, in order to demonstrate how the study was conducted; if it was to be repeated with the same participants in a similar context, it should generate the same findings (Woo, 2017). For this current study the researcher kept an audit trail of the research process to enhance the dependability of the study.

Confirmability can be defined as the objectivity of the data in the study (Woo, 2017). The field notes, audio recordings and a reflexive journal were kept, which enhances confirmability. Thus, the research process followed must reflect on the conclusions which emerged and not on the researcher's own perspective, biases and motivations.

Transferability refers to the generalizability of the data (Woo, 2017). Qualitative research cannot be generalized; however, it may be transferred to another setting by providing thick

descriptions of the participants, the context and the setting in which the research was conducted.

3.10 Summary

In this chapter the researcher provided a detailed overview of the research approach and design, research setting, population, sampling method, data collection, pilot study, data analysis, research ethics and trustworthiness of this current study. In summary, a qualitative explanatory, contextual design was employed. Chapter Four follows with the presentation of the findings.

CHAPTER FOUR

PRESENTATION OF THE FINDINGS

4.1 Outline

In this chapter the researcher presents the findings generated from nine individual semi-structured interviews that were conducted to understand the experiences of CS in creating a caring praxis in nursing education and training. These CS facilitate clinical teaching and learning in an undergraduate nursing programme. This chapter commences with a description of the demographic profile of the nine participants.

4.2 Participants' demographic information

Demographic information on the nine study participants is provided in Table 4.1. All of the participants included in this current study met the inclusion criteria. The researcher interviewed participants whose extent of working experience as a PN ranged from 8 years up to 42 years, some of whom had graduated with masters degrees and other only had postgraduate diploma in nursing education. The participants' current employment settings varied, with their experiences as CS ranging from 18 months to 13 years at an HEI in Cape Town in the Western Cape Province of South Africa

Table 4.1: Demographic characteristics of the participants

Participant	Extent of experience as a PN	Extent of experience as a CS	Nursing education qualification
P1	42 years	6 years	No
P2	5 years	5 years	Yes
P3	15 years	3 years	No
P4	25 years	13 years	Yes
P5	16 years	5 years	No

P6	8 years	8 years	Yes
P7	18 months	12 months	No
P8	7 years	7 years	No
P9	5 years	2 years	No

4.3 Presentation of themes and categories

The initial analysis of the data collected from the in-depth interviews using the interview guide questions (Appendix C) generated the 5 themes and 17 categories listed in Table 4.2.

Table 4.2: Final themes and categories that emerged from the data

No.	Theme	Category
1	Holistic client-centred approach to conduct clinical supervision	Interconnectedness, in all dimensions of care
		Communication as an instrument to negotiate between the care of the patient and the learning needs of students
		The ability to develop clinical judgement and clinical reasoning
		Application of ethical standards to maintain the caring relationships
2	Navigating the way to praxis through the conscious application of educationa modalities	The interconnectedness of theory and practice
		The creative ability to teach skill
		CS as a role model and educational instrument to enhance praxis in clinical learning
		Application of teaching and learning strategies to develop the ability to create and maintain a caring praxis
3	Precision and skilfulness to maintain praxis	Assessing and managing risk Adhere to scope of practice and SANC guidelines to ensure a safe and caring praxis

		Procedural versus non-procedural skill
4	Being mindful to Inhibitors of the praxis in the clinical learning environment	Patient-related aspects that interfere with praxis
		Complexities of a clinical supervisor
		Factors with the student that affect teaching and learning
		Attitude and behaviour of PNs towards the students' learning
		Aligning the training standard with practice requirement

4.4 Statement of findings

The semi-structured interviews with the CS revealed the five themes and 17 categories indicated in Table 4.2. The findings of this study are presented in terms of the themes and categories that were generated during the data analysis.

4.4.1 Theme 1: Holistic patient-centred approach to conduct clinical supervision

The findings signify that the CS needed to consider a holistic approach when engaging in clinical teaching with the undergraduate nursing students and to ensure that caring praxis is maintained. This theme has four categories: (1) Interconnectedness in all dimensions of care, (2) communication as a vehicle to negotiate between care of the patient and learning needs of students, (3) clinical judgement and clinical reasoning, and (4) application of ethical standards to maintain a caring relationship.

4.4.1.1 Category 1: Interconnectedness in all dimensions of care

Participants reported that it is important to determine the comfort of the patient during clinical supervision and accompaniment. One participant was of the opinion that before taking the vital

signs of hypertensive patients, the patient must be made comfortable and be calm, therefore creating a caring praxis:

> **P1:** *Somebody that comes in with pain and is hypertensive, now that vital signs may be different. Why would the vitals be different? Because the pain affects the vitals, you know. So, you need to get the patient to be comfortable in a calm position so that the vitals can stabilize.*

During clinical teaching it is advantageous for students and the CS that the patient's comfort and needs are met before engaging with the patient. In the opinion of one participant, it is essential to assess the needs of the patient first before clinical learning can take place. During clinical procedures requiring an immediate intervention the patient should be stabilized first, then their needs should be reassessed:

> **P7:** *So, the first thing that we need to know, we need to stabilize the patient first, once the patient is stable then we want to know who the patient is and what the need is.*

Further, when it comes to creating a caring praxis, it is important to create a caring the atmosphere to ensure that the student is conscious of the pathophysiology the client is presenting with, so that holistic care can be given:

> **P4:** *How do you care for a patient in labour? I`m wanting to know do they understand how a contraction works? What is the anatomy and physiology of the mother's uterus? What makes the contraction painful, so that they understand how to then do the skill; how to better care for the patient, because at the end that is what we want.*

While engaging the patient it is also important for the CS to be transparent with the student in all activities relating to patient care. This to also in order to act as a role model to students that this is part of the holistic care of the patient. It is a skill that is acquired when engaged with clinical supervision and accompaniment:

> **P4:** *I am very open with the students. I am open with them, and my mission is to make them empathic as possible when it comes to how you deal with a patient, any patient for that matter.*

4.4.1.2 Category 2: Communication as an instrument to negotiate between care of the patient and learning needs of students

To be able to create a caring atmosphere one should have mastered the skill of communication. Communication is not only the spoken word, it includes the way one holds oneself using body posture and interpersonal skills for effective communication. The intention is set in your approach to caring and interaction with the patient:

> **P8:** *One of the first things we do with the students, is to have sessions on communication skills. You must have that communication skills, it can be verbal or non-verbal.*

The participants are further of the opinion that communication can be used as a tool of reflection during clinical teaching. It is applied in a way where the student can articulate whether they are able to use skills confidently or reflect whether they still need some guidance:

> **P2:** *I always tell the students that with guided practice, that is your opportunity where you can get feedback on what you were doing wrong and where you can improve.*

P4 stated that communication is an important skill to have, not just for clinical skills development during clinical teaching and in clinical practice seeing to the needs of the patient, but as a functional part of the nursing profession when it comes to conflict management:

> **P4:** *If the student feels that they cannot confront the staff member about this for whatever reason, then I will go and speak to the staff member myself. So, I will go and find out their side of the story because sometimes, you know, there's his story and her story and then there's the truth in the middle.*

Good interpersonal skills should be instilled in the nursing students together with effective communication when sensitive issues regarding the patients are addressed. In creating a caring praxis, the CS should model this behaviour for their students:

> **P3:** *When you talk to the patient her privacy matters. When it comes to a college patient on how to take her medication when she is HIV positive.*

4.4.1.3 Category 3: Clinical judgement and clinical reasoning

Clinical confidence plays an important role when it comes to clinical teaching. The CS should prepare themselves theoretically and practically before they can teach a particular skill. To be clinically confident is to transfer the information in chronological order:

> **P6:** *We need to also have a copy of the module guide. We must also go onto Ikamva to check what has been put on the Ikamva so that we are in line with what the objectives are for the students. Preparation before you go to the students in placement.*

Teaching clinical skills with confidence also stimulates the students to become critical thinkers when engaging their patient in placement while performing a particular skill. The participants articulate that when engaging the student during a skill, when an emergency occurs, they must know how to complete the skill safely rather than in the way it was demonstrated:

> **P6:** *Just because they did it the other way. It's not that they forget, they'll know it is not the right way to do it, or that they didn't follow the correct steps. They will always refer to oh, but we know that we must, it should be done like this.*

When the students are exposed to specialized fields in their nursing training, they are expected to think critically about how they can safely execute their skills without disturbing the caring praxis. Therefore, the CS should be skilled in transferring knowledge taking into consideration the realities in practice. This will stimulate the clinical reasoning and judgement of students.

> **P4:** *So, then I will show them how they can do it as sterile as possible under the circumstances. I want to make them aware that we are not just teaching you the ideal way, because you're not going to work in an ideal situation where everything is available and at your fingertips. You're not going to be always working in facilities like that. I want to teach you how to do your best under difficult circumstances.*

4.4.1.4 Category 4: Application of ethical standards to maintain a caring relationship

For the CS one of the greatest contributing factors in creating a caring praxis is integrating ethical principles into clinical teaching. The CS must be conscious of how they transfer information to the students, so that students are aware of the ethical principles they should adhere to when engaging the patient. Caring for another human being embodies the consciousness of how to interact and how to apply the ethical principles. Prior to starting any form of physical contact during the engagement with the patient, consent is important. Skills development starts with gaining consent from the patient, as one participant reported:

> **P3:** *The students know that when they see me as the CS managing the patient, we must explain the procedure to the patient and the patient must give consent.*

Another participant is of the opinion that the patient has the right to informed consent. The patient has the right to know about the treatment they will receive:

> **P9:** *The patient has the right to informed consent, you know, the patient has the right to know about their treatment, and they also need to give consent to the treatment.*

Also, the participants alluded to other ethical principles, like privacy, respect, and non-maleficence:

> **P5:** *If you're busy with the breast only expose the breast and then cover other parts, but always ensure her privacy, always ask permission, especially the males, when you are with a female patient.*

The participant reported that they teach the students that the PNs have rights, but the rights of the patient are equally valued when it comes to their health. It is important to involve the patient with their health care and to respect them and their views:

> **P9:** *We need to know as much as we as PNs have rights, the patient also has rights. They have the right to knowing, to be involved in their health care. They have rights, you know, and they also need to be respected as well.*

The most important aspect that is learned in the medical profession is to do no harm to your patient. The same applies within the nursing profession: the nursing student must have an innate sense of care towards their patient. One participant expressed that different facilities have their own core values that are used as guidelines to how patients must be treated. There are national standard guidelines that all health professionals should follow in terms of ethical considerations towards their patients:

> **P7:** *I will do it in the skills lab, depending on what kind of procedure we're doing. If the skill is not going to harm the patient, like abdominal examination, then I can guide them on a real patient. If it is suturing, then I need to make sure they know how to handle the needle and forceps and practice before they can do it on a real patient.*

As a professional, one strives to enhance social justice and embed it in the praxis of the profession. Without the social element or the human factor, it is impossible to act in an acceptable manner and to facilitate caring during clinical teaching:

> **P8:** *I also just refer them to the professional practice and what they were taught there. I must remind them this is how you're supposed to behave.*

4.4.2 Theme 2: Navigating the way to praxis through conscious application of educational modalities

There are five categories related to theme two: (1) interconnectedness of theory and practice, (2) the creative ability to teach skills, (3) CS as a role model and educational instrument to enhance praxis in clinical practice, (4) different dimensions in teaching and learning to achieve praxis, and (5) teaching and learning strategies to develop the ability to create and maintain a caring praxis. The findings signify that the CS needed to navigate through theory and practice to ensure holistic care for the patient when engaging in clinical teaching with the undergraduate

nursing students. They are required to integrate knowledge, skills, and their confident attitudes to ensure that a caring praxis is maintained.

4.4.2.1 Category 1: Interconnectedness of theory and practice

When teaching and learning any skill – but more so in the case of clinical skills for nursing students – the CS must have the ability to breech the gap between theory and practice. The clinical skill takes on life when the theory is incorporated during skills development. Theory and clinical practice cannot be seen as individual topics in clinical learning. CS should build onto the theoretical foundation for the student to fully understand the whole picture:

> **P2:** *So sometimes you see the lack or you see that the student doesn't have the background knowledge, by integrating my skills and knowledge, I would fill the gap by adding a little extra just to give them the whole broad scene of the skill.*

It is important for the CS to complete the picture for the student. They must be able to comprehend fully when theory and a practice were integrated. By applying the steps of closing the theory and practice gap, the student learns how to care for their patient holistically:

> **P7:** *I think it can help them because they need to integrate a tool like the theory and practical as well, and then they see everything will make sense.*

> **P6:** *If I am teaching homeostasis, for example, I will make my own notes, and explain this is what homeostasis is and this is what's happening in the body.*

To integrate theory and practice the CS should build onto the foundation that was laid. It is always a good teaching approach to start off with the basics and then use a scaffolding approach as the learning unfolds. When teaching is discipline-specific, the CS focuses on the terminology involving the skills that are being taught.

> **P8:** *For me, to make it easy for the students in our level, we must make sure the student understands. I always start with terminology if I am going to introduce a topic, to make sure they understand.*

4.4.2.2 Category 2: Creative ability to teach a skill

During the COVID-19 pandemic when the world was in lockdown, teaching clinical skills had to take place online, because clinical practice was a restricted area for students. It was challenging for the CS to demonstrate skills and do clinical teaching. They had to become creative and do some research on how to integrate theory and practice. Some CS resorted to visual aids of all forms to assist here. The participants revealed that they used audio-visuals as a reflection tool for students who had some learning barriers.

CS had to facilitate their teaching by using videos and presentations which the students could refer to when they prepared to study. This material was made available to the students, and they could access it as many times as they liked:

> **P4:** *We are moving toward using other media like video and presentations that the students can refer to, so that they have more opportunity other than the placement to practise.*

One participant said that they also had to rely on videos from internet sites to prepare themselves to be able to teach online. They did not have access to their skills laboratory and relied on other methods in preparing to teach online. This method evidently could alter the praxis from the norm:

> **P7:** *I use internet as well, especially YouTube. YouTube helps me a lot with certain procedures, because they also upload features that explain how to examine material that needs to be examined.*

The creative ability between CS differs considerably, according to their experience and how they can integrate their knowledge. One participant was quite innovative in teaching the clinical skills and finding ways to share and demonstrate:

> **P1:** *I use a lot of mu own props, which I made. I even resorted to using hand puppets with latching, to show how the procedure is done. Sometimes using a different type of prop makes it easier for them to understand.*

4.4.2.3 Category 3: Clinical supervisors as a role model and instrument to enhance praxis in clinical learning

To ensure that the praxis is maintained throughout clinical teaching and learning, the CS rely on their own previous clinical experiences and integrate them during clinical teaching. Besides their clinical experience, they also acknowledge their rich knowledge and ideas on how to teach clinical skills:

> **P4:** *I am a clinical educator, that teaches from experience, so I will always interject my learning by teaching the students with stories with experience.*

Another participant is of the same opinion that teaching from experience makes it easy for the student to understand:

> **P7:** *Things I will explain to them based on my experience, so that the student will have a very clear understanding of what I am talking about.*

Another contributing factor to strengthen the praxis is the development of the need to learn of the CS themselves. What skills do they need to ensure that they create a caring praxis in clinical teaching and learning? Who is responsible for their development and support?

> **P6:** *So from an employee point of view, I don't think the employer is doing enough in keeping us updated with the latest. I spend money out of my own pocket to keep myself updated, which shouldn't be the case, because if we are a teaching institution, it`s the employer's responsibility to keep their staff upskilled.*

> **P1:** *I would link up with the training department of the city and find out what training is available in the vac* [vacation]. *We wouldn't take leave. If it was something related to primary health or child health or something different in the schedule, we would go for the sessions. I can assure you, it makes a big difference, because when the students go out, they would see it in the way the person who has been updated is training them.*

One participant expressed that there were times that training was offered to those CS who needed to know what is current in practice in order to teach the relevant skills to the students. They confirmed that the CS themselves had to link up with a training department and go for updated training courses during their vacation.

4.4.2.4 Category 4: Application of teaching and learning strategies to develop the ability to create and maintain a caring praxis

Through their teaching and learning strategy, the CS must develop not only the cognitive ability but also the affective and the psychomotor ability of the student, in order to strengthen the student's ability to care for their patient holistically. During skills development the CS stimulate all of the senses of the student, to be able to transfer knowledge and skills:

> **P5:** *Remember, as a midwife, your hands are your eyes. When you send an image to the student, they can visualize while they are with the mother.*

There are times during skills development in clinical teaching that the CS must be creative to teach the student to be flexible, since the skills or procedures might be slightly adjusted in the real-life setting. One participant is of the opinion that the students feel that it is better to practise their skill on a real-life patient rather than in simulation:

> **P4:** *Some students will say it is useful, some students will want to know why I am I doing it on a model, I am already doing it in the facility.*

Reality brings more opportunity for development of skill. The student is faced with a patient who can respond and who has feelings, rather than the mannequin in the simulation laboratory. The reality can refine the skills more when practiced.

> **P2:** *With a real-life patient you can continue with your skills that have been practiced.*

There are many teachings and learning opportunities in the clinical facilities. Evidence has proven that students are able to apply their acquired skills appropriately. In the facility the CS identifies opportunities to teach each student individually as the need arises.

> **P5:** *Practical-wise, when I go to the clinical placement, I would do one-on-one training. One-on-one meaning one student, so then I will give ample time to that student if there is maybe something that the student does not understand about a clinical skill. I am only giving attention to that student.*

Teaching moments in the clinical setting also refer to teaching that is specific to both the needs of the student and the patient. The CS must have the skill to teach at the bedside of the patient, promoting a holistic approach while creating a caring praxis:

> **P6:** *I also do bedside teaching at the hospital for the students. It is teaching potentially in a new hospital or clinic, and I will ask the staff`s permission and then I will teach them there.*

One participant's view is that they gather the group of students after their session and just ask questions on the spot to gauge whether learning took place:

> **P4:** *On the spot, I use questions and answers. So, I will in a group which is most of the time working in a group. I will ask questions pertaining to the skill that is applicable.*

4.4.3 Theme 3: Precision and skilfulness to maintain praxis

There are two categories related to theme three: (1) student participation and involvement to minimize the risk by adhering to regulatory guidelines in praxis, and (2) adhering to scope of practice guidelines to maintain praxis. The findings indicate that the CS should be able to ensure the safety of the patient when they are working with students during clinical supervision. They are obligated to consider the risk associated with offering care. The CS should ensure that the

procedures are executed effectively to maintain the caring praxis, and that they adhere to the scope of practice in order to minimize risk.

4.4.3.1 Category 1: Students' participation and involvement to minimize risk by adhering to regulatory guidelines in praxis

When involving patients during on-the-spot clinical teaching during supervision, the CS must make it clear that the student needs to adhere to the safety principles during the application of skills. The student should follow protocol, especially when it comes to invasive procedures:

> **P3:** *Let me say there's five students, all of them cannot do a PV* [per vaginal examination] *at the same time, we want to prevent and reduce the risk of infection ...*

When students are engaging patients to do procedures, the CS or PN should be present. Students are not allowed to do procedures unsupervised, whether they are with the CS or not. The PN in the facility has the responsibility to be present when students are engaging the patient. The reason for this is to identify and manage any risk that could be harmful for the patient and the student. When a risk is identified, the CS should intervene and act as an advocate for both student and patient:

> **P8:** *I intervene, I request the student to stop. The moment you allow the student to continue, I know it is not going to be a pleasant assessment, because there must be something wrong.*

To manage the risk during a procedure, the CS must ensure that the student follows all of the necessary steps. They must also create awareness around how easy it could be to make a mistake that could hold them accountable for their actions. Encouraging good work etiquette and practice diminishes the risk of making mistakes:

> **P4:** *Let them know that they are still learning, you know, mistakes can happen. We try to avoid mistakes, that's why it is important that we practice, that's why it's important that we have the knowledge.*

While managing the risk and being aware of the student's ability to do certain procedures while engaging the patient, the CS and the student should also be aware of the regulatory guidelines

that govern the praxis. The regulatory body has strict rules about procedures and who are permitted to do them:

> **P1:** *If the patient is put at risk, the reports and disciplinaries are reported to SANC.*

The scope of practice is not only there to protect the patient, but also to protect the PN and students in practice. Certain procedures are not permitted and cannot be executed by the nurses or students, even if they feel confident in doing it:

> **P1:** *If it was a medical student, it is a different thing. As a nursing student you are not allowed to carry out that specific procedure.*

4.4.3.2 Category 2: Adhering to scope of practice guidelines to maintain praxis

While managing the risk and being aware of the student's ability to do certain procedures while engaging the patient, the clinical supervisor and the student should also be aware of the regulating guidelines that governs the praxis. The regulatory body has strict rules about procedures and who are permitted to do them. Malpractice that influences the praxis are reported to the South African Nursing Council and the repercussion are great.

> ***P1:*** *If the patient is put at risk, the reports and disciplinaries are reported to SANC.*

From a mental health point of view the participant conveys that the South African Nursing Council holds liable for our acts and omissions. The acts are there as a guideline to keep the patient safe and free from harm.

> ***P9:*** *It`s important because when the Sout African Nursing Council holds us liable. We have Acts in place that keep us liable to ensure that we follow protocol and legislations.*

The scope of Practice is not only there to protect the patient, but also to protect the registered nurse and students in practice. Certain procedures are not permitted and cannot be executed by the nurses or students even if they feel confident in doing it.

> ***P1:*** *If it was a medical student, it is a different thing. As a nursing student you are not allowed to carry out that specific procedures.*

4.4.4.2 Category 3: Procedural versus non-procedural

Sequence is an important part of the procedure during skills development. Ensuring that all steps are covered during a procedure improves the praxis. Students need to apply their critical thinking skills during a procedure when there is an emergency. They must ensure that all the steps are covered while managing the patient. A participant articulated this as follows:

> **P6:** *You can easily have a crisis in the middle of a procedure, and you're not able to, for example, complete. If you look at wound care, the wound starts to bleed, you can't carry on and clean the wound, you need to stop the bleeding.*

It is evident that the CS know that the procedure must follow a sequence and that the skills that are demonstrated in that order.

> **P2:** *It is very important, because you need to start with your basic steps in order to get the whole picture of a procedure.*

One participant articulated that following a sequence during a procedure gives structure to how things are done. They expressed that if the students don`t follow a sequence, they will only end up confused:

> **P9:** *It is definitely important. If you are not following a step-by-step approach, it could lead you all over the place, which could result in the student ending up being confused at the end the day.*

When teaching students skills during their clinical training, the CS should also teach them how to apply those skills during an emergency. In real life things don't necessarily follow a set sequence, but the knowledge should be applied to create a caring praxis:

> **P4:** *If we do a vaginal examination in the skills lab, I will tell them that it doesn't always happen from step A-G. Sometimes you must do G before A, you put your fingers in and the head is there, and that is the end of your vaginal examination.*

In an emergency it is important to assess what the situation is regarding the patient and start with the important step first. P7 indicated that the student should know the difference between real life and simulation when the patient finds themselves in an emergency:

> **P7:** *If we teach the student how to manage PPH* [postpartum haemorrhage], *we know it is an emergency. There is no time to identify the patient, no time to check the environment when we say PPH. It is because we know the patient can lose consciousness, we need to manage the patient as soon as possible.*

There are also non-procedural skills that the student is shown, for example, how to manage the patient when you engage with them. Not all procedures involve physical contact; the patient could just need some guidance or health education regarding their wellness:

> **P6:** *You know, I always say that just serves as a guide. Every patient is different, if you do what you need to do without causing harm to the patient.*

P1 also expressed that a procedure like history taking is not a physical procedure, and they make use of a simulated patient to demonstrate that skill:

> **P1:** *We have the sim dolls and the sim patients who assist us, especially when there is history taking and we need someone who actually is able to communicate.*

4.4.5 Theme 4: Being mindful of inhibitors of the praxis in the clinical learning environment

There are five categories related to theme 5: (1) during clinical teaching the CS must consider the patient-related aspects that interfere with praxis, (2) they should be mindful of the complexities of a CS, (3) factors with the student that affect teaching and learning, (4) attitudes and behaviours of PNs towards student learning, and (5) the safe space within the boundaries of the skills lab.

4.4.5.1 Category 1: Patient-related aspects that interfere with praxis

It is important during engagement with the patient that all of their needs are assessed to create a caring praxis, ensuring that the patient is satisfied with the care that has been provided:

> **P3:** *The other thing is to make sure that my patient is satisfied and give the patient feedback.*

During a procedure it is important to make sure that the needs of the patient are met and that their condition is attended to. If the patient is not cooperating, one has to determine what could be the cause of it. The patient's history is very important:

> **P4:** *Maybe you should take a step back and think about why is the patient not cooperating? Is she maybe a victim of sexual abuse? Has she been raped? You know, think about it.*

There are barriers that could possibly interfere with the patient's nursing care and with the caring praxis. According to one participant, it is rather difficult for the patient when language is a barrier. The language barrier is not only a problem for the patient, but also for the student:

> **P8:** *I find it so difficult to translate to some of my patients, some patients cannot understand because of the accent. You know, students come from across Africa, so now the accent is difficult.*

4.4.5.2 Category 2: Complexities of a clinical supervisor

The CS plays a pivotal role in creating a caring praxis. Their engagement with the student and the patient has an impact on how the praxis unfolds. The CS's attitude toward the praxis could be motivating or discouraging to the students they teach. Their support and encouragement ultimately prepare the student for the profession and the practitioners they will become:

> **P9:** *That is basically where we guide and help and develop the student in the practical field. That is why we follow up with the student, to be with them and to teach and guide them when they are physically busy with the patient.*

One participant also felt that the students are challenged when they work with difficult staff, and that can have implications for the caring praxis. Therefore, their support of the student makes this manageable for them:

> **P4:** *I find myself sometimes having to teach them how to work around difficult staff in difficult circumstances so they can be better practitioners. It is not always easy for them.*

According to one participant they also identify students that need that extra support during skills development. The CS encourages such students to put in the extra work and is there to support them:

> **P2:** *To assist the student I would focus more on that student, take a student or practice with the student under guidance.*

4.4.5.3 Category 3: Factors with the student that affect student teaching and learning

Students face lots of challenges regarding their learning, and they are not always brave enough to speak up or to reach out for help. When they are in the clinical facilities and they identify with the issues that they must attend to, they become less interactive and miss out on learning opportunities:

> **P9:** *In some cases it does impact their learning because they tend to not want to be there in the clinical setting. They are not so interactive as the other students in certain activities.*

Students encounter mental health issues during their training since they identify with various diagnoses. One participant is of the opinion that they encourage students to reach out for help so that they can be referred to the correct people for assistance:

> **P4:** *I try to encourage them in that way, for them to open and to voice their concerns, their fears and their anxiety. I want to create a safe environment where they feel free to do so.*

When students face adversity in their learning, they must be mature enough to admit they require some guidance. It is their responsibility to reach out and attend extra classes or group sessions. One participant verbalized that they could give of their time to help and assist, but if the student does not make an effort, it will all be in vain:

> **P6:** *I can offer her my own time and tell her I'm going to teach you this. I will take you on your own to explain or demonstrate the procedure. I feel the student as much as the CS are responsible to ensure the student is sorted.*

4.4.5.4 Category 4: Attitude and behaviour of PNs towards student learning

The role of the CS as an educator is vitally important for the student during clinical teaching and development. P9 is of the opinion that the educational role of the CS is contributing to the caring praxis:

> **P9:** *Clinical supervisor, I believe your role is quite important, and the role is to know you can contribute to the development of the student. You support your student then you also guide them and show them the correct manner of doing things. When the students are out there as registered professional nurses, the foundation was laid, and it contributes to quality nursing care.*

The role of the CS plays a part in practice implications, and even more so does the role of the PN. If the PN does not act in the capacity of an educator, the student cannot practice their skills, and this has negative implications for the praxis. During assessment or procedures, it is the PN who will identify an appropriate patient for the student to use:

> **P7:** *Sometimes they need to consult the professional nurses that they are working with in the ward, if it is safe to do a skill on a particular patient.*

Likewise, one participant stated that when the student is in the facility, the CS should see where the gap is between what is being taught in the skills lab and what occurs in practice:

> **P1:** *When we get to the placement, we also need to be able to see immediately where the gap is now between what is that skill and what we teach them. So that we can point that out to the student.*

The COVID-19 pandemic also had an impact on practice, since during this time there was no updated training for the CS for their skills development:

> **P6:** *It hasn't been done in the past two years now because of COVID-19, but we are getting back into it.*

Another factor that impacts the praxis is the outdated equipment in the skills lab versus the modern equipment that is used in practice:

> **P1:** *The other area which they have been exposed to is that we may still be using some manual equipment, where in placement they have electronic equipment. We noticed there is a difference in our emergency trolleys than the ones in placement. They are differently packed and have more equipment on their trolleys than we have in our skills lab.*

4.4.5.5 Category 5: The safe space within the boundaries of the skills lab

Simulation is an important tool in the development of skills. It stimulates all of the senses that one uses to form a picture. The skills lab has some equipment to make the clinical teaching experience real for the student:

> **P4:** *We have birthing models in our skills lab. We have a few models that they can use to practice on, even though it's limited because they can't use them in self-directed learning, so they can't use it on their own. We also have models that are not mechanized that they can practice on, it is safe, and it won't break.*

Simulation is a better tool to use in the skills lab rather than the actual practice. During simulation the CS can explain, pause and demonstrate, which they are not able to do in practice:

> **P7:** *I think it's much easier because sometimes when we're in the skills lab you have enough time to explain. When you are at hospital or the clinical setting, the patients, they are very much impatient most of the time.*

4.4 Summary

In this chapter the findings of the data analysis were presented. The findings were discussed under the five themes and 17 categories outlined in Table 4.2. It is evident that the participants identified that there are factors that influence the caring praxis, and that their knowledge, skills, and experience need to be aligned with the practice. The results also revealed that the CS have different roles to perform in their clinical teaching. Chapter Five will address the discussion pertaining to the findings described in Chapter Four.

CHAPTER FIVE
DISCUSSION OF THE FINDINGS

5.1 Outline

The researcher presents a discussion of the results of this study in this chapter, based on the available evidence in the existing literature. The objective of the research study was to explore the experiences of CS regarding their ability to create a caring praxis during clinical supervision, and to identify the needs of CS in order to ensure a caring praxis in nursing education and training. The findings of this current study were derived from the model of practical skill performance that was outlined in Chapter Two as the theoretical framework guiding this study. In this chapter the findings are discussed according to the framework and the themes that were generated during the data analysis (Table 5.1).

Table 5.1: Articulation of the theoretical framework and themes

Framework	Theme
Caring comportment	Holistic patient-centred approach to conduct clinical supervision
Integration	Navigating the way to praxis through conscious application of educational modalities
Accuracy & Substance and sequence	Precision and skilfulness to maintain praxis
Fluency	Being mindful of inhibitors of the praxis in the clinical learning environment

5.2 Overview of the main themes

Five themes emerged from the data analysis, as captured in Figure 5.1. These themes are derived from and based on the theoretical framework that was adopted in the study. The themes are therefore connected and interwoven in five comportments, as reflected in Figure 5.1, which shows that the comportments are interrelated and spontaneously connect with each other.

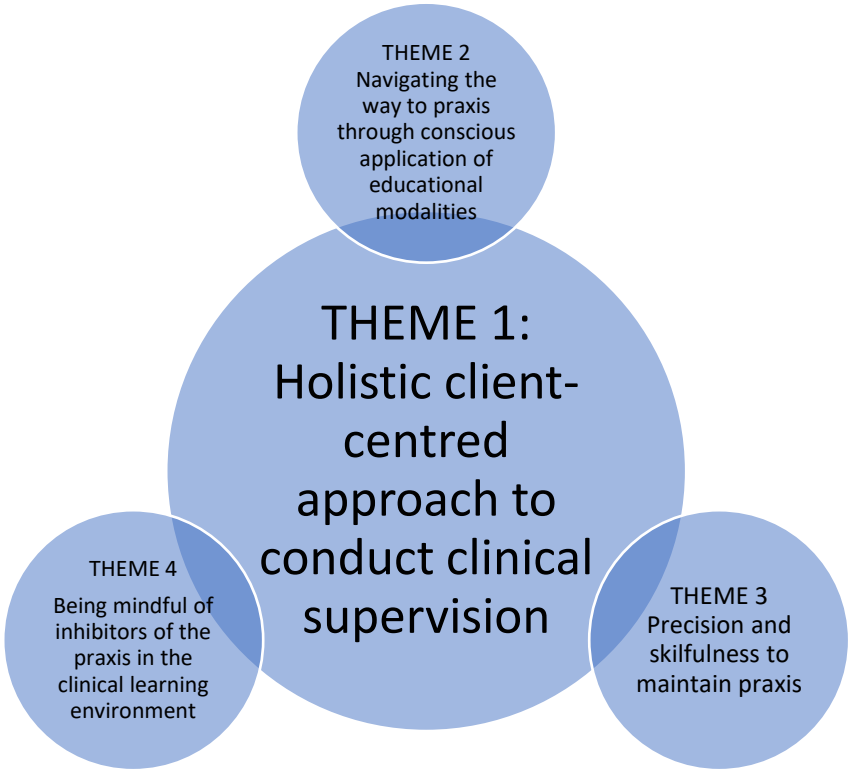


Figure 5.1 Relationship between the comportments or themes

5.2.1 Theme 1: Holistic patient-centred approach to conduct clinical supervision

To create a caring praxis, the CS needed to consider a holistic approach when engaging in clinical teaching with the undergraduate nursing students and ensure that a caring praxis is maintained. The patient's dignity should be kept intact throughout the process and the human factor should always be considered. The caring praxis encapsulates all of the other factors collected in the data set of this study.

5.2.2 Theme 2: Navigating the way to praxis through conscious application of educational modalities

The findings indicate that the CS needed to implement steps to care for the patient holistically when engaging in clinical teaching with the undergraduate nursing students. However, they are required to integrate knowledge, skills, and their confident attitudes to ensure that a caring

praxis is maintained. To teach clinical skills requires the CS to have profound knowledge that is transferable to the students.

5.2.3 Theme 3: Precision and skilfulness to maintain praxis

The CS should be able to ensure the safety of the patient when they are working with the students during clinical supervision. They are obligated to consider the risk associated with offering care. CS must ensure that the caring praxis is maintained throughout the engagement with the patient. Students need guidance to lower the risk while engaging with the patient. CS should ensure that the procedures are executed effectively to maintain the caring praxis, and they should adhere to the scope of practice to minimize risk. The findings indicate that the CS should be able to follow and adhere to the guidelines available to them when engaging in clinical teaching. They should adhere to the policies that are available within the practice to contribute to a meaningful caring praxis. Following the guidelines and policies ensures that a caring praxis is maintained throughout clinical teaching and learning. It forms a boundary that creates a safe space for the student to practice.

5.2.5 Theme 4: Being mindful of inhibitors of the praxis in the clinical learning environment

The findings indicate that during clinical teaching the CS must consider the patient's needs when they are creating a caring praxis. They should be mindful of the condition that arises from the patient's needs; the patient's condition will determine whether the student will be able to complete procedures and give care to them. The role of the CS in ensuring that the student is ready for the praxis is important, as they shape and mould the students. The students' social and personal health has an impact on how they learn, and that could affect the praxis.

Discussion

5.3 Theme 1: Holistic patient-centred approach to conduct clinical supervision

To create a caring praxis, the CS should uphold a caring atmosphere when engaging the patient and ensure that the caring environment is enhanced. They should have a holistic approach to ensure that the caring praxis is maintained. The dignity of the patient should always be kept intact, and the patient must not be harmed. To ensure that the caring praxis is maintained, the CS must be a skilled and knowledgeable nurse educator. According to Rafii, Nasrabadi, & Tehrani, (2022), caring is the primary goal of nursing practice, which is to centralize nurses' thoughts and behaviours to value others and to help them.

The findings of this study show that the CS should address the patient's comfort during engagement, and they should be articulate with good communication skills. Clinical confidence is needed to teach the students different clinical skills, and while doing that they should be ethical and professional. All of these steps should be embedded while creating a caring praxis. Praxis refers to practical human behaviour that can be artistic, ethical, or political, but its central meaning is the application of knowledge in practice (Rafii et al., 2022).

5.3.1 Category 1: Interconnectedness in all dimensions of care

CS have a responsibility to ensure that their students know how to perform a needs assessment of their patients, regardless their age or the reason for seeking medical care. One quotation related to the management of a hypertensive patient that requires the student to ensure that the most basic needs are met, for example the comfort needs, since this will influence the findings on the blood pressure of the client. Addressing the holistic needs of the client maintains and ensures the caring praxis. During clinical teaching, the CS creates awareness that the patient's comfort forms part of their holistic care. This finding is consistent with research that showed that nurses should be conscious and intentional with their attitudes toward touching the patient, and that this can have a strong influence on the quality of the overall caring experience (De Luca, Fatigante, Zucchermaglio, & Alby, 2021). In this study the CS encourage the nursing students to show empathy towards their patients during clinical learning. This element in the

finding is consistent with those of Sipos (2022), who also observed that student nurses demonstrate compassion.

5.3.2 Category 2: Communication as a vehicle to negotiate between care of the patient and learning needs of students

Communication is verbal and non-verbal, and like all other skills it needs to be acquired and understood in order to have meaning. During clinical teaching communication skills should be developed in nursing students, to ensure their full comprehension of the nursing praxis. Communication is an important skill for the implementation and execution of clinical procedures. Cultural understanding and interpersonal communication create the groundwork for nursing goals, education, and compliance, and are essential to safe, high-quality nursing care (Larsen, Mangrio, & Persson, 2021). Communication is thus a fundamental part of the caring praxis – without good communication skills nursing students are seen as a risk while engaging with the patients. A lack of communication can result in misunderstanding or mistreatment of the patients, which can lead to a compromised praxis. Therefore, CS have small group activities to enhance the interpersonal skills of their students. The risk of miscommunication and the potential for resulting damage increases considerably when patient and caregiver do not speak the same language, or if other cultural or social barriers exist (Larsen et al., 2021). In this study the CS practise communication as a tool in nursing education for students to reflect on the development of their clinical skills and their shortcomings. For communication in nursing education to advance globally in strategic ways, an understanding of the current educational landscape is critical (Kerr, Martin, Furber, wintreburn, Miles, Nielsen, & Strachan, 2022).

5.3.3 Category 3: The ability to develop clinical confidence

Clinical confidence is crucial in the practice of both nursing students and PNs (Guerrero, Ali, & Attallah, 2022). Clinical confidence plays an important role when it comes to clinical

teaching, since CS must prepare a lesson plan to teach a particular skill. To be a nurse educator the CS must be clinically confident and must possess the knowledge and aptitude to transfer information in chronological order to teach their students. A study carried out at an HEI in Australia found that nurse educator expertise is crucial to the retention, maintenance and enhancement of the nursing workforce and associated desired health outcomes (Woods, Cashin, & Hortsmanhof, 2022).

To be clinically confident, the CS encourages the students to become critical thinkers who are decisive in the nursing profession. Literature describes the need for educators to develop alternate clinical learning experiences. Clinical confidence also requires the CS and students to work within a framework that is regulated by the SANC, and this provides guidance in nursing training in South Africa (Fadana & Vember, 2021).

Codes which emerged from the data analysis under this category are now briefly discussed. ***Preparation for skills development and engagement is important for clinical confidence*** and the role of the CS is to mentor and facilitate the development of clinical skills in students to shape their knowledge and self-confidence. Research on student success in practice-based clinical education, such as nursing, has confirmed the importance of students' efficacy beliefs, specifically clinical self-efficacy in supporting academic and clinical competence; professional commitment; and, importantly, quality of patient care (McBride, 2022). ***Developing critical thinking and problem solving*** occurs when CS stimulate the students' critical thinking ability by referring to different clinical scenarios for conceptualization. Canadian and international nursing educators are increasingly concerned about the quality of university nursing education (Racine & Vandenberg, 2021). They are of the opinion that critical thinkers and problem solvers are better equipped to succeed in the highly competitive and ever-changing labour market.

The role of the regulatory body and scope of practice is to ensure that all patients are treated and cared for fairly. The SANC acts as a governance authority that is responsible for exercising autonomous power in a licensing and regulatory capacity (SANC, 2014). According to the SANC (2006), the R425 programme is part of an integrated course, namely a four-year diploma or degree leading to registration as a PN in general, psychiatric, and community nursing and midwifery, which aims to provide for the personal and professional development of the student. Admission to the course requires all four disciplines to be followed, as there is no choice of a particular course to follow for a nursing diploma or degree. The new R174 programme provides training to become a PN and midwife over a period of four years, and the qualification will be a bachelor's degree (SANC, 2013). ***Clinical confidence requires peer learning and engagement*** is a teaching and learning tool which is facilitated through group work and provides a safe environment for students to reach out for assistance where necessary. Peer learning is a structured educational model where students develop independence by learning from and with each other. Peer learning aims to support students' collaborative learning process without immediate interference from the preceptor (Sandvik, Karlsson, Zetterman, & Eskilsson, 2021).

The importance of the role of the PN in clinical confidence is in applying their educational function to mentor students in the practical facilities. The role of the PN is to facilitate bedside nursing and integrate in-service training to groom the students for the profession, and to observe whether the student is competent in their procedures. Health profession education purposefully includes multiple clinical placements for students to develop competence in different authentic communities of practice. While students learn the most from these placements, they typically experience uncertainty when starting a new clinical placement. Moreover, at any given time the expectations of their current practice setting may conflict with expectations gained at school or

from their earlier placements (Stoffels, van der Burgt, Bronkhorst, Daelmans, Peerdeman, & Kusurkar, 2022).

5.3.4 Category 4: Application of ethical standards to maintain a caring relationship

As professional PNs we are under oath to care for our patients ethically in the most dignified way we possibly can. The CS grooms the student to become a registered professional under the regulatory body of the SANC to pledge their work for humanity. The CS implements ethical principles during clinical teaching to maintain the caring praxis.

Nursing students are groomed in professional practice to be the advocate for their patients and to ensure that the Batho Pele principles and Patient`s Rights Charter are reflected in their actions during engagement with the patient. There are four main ethical principles which the nurse should adhere to in order to create a caring praxis: autonomy, beneficence, justice, and non-maleficence. These principles are guidelines of the Western Cape Health Department in South Africa. The Patient`s Rights Charter is the bill of rights that the patient has when seeking medical care (Patient`s Rights Charter, Act No. 108 of 1996, Department of Health, 2007). Informed consent is required before the student can engage with the patient to continue care, and they must be conscious of different cultures and religions and respect the differences.

The “major polarities of the medical practice,” including “respect for the patient, health-care quality, and humaneness, as well as aiming at matching the needs of the whole population equitably” are complicated by concerns about patient autonomy, the altered nature of the professional–patient relationship, the lack of the human touch in care, and the medicalization of the home environment (Keenan, Tsourtos, & Tieman 2021). The following codes which emerged from the data analysis under this category are briefly discussed. ***Privacy*** refers to medical or health confidentiality and involves the patient’s diagnosis, treatments, and records.

The privacy of the patient is important during the procedures that the student performs; it is part of the caring praxis to keep the patient's dignity intact. In health services, it is expected that the patient's body will not be too exposed; only the part where the intervention is to be made will be exposed, and thereafter it will immediately be covered (Ak, Tanrikulu, Gundogdu, Yilmaz, Oner, Ziyai, & Dikmen, 2021). ***Consent*** means that enough information was given to the patient for them to make a decision regarding their care, and that they understand the information and the implications of acting on it. Ethics simulation enables students to understand caring ethics through experiencing and discussing ethically difficult situations. Difficult situations are marginal, complicated, recurring and part of the clinical caring reality (Honkavuo, 2021). ***Respect*** is a form of caring and students are expected to behave accordingly to maintain the caring praxis. All patients' cultural and religious beliefs must be respected. The other ethical principles are respect for autonomy, doing good (beneficence) and justice. These principles represent a culturally neutral approach and provide a basic and accessible moral analytical framework, which can be helpful in discussions and decision-making in relation to ethical dilemmas in healthcare (Jorgensen & Kollerup, 2022).

5.4 Theme 2: Navigating the way to praxis through conscious application of educational modalities

Integration of the practical skill should be applied and adjusted to provide holistic care to the patient, and this requires the CS to integrate their knowledge, skills, and attitudes to ensure that the practices are aligned to the caring environment. The applicability of nursing care is described by the nurse, as a promoter of scientificity in everyday nursing care, expanding the knowledge of nursing science (Junior, Miranda, Dias, Costa, & Menses, 2022).

In this study the CS are required to teach by means of integration of their knowledge and their ability to breech the gap between theory and practice. During clinical teaching the CS augment

the theoretical foundation when they introduce new clinical concepts to the students. To understand the phenomena at hand the student must also have prior knowledge in order to conceptualize how to apply the information they receive. The CS have to become creative in their way of coaching new clinical skills and have to identify learning barriers that influence the progress of their students and need to assist them to overcome those barriers. In this study it was very evident that the learning needs of the CS to further their studies as individuals came across robustly. To be an educator, the CS articulated that they need to be updated and upskilled with the newest skills to be able to produce a good-quality health practitioner. Nursing education educators are responsible for preparing nursing students to provide quality care that is culturally safe (Minton, Burrow, Manning, & van der Krogt, 2022).

5.4.1 Category 1: Interconnectedness of theory and practice

When teaching and learning any skill – and particularly in the case of clinical skills for nursing students – the CS must have the ability to breech the gap between theory and practice (Klitkou, Bolwig, Huber, Ingeborgrud, Plucinski, Rohracher, & Zuk, 2022). The clinical skill is better understood when the theory is incorporated during skills development, and therefore cannot be taught as an individual concept (Klitkou et al., 2022). Clinical concepts should be facilitated in such a way that they enthuse the students to want to acquire more knowledge. Clinical skills are a practical entity to learn, but the rationale creates the meaning. The importance of updated scientific knowledge results in an axis that sustains and moves the scope of knowledge and professional performance. Therefore, the development of research skills is also a field of interest for nursing, since it is necessary to consider the relationship between science and social changes based on the exercise of the profession based on updated scientific knowledge (Silva, Ventura, Costu, Silva, Silva, & Mendes, 2021). The following codes which emerged in the data analysis under this category are briefly discussed. Healthcare is constantly evolving, and the theory-practice gap keeps on expanding. To breech the gap there should be collaboration

between the HEIs and clinical practices, where clinical policies and guidelines are formed. ***Breeching the gap between theory and practice*** requires one to integrate what is learned in the classroom and apply it to clinical practice. Bridging the gap between classroom and clinical practice will improve care at all levels. Nurses depend on theoretical knowledge to articulate the rationale behind their delivery of care (Gassas, 2021). ***Integration as a clinical learning tool for support*** is where the CS enhances the growth and development of their students. Peer support in clinical learning makes the experience of clinical practice easier for students, as this will encourage them to share their experiences through learning. Students can integrate their theory into practice and in partnership apply the knowledge to the skills. In the practical facilities, where more than one student can be assigned to one registered practitioner and peer learning takes place, this plays a pivotal role in upscaling the education opportunities for the future workforce (Markowski, Bower, Essex, & Yeurly, 2021). A ***scaffolding approach to integrate theory and practice*** introduces new clinical skills to students, and they follow a simulation method to further guide and support them in understanding the concepts and refining their skills. Concept-based teaching has been central to nursing education for several years, and integrative teaching has been credited with supporting deep learning and retention of knowing which then supports application of knowledge (Epp, Reekie, Denison, de Bosch, Kemper, Wilson, & Marck, 2022).

5.4.2 Category 2: The creative ability to teach a skill

During the COVID-19 pandemic when the world was in lockdown teaching clinical skills had to take place online. It was challenging for the CS to demonstrate skills and do clinical teaching. They had to grow creative and do research on how to integrate theory and practice online. Clinical skills labs were not accessible, and the CS had to support the development of clinical skills via online learning management systems using applications like PowerPoint, Google Jamboard and so on. During this study it was found that CS had many challenges in performing

their task in an online environment, as not all students had data to access the online skills lab sessions, while others did not participate during these sessions. The CS had to rely on creating video recordings and some resorted to making props and visual aids to assist during clinical teaching. Clinical practice was a restricted area during the initial hard lockdown level 5. This contributed to a lack of exposure, and inability to integrate theory into practice has a negative impact when it comes to creating a caring praxis (Adams, 2021). Literature further states how nurses had to adapt to new technologies, and the importance of providing good access to information, software, the internet, and support (Adams, 2021). The following codes emerged in the data analysis under this category and are briefly discussed. ***Multiple types of visual aids to stimulate learning*** were integrated during the COVID-19 pandemic to assist with online learning, and this teaching strategy was used to allow the CS to engage with their students despite the challenges. Through presentations, videos and group sessions the students were engaged to enhance their understanding of the content being imparted. Their response in terms of participation was vital for their learning. ***Creativity in teaching skills online during the pandemic*** forced CS to think outside the box to teach clinical skills. CS had to apply their minds to patient care simulation, and they used simple and efficient methods to accomplish their goals. The process of conceptual development comes from three distinct influences, that is, the meaning, use and application of a concept in the praxis of professionals. A concept acquires meaning/s through the possibility of it serving the purposes established by people before application in practical situations emerging from their daily lives. This is because a concept provides possibilities for problem solving, the characterization of phenomena in an appropriate way, and the construction of feasible ideals (Salbego, Nietsche, Teixeira, Girardon-Perlini, Wild, & Ilha, 2018).

5.4.3 Category 3: CS as a role model and educational instrument to enhance praxis in clinical teaching

CS are required by the SANC to conduct clinical supervision and clinical accompaniment to ensure that nursing students are clinically equipped to be able to maintain a caring praxis (SANC, 2014). During clinical supervision and accompaniment, the CS count on their own clinical experience to enrich the clinical learning opportunities for their students. The findings of this study indicate that CS perform their duty, relying on their experience and the professional values they prescribe in their engagement with students and patients in practice. Their experiences provide deeper meaning to the concepts they are required to break down for the students and guide the students on how to create a caring praxis when engaging their patients during clinical teaching in the clinical facilities, the CS integrates their experience while engaging the patients in order to provide real-life experience that supports the theoretical component. Nurse educator expertise is crucial to the retention, maintenance and enhancement of the nursing workforce and associated desired health outcomes. Globally, the construction of nurse educator identity has been explored in the context of academic or bachelorette nurse education roles, with limited teacher training and role transition support found (Woods et al., 2022). In a study carried out in Australia health workforce reforms have resulted in a significant investment of resources focused on the development of education in clinical practice. Sector-based nurse educators work in healthcare settings such as hospitals and community health services, as opposed to HEIs. Importantly, these nurse educators support new nursing graduates who, internationally, have been found to have higher rates of clinical errors than their more experienced peers (Woods et al., 2022). The following codes emerged in the data analysis under this category and are briefly discussed. ***CS experience as a vehicle in clinical teaching*** gives the content deeper meaning and adds value to the experiences in nursing education. The CS rely on the culmination of skills, exposure and training acquired over their time frame in practice to enable them to perform their clinical teaching optimally. Role modelling of clinical faculty and PNs, creating a conducive clinical learning environment, effective communication

skills, positive effect of simulation and alternative clinical placement, may help to facilitate the development of caring behaviours among nursing students (Inocian, Hill, Felicilda-Reynaldo, Kelly, Paragas, & Turk, 2022). ***Own development of CS is critical to strengthen the praxis*** – therefore, without the experience and the correct educational development, the caring praxis cannot be maintained. Practice development for the CS is a continuous process of developing their practical skills and qualities to strengthen the praxis. The nursing workforce cannot be functional if there is not continuous development of knowledge and practice. Clinical supervision is undergirded by a developmental approach which requires clinical educators to change their expectations of clinical practice in accordance with the level of clinical preparedness (Mupawose, Adams, Moonsamy, & Masitry, 2021).

5.4.4 Category 4: Dimensions in teaching and learning to achieve praxis

To strengthen the student's ability to care for their patient holistically, the CS must develop not only the cognitive ability but the affective and psychomotor ability of the student through their teaching and learning strategy. To stimulate these learning abilities, the CS educates the students that first impressions before performing a procedure are important. Psychomotor ability, affective ability, and cognitive ability will determine how effectively the student will interact and engage in the nursing task when working with the patient. In this study it is apparent that the CS integrate a hands-on approach during clinical teaching and this teaching strategy is to develop the learning domains. The CS compared simulation in the skills lab to the real-life patient for the students to fully understand the phenomena at hand.

Undergraduate nursing students play an important role in the future nursing profession, and their clinical competence is essential to ensure good quality of care and a high standard of nursing services (Yu, Tong, Li, Wu, Hong, Wang, 2021). In a study carried out in China, learning in clinical practice was shown to play an important role in undergraduate nursing education and clinical competence was defined as the student's ability to incorporate

knowledge, skills, attitudes, and values into specific nursing practice, as a core component of nursing professional standards (Yu et al., 2021). To improve undergraduate nursing students' clinical competence, many nursing researchers are committed to exploring the factors that may affect students' clinical competence (Yu et al., 2021). The following codes emerged from the data analysis under this category and are briefly discussed. ***Developing learning abilities to facilitate the praxis*** is to merge the professional interests, nursing attitudes and nursing values relating to patient that will result in a caring praxis. Nursing praxis is a two-way process between patient and nurse aimed at helping the patient and caring for him/her. According to Newman the first process refers to meeting the patient's needs by caring for them, and the second process is where trusting relationships form and compassion is shown in the praxis (Racine & Vandenberg, 2021). Praxis in holistic care is to establish relationships of compassion, trust, and sympathy, and to accept the risk associated with the patient, where the nurse considers the patient to be an integrated human being with an inherent ability to grow and recover (Rafii et al., 2022). ***Real-life experiences compared to simulation:*** high-fidelity mannequins and equipment are utilized before students can go into the real-life setting in practice. In simulation training the skill set is practised and refined, while in real life the knowledge of those skills should be applied and practised. Application of ethics, emotions, compassion, and sympathy along with knowledge and wisdom are factors in human-friendly and holistic nursing care (Rafii et al., 2022). The real-life environment, for example the hospital and clinic environment, is characterized as a setting that is predominantly conceived through the use of sophisticated tools which aid in the practices performed by nurses and other health professionals. Technology, as a product, encompasses computerization, information, and artifacts; technology, as a process, encompasses resources related to the teaching and learning of nurses, as well as the knowledge and structured knowledge of nurses that can allow the structuring of products (Salbego et al., 2018). In this study it was found that the equipment used to train nursing students is outdated,

and procedures are not aligned with how training is done in First World countries. CS are not technologically skilled or equipped to introduce teaching through sophisticated equipment. As one participant put it: “In First World countries we do know that to compare with Third World countries, so that they are aware of the differences, and also that things are done differently.”

5.4.5 Category 5: Teaching and learning strategies to develop the ability to create and maintain a caring praxis

The findings of this study indicate that CS use a variety of teaching and learning strategies in the clinical facilities and these are used to explore the best ways to increase the nursing student’s academic engagement (Ghasemi, Moonaghi, Heydari,2020). During clinical training the CS explains at the bedside so that the student can look at, feel, and interact with their patient. In this study it was found that CS often test the student’s competencies to ensure that quality teaching is aligned with the praxis. On-the-spot teaching is done with the students in the facilities, while guided practice is done in the skills lab when students develop their newly acquired skills. CS also encourage peer learning as a teaching strategy to develop confidence in the nursing student. Students have to submit a portfolio of evidence as proof of their skills learning; this is evidence-based practice as a teaching and learning strategy.

In a study carried out in Australia it was found that a PN employed by either the tertiary provider or the health service provides clinical learning support to a group of students, including clinical assessment of them. The clinical facilitator does not have a patient load. Clinical facilitators are also regularly involved in assessing and providing feedback to students and can have an enormous influence on decisions about whether a student successfully completes the clinical placement or not (Ryan & McAllister, 2019). The following codes emerged from the data analysis under this category and are briefly discussed. ***Self-directed learning to enhance clinical skills*** is where the student can practice and get guidance during skills development. The CS utilizes this opportunity to give encouraging feedback and students identify their learning

needs and formulate their learning goals. Critical thinking is a basic curriculum skill that also affects other learning competences, such as self-directed learning and problem solving. Critical thinking significantly affects self-directed learning, an outcome of taking responsibility for one's learning, and represents a key competency for nursing students (Song, Lee, Lee, 2022). ***Teaching of relevance to the interest and skills of the CS*** functions to facilitate learning through their skills and experience in their respective disciplines and brings relevance to the nursing praxis. With the increased complexity of patient care in a rapidly changing healthcare system, the role of the nurse has transformed dramatically over the past decade. Reform of the existing healthcare system includes transformation of nursing education. The way in which student nurses are educated needs to keep pace with the transformative role of the nurse in an ever-changing healthcare system, to include integration of evidence-based practice and effective clinical decision-making in a rapidly changing environment (Bowles, Buck, Brinkman, Hixon, Guo,& Zehala, 2022).

5.5 Theme 3: Precision and skilfulness to maintain praxis

In nursing the complex nature of clinical competence challenges the nurse educators to identify suitable assessment methods that measure all of the key attributes of nursing students in a way that is reliable, objective and valid, especially during high-stake summative examinations. Educators therefore need to adopt methods that accurately measure the students' level of desired knowledge, skills, and attitudes as they move towards graduation. The high expectations for clinical competence among nurses are vital, since nurses significantly impact patients' well-being and healing process (Vincent, Arulappan, Amirtharaj, Matua, Hashmi, 2022).

CS are required to work with precision and skilfulness when developing skills in undergraduate nursing students. From the findings of this study, it is evident that CS must be able provide comprehensive care to meet the diverse healthcare needs while simultaneously attending to the

learning needs. To ensure that the nursing student is competent in the procedures, the CS encourage the students to practice continuously and avail themselves for guidance. Competence is then assessed, where the student does the procedure without guidance. In this study it was found that the competency of the student in doing procedures on patients is assessed. During these procedures the CS must ensure patient safety and should identify any student who poses a risk of causing harm to the patient. Such students should be guided or encouraged to practice in the simulation labs environment so as not to impede the caring praxis.

5.5.1 Category 1: Student participation and involvement to minimize risk by adhering to regulatory guidelines in praxis

During student participation and involvement with the patient, the CS must ensure that all safety principles are adhered to during procedures. The more that the student participates during skills development, the better the student will become at a skill, and the more confident they will be. Participation and involvement in their clinical training prepares the students to become safe practitioners. To further quality improvement, many healthcare systems have integrated the concept of *safety culture* into their overall organizational culture. Safety culture represents an organizational commitment to safety at all levels (from frontline to leadership) by minimizing adverse events, even when carrying out complex and hazardous work (Gaur, Kumar, Gillespie, & Jump, 2022).

The following codes emerged from the data analysis under this category and are briefly discussed. ***Considering the patient's safety by determining the risk*** is a healthcare discipline that emerged from complications in the healthcare system, the result of a rise in patient harm in healthcare facilities. The CS should identify those students at risk and give them extra support. Safety culture seeks to create a blame-free environment that in turn encourages healthcare workers to recognize and report errors or near-misses that could result in patient harm (Gaur et al., 2022). ***Paying attention to procedures done to manage the risk*** takes place

by teaching clinical procedures in a sequence. This practice is to identify potential risk and then adapt the procedure to minimize that risk. Risk management involves analysing existing practices and processes. The knowledge and close involvement of CS in the daily operations of many healthcare settings make them uniquely qualified to carry this out. They should provide patient-centred care, work in interdisciplinary teams, use evidence-based practices, improve safety and quality, and meet the needs of patients in the 21st century. Nurses must be equipped with patient safety competencies either in their studentship or their working periods (Torkaman, Sabzi, & Farokhzadian, 2022). ***Weighing the risk versus the benefits*** is to create awareness around mistakes made in practice; the CS therefore encourage their students to practise their clinical skills and become competent to avoid making mistakes. To weigh the risk and benefits is a multifaceted set of clinical and administrative systems, processes, procedures, and reporting structures designed to identify, monitor, assess, mitigate, and prevent risks to patients. Nurses should be trained in the fundamentals of patient safety and risk management to develop their patient safety competency. Educational innovations and patient safety competency evaluation have been recommended to enhance patient safety among nurses (Torkaman et al., 2022). ***Assessing clinical competence minimizes the risk*** of health and safety incidents occurring, and therefore CS are responsible for assessing the competency levels of the student's skills. Their continuous assessment is done in clinical facilities and their formative assessments are carried out as an objective structured clinical examination. To test the student's level of competence is to test the skill, knowledge attitudes and abilities that each nurse must possess. In nursing, the complex nature of clinical competence challenges the nurse educators to identify suitable assessment methods to measure all of the key attributes of nursing students in a way that is reliable, objective and valid, especially during high-stake summative examinations. Educators therefore need to adopt methods that accurately measure the students' level of desired knowledge, skills, and attitudes as they move towards graduation (Vincent et al., 2022). ***Scope***

of practice to ensure a caring praxis is maintained through the CS facilitating their clinical learning within the scope of practice. These are the guidelines prescribed to ensure that CS groom professional and safe practitioners. The requirements of the programme must be read and applied in conjunction with the directives of such programme, as determined by the SANC. Such directives shall be published by notice in the *Government Gazette,* and are currently as follows: (1) learners are required to achieve all exit-level outcomes of the qualification; (2) the duration of the programme is four academic years of full-time study; (3) a learner shall, throughout the programme, receive integrated education and training to achieve both theoretical and clinical outcomes; (4) a learner shall comply with all clinical placement requirements of the programme as determined by the Council; and (5) the maximum period that a learner may spend in a simulated learning environment must comply with the conditions determined by Council, which may be published by notice in the *Gazette* at the discretion of the Council (SANC, 2013).

5.5.2 Category 2: Adhering to scope of practice guidelines to maintain praxis

Scope of practice to ensure a caring praxis is maintained the CS should facilitate their clinical teaching within the scope of practice. These are the prescribed guidelines to ensure clinical supervisors groom professional safe practitioners. During clinical teaching and learning CS should create awareness in their students while executing procedures and ensure that the students are able to perform their skills well. While engaging the patient, the CS and the student should also be aware of the regulating guidelines that governs the praxis. The student should only do clinical skills following their program which makes it safe and within their scope of practice. The regulatory body has strict rules about procedures and who are permitted to do them (Torkaman, et al, 2022).

5.5.3 Category 3: Procedural versus non-procedural

An important part of the procedure during skills development is ensuring that all steps are covered, and the praxis is maintained during a procedure. Thus, procedural skills follow a sequence to maintain the caring praxis, while non-procedural skills like history taking do not follow a set form or sequence. Students need to apply their critical thinking skills during a procedure when there is an emergency. They need to know which steps to skip and which steps to apply without compromising the patient. In healthcare students are exposed to a complex of practical procedures, some of which are part of their daily duties and others that are at a higher level of function. During practice the student has a routine that they follow and become quite competent and confident to execute some procedures. In this study it was found that CS needed to give novice students some guidance during their procedures. For example, if a student did a procedure like wound care and the wound started bleeding, the student needed to improvise and adapt the skill by skipping some steps in the procedure. It is apparent that the student's critical thinking needed to be guided as to what happens next.

The following codes emerged from the data analysis under this category and are briefly discussed. ***Sequence is important for the procedure during skills development*** and ensures that the caring praxis is maintained, and holistic care is given to the patient. Following a sequence during a procedure also helps to standardize clinical practice and ensure that quality care and service are given. Care and training developed by nurses in their different settings do not need to be dissociated from each other; that is, during a care practice training can also be present. Following this linearity, praxis reveals itself as people demonstrate levels of consciousness before completing a practical process, with or without the use of technology (Salbego et al., 2018). ***Applying the important steps of the procedure during an emergency*** is when a life-threatening event occurs in health practice, and the healthcare workers adapt the procedure to save the patient. To apply the relevant steps, the healthcare worker should be calm and think rationally in order to provide comfort to the patient in distress, ensuring that the caring praxis

is maintained. In essence the emergency procedure is then seen as a recovery process. Its theoretical essence elements characterize it as facilitator of the care process and training in health, subsidized by the construction of individual and collective knowledge. This provides the individual/s with effective interaction and exchange of experiences, leading to the improvement of competences (Salbego et al., 2018). ***Non-procedural skills*** do not necessarily follow a sequence and can be started at any point. During a non-procedure like history taking, for example, the student can ask questions until all the information is obtained; this process will not put the patient at risk of being harmed or their health compromised. Non-procedural skills render support to the patient and show empathy towards them, as opposed to direct diagnosis or treatment of care (Sandnes & Uhrenfeldt, 2022). ***Clinical procedures demonstrated differently in other countries*** depends on the equipment or simulation equipment that is used. Advanced procedures have specialized equipment and require special training. Nursing is becoming more digitalized and newer equipment is used to make practice easier and the care of patients effective. In Australia the role of the expert nurse was examined as a compassionate carer through their interpersonal relations with patients and colleagues. The emergency department role required experienced nurses to operate within an extended scope of practice in acute clinical areas, to assess, initiate diagnostic tests and treat and manage a range of patient conditions (Fry, Macgregor, Ruperto, Jarnett, Wheeler, Fong, & Fetchet, 2013).

5.6 Theme 4: Being mindful of inhibitors of the praxis in the clinical learning environment

During clinical teaching the CS must consider the patient's needs when they are creating a caring praxis. The patient's health needs, whether physical or emotional, should be the focal point of the engagement, and therefore they must be gratified with the service they receive and the care that was rendered. Other factors that impact on the praxis are the relationship between the CS and students in the clinical facilities during supervision, the way they conduct

themselves in front of the patient during engagement while they are busy with procedures, and the PN`s attitude when there is clinical teaching and when guiding the students during engagement with the patient. The student's behaviour towards their learning influences their development and growth, and they may face mental health challenges and some social challenges that they are not able to manage.

In a study carried out in New Zealand it was found that nurses use verbal and non-verbal communication, including physical touch, eye contact and gestures, in their interactions with patients to express empathy and to show understanding and respect. Nurses have the communication skills and the adaptability to provide virtual assessments and meaningful interactions with their patients (Collins & Honey, 2021).

5.6.1 Category 1: Patient-related aspects that interfere with praxis

During engagement with the patient, it is important for the student to ensure that the needs of the patient are ascertained, and that patient satisfaction is reached. The patient and the student should identify barriers to them both reaching the outcome they desire. Students must be prepared for the procedure and ensure that they have all the necessary equipment to assist them. When there is a language barrier between the student and patient it is advisable that an interpreter is present, and consent is given to help overcome this.

One of the categories that could facilitate praxis in nursing practice is effective nurse-patient communication, that is related to the awareness of the behaviours of different age groups and of how to communicate with them (Rafii et al., 2022). The occupational barrier is another praxis barrier to nursing practice, such as discrimination among nurses by superior authorities (Rafii et al., 2022).

The following codes emerged from the data analysis under this category and are briefly discussed. In ***assessing the patient's needs to create a caring praxis***, the student must display compassion, competence, and confidence. This will result in the patient being comfortable and allow a trusting rapport to be built. The correct needs assessment can be done, and early interventions can be implemented. Management aspects were also considered, because nurses manage care, either directly or indirectly, aiming to qualify in care and train in health. The management process in nursing presents users as the objects of their actions, with the need to plan care based on previous planning, direction, supervision, and evaluation of the actions performed by nursing professionals. This process is developed by considering the needs of the subjects involved (Salbego et al., 2018).

5.6.2 Category 2: Complexity of a clinical supervisor

The CS plays a pivotal role in creating a caring praxis through their engagement with the student, and the patient has an impact on how the praxis unfolds. Their support and encouragement ultimately prepare the student for the profession and the practitioners they will become. The role of the CS as a nurse educator is important since they shape and groom the nursing student by imparting the knowledge and skills, they need to be functional in the healthcare workforce. The role players of the caring praxis are everyone involved in providing clinical teaching, from the CS to the PN in the practice. Mastery of clinical skills is central to nursing practice and embodies the caring aspect of nursing (Foster, Payne, & Neville, 2022). Student learning focuses on effectively managing disease processes together with preparing the student to work as a PN. At this juncture a nurse education discourse constructs the work in aged care as being complex and requiring advanced skills. The role of a PN in aged care also carries high levels of accountability and responsibility, signalling a competent nurse (Foster et al., 2022).

The following codes emerged from the data analysis under this category and are briefly discussed. ***The role of the CS to create a caring praxis*** requires a positive and encouraging attitude toward the students. The CS has a supportive role to play, they must be student-friendly and approachable to assist the student when there is a learning need. Being an effective educator is linked to the formation of a strong professional identity; then the methodology employed for this local study can be applied to diverse contexts to advance the role of nurse educators (Woods et al., 2022). ***Attitude and behaviour of the CS to maintain a praxis*** is to be aware of the diverse group of students they are faced with in nursing education. Students have different beliefs and religions and come from different backgrounds. The CS should behave as a mentor that is educating and preparing the nursing students for the health workforce. Their attitude should exude positivity toward the praxis and display care and compassion during their clinical teaching. Students prefer an environment with a higher level of personalization, student involvement, satisfaction, task orientation, teaching innovation and individualization. However, factors of and in the clinical learning environment that help shape the caring behaviours of nursing students as part of their education journey remain understudied. Caring is the essence of nursing practice and a core value of the profession (Inocian et al., 2022). ***CS own development is critical to strengthen the praxis*** – without experience and the correct educational development, the caring praxis cannot be maintained. For the CS practice development is a continuous process of developing their practical skill and qualities to strengthen the praxis. The nursing workforce cannot be functional if there is not continuous development of knowledge and practice. Clinical supervision is undergirded by a developmental approach, which requires clinical educators to change their expectations of clinical practice in accordance with the level of clinical preparedness (Mupawose et al, 2021).

5.6.3 Category 3: Factors with students that affect teaching and learning

Students face many challenges during their training in the undergraduate nursing programme. Some of them find it difficult to integrate theory into practice, while others find it difficult to do clinical procedures. Students also find it challenging to admit when they are struggling academically. These factors compromise the praxis. Often students do not reach out for help, guidance or assistance during their struggles and therefore are unable to concentrate on their academics, which impacts on their success. Students are placed in a range of disciplines throughout their training, and when they identify with real-life issues that they must deal with, they become less involved in their learning. The reality of events becomes too much of a challenge, and students are not emotionally equipped to manage their situation. CS must identify the students at risk and intervene by referring them to the appropriate departments for assistance. Awareness of weaknesses somehow refers to personal knowing, as one of the four fundamental patterns of knowing is achieved through self-discovery and discovery of others and through reflection, perception, and communication with what is known. Thus, the nurse achieves self-awareness and openness to herself/himself and others through participation in daily events, thinking, and understanding and communication with his/her own experiences. Self-awareness is a continuous, purposeful, intrapersonal, interpersonal, relational, and contextual process, which improves the therapeutic relationship between nurse and patient (Rafii et al., 2022).

The following codes emerged from the data analysis under this category and are briefly discussed. ***Student academic issues*** are when the student faces an inability to integrate their knowledge or cannot successfully pursue their academic goals or objectives. The student may not reach out to the CS for assistance and guidance during their learning difficulties. Nursing progress is conditional on the ability to collaborate in the development of societies based on meeting people's health demands. For this reason, it is important to consider the complexity underlying their objects of interest, given that nurses can involve the contextual specificities in

which they are inserted in their work process, without decontextualizing the local phenomena of their global relationships (Silva et al., 2021). ***Personal, social, and mental health*** are factors that interfere with learning during clinical training. Students who suffer from personal health issues are not fully in control of their learning. This could negatively impact the caring praxis when students engage in clinical learning. Students pose a risk of not completing or achieving their academic goals. Factors contributing to nurse burnout include increases in mental health issues, experiencing trauma, and work-related stressors. These high-stress environments appear to cause more psychological distress in younger versus older nurses. As stressors increase, nurses seek ways to cope. One maladaptive coping strategy is using substances, including alcohol (Foli, Foster, Cheng, Zhang, & Chiu, 2021).

5.6.4 Category 4: Attitude and behaviour of PNs towards student learning

The importance of the role of the PN in clinical confidence is to apply their educational function to mentor students in the practical facilities. The role of the PN is to facilitate bedside nursing and integrate in-service training to groom the students for the profession and observe whether the student is competent in their procedures. Health profession education purposefully includes multiple clinical placements for students to develop competence in different authentic communities of practice. While students learn the most from these placements, they typically experience uncertainty when starting a new clinical placement. Moreover, at any given time, the expectations of their current practice setting may conflict with school expectations or those from their earlier placements (Stoffels et al., 2022). ***The role of the PN in the caring praxis*** is to groom the nursing student while they are within the clinical facilities. They expose the student to what is expected from them when they are part of the workforce. The PNs also have an education function and they educate and guide the student in the clinical facilities. Their

attitudes determine how the students will perform their duties and how well the students learn. Nurses in their workplace, especially when entering the nursing profession, are influenced by the behaviours and beliefs of nursing educators and their colleagues (Rafii et al., 2022).

5.6.5 Category 5: The safe space within the boundaries of the skills lab

The CS negotiate between simulation in the skills lab and the real-life patient in order for the student to fully understand the phenomena at hand. Clinical procedures in the simulation lab are adjusted in the real-life situation, where clinical skill is adjusted to maintain the caring praxis.

The following codes emerged from the data analysis under this category and are briefly discussed. ***Real-life experiences compared to simulation*** **–** high-fidelity mannequins and equipment are utilized before students can go out into the real-life setting in practice. In simulation training the skill set is practised and refined, while in real life the knowledge of those skills should be applied and practiced. Application of ethics, emotions, compassion, and sympathy along with knowledge and wisdom are factors involved in human-friendly and holistic nursing care (Rafii et al., 2022).

5.7 Summary

In this chapter the findings of the data analysis were discussed, based on the experiences of CS creating a caring praxis in education and training. The discussion of the findings revealed that the role of the CS is important in the education and training of undergraduate nursing students. They create a caring praxis by integrating their knowledge and experiences into clinical teaching. In Chapter Six the limitations, recommendations, and conclusion of the study are presented.

CHAPTER SIX

SUMMARY OF MAIN FINDINGS, LIMITATIONS, RECOMMENDATIONS, AND CONCLUSION

6.1. Outline

In the previous chapter the findings of the study were discussed. This final chapter comprises a summary of the findings, the limitations of the study, recommendations based on the findings which emerged from the study, followed by the conclusion.

6.2 Summary of main findings

Five themes emerged from the semi-structured interviews conducted with the CS at an institution of higher education. The data collected and analysed responded to the two objectives of the study: firstly, to explore and describe the experiences of CS regarding their ability to create a caring praxis in nursing education and training; and secondly, to identify the needs of CS to create a caring praxis in nursing education and training. The main findings of each of the five themes are summarized below.

6.2.1 Holistic client-centred approach to conduct clinical supervision

To create a caring praxis in nursing is to ensure that the atmosphere is of a caring nature and that the patient's dignity will be unharmed. The CS implemented the caring attributes in their clinical teaching to ensure that the caring praxis is maintained when engaging their students. To create a caring praxis the CS needed to ensure that their students were clinically confident in their clinical skills. They often intentionally developed critical thinking and problem-solving skills through reflection, and one-on-one sessions with on-the-spot teaching. The role of the CS is to ensure that the students practice under the scope of practice of the regulatory body. A large

component of the caring praxis is the ethical principles. The CS should be consistent by ensuring that the student is aware of their conduct with the patient. To create a caring praxis students are taught that they should do no harm to their patients and need to treat their patients with dignity and respect. During clinical engagement students needed to ensure the privacy of their patient and gain informed consent from their patient for any procedure. The CS are tasked to socialize students to become professionals by role-modelling to them what is expected within the nursing profession. To maintain a caring praxis, the values associated with nursing should be considered, for example skilled communicator, sound clinical reasoning and judgement, maintain ethical standards, and integrating practice guidelines.

The educational background, qualification, and work experience of the CS will guide them in their clinical teaching to ensure that the students who graduate are qualified health professionals.

6.2.2 Navigating the way to praxis through conscious application of educational modalities

It is required of CS that they breech the gap between theory and practice. During skills development the CS integrated the theory by giving short notes on the specific skill they were teaching for the student to understand. They started with some anatomy and physiology and then the rationale of carrying out a certain skill.

The CS had a supportive role to fulfil to ensure that the student can breech the learning gap. Peer learning was also a teaching tool to assist the students with their clinical learning. Before the CS can teach a new clinical skill, they need to assess whether the students have prior knowledge, in other words whether they had received the theory lectures on a particular topic. This will assist the student to better understand and apply their knowledge.

During the COVID-19 pandemic the CS needed to be innovative in their teaching strategies. The country was on lockdown and teaching took place online. The CS relied on visual aids, for example videos, puppets, and presentations, to integrate their clinical teaching and make it sensible for the students.

During the integration of theory into practice the CS need to identify the students at risk of learning barriers or difficulties that could negatively impact their learning. By utilizing the self-reflection tool, the CS need to avoid cognitive overload when it comes to new clinical concepts.

The need for development of the CS themselves is important when they must engage in clinical teaching. They relied on their own resources and finances to get themselves updated and upskilled to teach new and relevant skills in line with current practice.

6.2.3 Precision and skilfulness to maintain praxis

During skills development the CS assessed the students for competency of their newly acquired clinical skills, to ensure that the student can execute these skills. It is important to ascertain the safety of the patients when creating a caring praxis. Precision and skilfulness focus on the steps that are followed to ensure that the procedure is safe for both the student and the patient. CS need to encourage students' participation and involvement in their clinical learning.

CS assessed the risk of students who engaged in clinical procedures, to ensure patient safety by assessing the students' ability to do the procedure.

CS should align skills development with the relevant standard operating procedures and guidelines used in practice to ensure the safety of the patient.

The procedure must have a flow when there is physical contact with the patient to maintain the caring praxis. Non-procedural skills do not necessarily follow an exact pattern but must be sensible in the management of the patient.

CS teach clinical skills in a simulation environment which is safe for the student, to ensure that the student practises and will be ready to apply the knowledge in practice. However, the same procedure that is taught following a sequence in simulation might not follow the same steps when it comes to real-life situations. The CS then guides the student on how to apply the important steps of the procedure to manage their patient safely.

6.2.4 Being mindful of inhibitors of the praxis in the clinical learning environment

The patient's needs should be considered when creating a caring praxis. The CS should do a needs assessment and a reflective practice as measures to ensure the quality of care provided.

Practice implications can affect the praxis if the practical skills and equipment being used are not effective. The needs of the patient cannot be satisfied if the equipment used in training is primitive and outdated or the skills do not line-up with the current practice.

The support from the higher education institute where the CS engage in clinical teaching should invest in the teaching programme by getting modern equipment and having easily accessible simulation labs.

The CS have a role as educators and therefore need to have all the equipment that they need to ensure the success of the clinical programme. Their role is also as a support to the students, to guide them and ensure that they are successful in completing their course.

The PNs in the practical facilities have an educational function which they need to fulfil. Their support and attitude can make or break the students and have an impact on the type of practitioner they will become. The PN socializes the nursing student into a professional role and prepares them for the nursing profession. The HEI, the CS and the PN are the relevant stakeholders in healthcare when it comes to creating a caring praxis.

6.3 Realisation the research objectives

In this thesis the researcher addressed the immediate research objectives as it was achieved and demonstrated throughout the study. The study had two objectives: 1) *to explore and describe the experiences of clinical supervisor regarding there ability to create a caring praxis in nursing education and training),* and objective 2) *to identify the need to the clinical supervisor to create a caring praxis in nursing education and training.*

Objective 1: To explore and describe the experiences of clinical supervisor regarding their ability to create a caring praxis in nursing education and training

Four themes emerged in this study. Across the four themes elements of objective one was addressed in theme one, three and four. Theme one demonstrated that the clinical supervisor must be able to provide clinical supervision within a holistic client-centred approach to enhance the caring praxis. This furthermore characterised through an interconnectedness throughout all dimensions of caring comportment, and they should have the ability to demonstrate clinical judgement and clinical reasoning whilst doing clinical supervision. It is also required that the clinical supervisor pay attention to assessing and managing risk of patients while doing clinical supervision. Lastly adhering to the scope of practice of a professional nurse, SANC guidelines and practice guidelines will ensure that students are socialised into the caring praxis.

Objective 2: To identify the need to the clinical supervisor to create a caring praxis in nursing education and training

This objective was achieved as the findings of this thesis indicated that the CS must be able to navigate the way through the conscious application of educational modalities to achieve a caring praxis. The CS need to be aware of the interconnectedness of the theoretical aspects and practical aspects to maintain the caring praxis. It is often required of them to be creative in the way they demonstrate and teach skills to nursing students. The need also exists amongst CS

that they should be conscious of the relevant teaching and learning strategies to enhance and maintain a caring praxis. The findings of this thesis also confirm that the CS is a role model and the CS is further identified as a pivotal educational instrument to enhance and maintain the caring praxis during clinical learning. Finally, this role model should be mindful of the inhibitors of the caring praxis in the clinical learning environment which expands across the HEI and the clinical practice. Typical inhibitors were determined in this study to be patient related aspects that can interfere, the complexity of the CS, and factors with the student that affects teaching and learning, and the attitude of healthcare staff towards students in the clinical practice environment. Laslty they need to be mindful of training standards and practice guidelines to maintain the caring praxis.

6.4 Limitations of the study

The study was conducted at one HEI in the Western Cape, and the participants were employed within the institution. This study was conducted in nursing education and training, but not all of the participants had an additional qualification in nursing education. The SANC requires everyone teaching the new R174 curriculum to have a qualification in nursing education.

Therefore, the findings are limited to the HEI setting, and cannot be generalized beyond the study context as they are specifically applicable to this study context.

6.5 Recommendations for education and practice

CS teaching the R174 curriculum who do not have nursing education as an additional qualification should be encouraged and given the opportunity to further their studies to become qualified in order to apply teaching and learning strategies and navigate through the curriculum.

The CS should engage the HEI to keep them updated with new and relevant practices and guidelines, and therefore must be sent for regular training updates and short courses with the Department of Health.

The CS who are trained with updated skills and procedures must train and update new staff who join the clinical team.

6.6 Recommendations for future research

Similar research may be repeated with more institutions to make the findings more generalizable and also to include quantitative research findings on CS.

Performance indicators that are aligned to SANC and WHO standards should be developed for CS for quality assurance purposes.

6.7 Conclusion

The CS have been the focus of previous research studies using qualitative methods. However, this study is the first of its kind to examine a caring praxis in clinical supervision. This study explored the experiences of CS in nursing education and training creating a caring praxis. The researcher has made recommendations that may enhance and maintain the caring praxis in nursing education and training. The researcher anticipates that the proposed recommendations will be implemented to assist in the development of CS during their clinical teaching and learning.

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Appendix A:

INFORMATION SHEET

Project Title: Creating a Caring Praxis in Nursing Education and Training: The Experiences of Clinical Supervisors

What is this study about?

This is a research project being conducted by Beverdene Syme at a university in the Western Cape. We are inviting you to participate in this research project because you are a CS and a suitable candidate. The purpose of this research project is to understand the experiences of clinical supervisors in creating a caring praxis in nursing education and training. The researcher wants to explore and describe the experiences of clinical supervisors regarding their ability to create a caring praxis in nursing education and training. The researcher wants to identify the needs of clinical supervisors to ensure a caring praxis in nursing education and training.

What will I be asked to do if I agree to participate?

You will be asked to participate in a semi structured interview. The interview will have questions that will help the researcher understand your experiences as a clinical supervisor. Due to the COVID-19 pandemic, the interview will be virtual in an environment that will be safe for you. The interviews will be approximately 45-60mins or till you as the participant has answered all the researchers' questions.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, the information collected from the participants will be kept confidential and stored in a secured location. The researcher will not use the name or any form of identification of the participant. Data will only be accessible to the researcher and those involved in the study. According to the institution's policy, all data will be kept for at least five (5) years after the results have been published.

To ensure your confidentiality, the information collected from the participants will be kept confidential and stored in a secured location. Data will only be accessible to the researcher and those involved in the study. The participants will remain anonymous, and their information will be kept confidential. Only the researcher will be able to link any information to the participant. All sensitive information will be protected to ensure that the identities of the participants are kept anonymous.

If we write a report or article about this research project, your identity will be protected. In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities' information that comes to our attention concerning child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be some risks from participating in this research study. The researcher will aim to guarantee the well-being of participants by minimizing harm and discomfort throughout the study. If the participant experiences any discomfort the researcher will refer the participant for a debriefing session with a suitable professional. All human interactions and talking about self or

others carry some amount of risks. We will nevertheless minimize such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about clinical supervisor's ability to create a caring praxis in clinical teaching. We hope that, in the future, other people might benefit from this study through improved understanding of what and how to ensure caring praxis.

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.

What if I have questions?

This research is being conducted by Beverdene Syme from the School of Nursing at the University of the Western Cape. If you have any questions about the research study itself, please contact Beverdene Syme *at*: 63 May Street, Avonwood, Elsies River, 0790412067, bsyme@uwc.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:

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Appendix B: CONSENT FORM

Title of Research Project: Creating A Caring Praxis in Nursing Education and Training: The Experiences of Clinical Supervisors

The study has been described to me in language that I understand. [Yes/No]

My questions about the study have been answered. [Yes/No]

I understand what my participation will involve, and I agree to participate of my own choice and free will. [Yes/No]

I understand that my identity will not be disclosed to anyone. [Yes/No]

I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. [Yes/No]

I agree to be **[a**udiotaped**]** during my participation in this study. [Yes/No]

Declaration

I……(full names of participant) hereby confirm
that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.
I understand that I am at liberty to withdraw from the project at any time, should I so desire.
I consent / do not consent to this interview being recorded.

Participant's name……

Participant's signature…….

Date……

Appendix C:

Semi structured Interview Schedule

Title: ***Creating A Caring Praxis in Nursing Education and Training: The Experiences of Clinical Supervisors***

1. Kindly introduce yourself
2. Please explain, how do you integrate knowledge, practice guidelines, research during clinical supervision?
3. Tell me what is required to create a caring praxis when engaging students during clinical supervision?
4. Describe the importance of the safety and security of the client when engaging students in clinical supervision?
5. Explain the process you follow to ensure that the client's needs are satisfied when engaging students during clinical supervision and clinical accompaniment?

Appendix D

Transcript

I Good afternoon, Participant 1. I'm Beverdene Syme, I am a second-year master's student. I am currently in the process of collecting my data. And my study is about creating a caring practice in nursing education and training, the experiences of a clinical supervisor. I am particularly interested in you as a participant because you've been a clinical supervisor. And what do I mean when I say creating a caring practice? It means how do we integrate our knowledge, our experiences, theory into clinical teaching?

P Alright. I am ready to answer.

I Okay, so can you briefly introduce yourself to me, and give me a little bit of background about yourself, your qualifications, and your registration with SANC please?

P I am Participant 1 . I'm with the University for six plus years now. My specialty was community. I've been registered with SANC from 1980 90, that was after Midwifery. I was still in the old curriculum with general and midwifery. I have done studies after my qualification as a Professional Nurse and midwife, so I have done community a year, and also nursing management, which was 18 months, but it is at a BTech and not at the University of the Western Cape. My specialty has been community. So I have had additional training in the aspects of Community Health, which is Child Health and Primary. I have not done the primary health care course, because I have been a manager in community for 15 years. And we have to give preference to the Professional Nurses who were actually active on the floor.

I Thank you Participant 1.

P While at the university I commenced with B. Nur 3. And I have been with B. Nur 2 to just before lockdown to help with the new curriculum, and the aspect of community and unfortunately went under lockdown. And then we returned

January at level one this year 2022. And due to shortages at B. Nur 3 I was actually asked if I could return to assist in the B. Nur 3 community, R4 to 5 again.

I Thank you, Participant 1. Okay, my first question for you is when you work with your students or when you are engaging them, how do you integrate knowledge, practice guidelines and research during clinical teaching, when you are demonstrating a skill, may it now be in the clinical placements or in the skills lab laboratory?

P The first thing that I always ask my students is if they have been prior learning, because this will influence the participation when you are busy in a group discussion. And also to allow the others also to participate. One needs to be aware of anyone else who has prior knowledge who may sometimes tend to be more verbal than the others. What I have also made a point of is always to ask students what their first language is. And also, a little bit about their background and what their goal is. Once I have that information, it is easier for me to be able to dialogue with students and also to understand the level that I need to communicate with because we at the University of Western Cape are busy with a lot of diversity. And a lot of students who are foreign national and have difficulty in the language, there is a language barrier, a definite language barrier. So, English is not their first language and neither is Afrikaans, but the community we work in is predominantly Afrikaans depending on whether you are in the northern suburbs, or in the southern suburbs. So that one needs to perform this baseline, before you can do any studies with the students or training with the students at facility level or at the skills lab, is to get to know the student. And also, something for me, which is very important is that observation during a session to see what the strengths are of the student and also where the weaknesses are. I allow students during some of our demonstrations or some of the training on site, or at placement or at skills lab, that students are allowed at any time to be able to record especially if there is a language barrier, but only to record things that are relevant to the studies. I think what is very important is that one needs to link up their theory with the practical skills that they need to develop. And what I have noticed with regard to students sometimes is that there is a tendency for them to lack doing their own research. So in these years, I have learned to give, even at skills lab, give them something that they can

research on their own, whether it's on Google, or give them a little scenario that they can work in as groups and in the facility, always leave them with something that they need to find out via the staff or through their own research regarding one of their objectives, it is very important not to spoon-feed the students, because they need to be able to use their critical thinking, and also that they must develop their own skills. Giving too much theory and also, too little of clinical can also pose a problem because when they get to placement, they don't know how to implement what they've learned. So, it's important and this I tell them all the time is that you need to find the balance between the two.

I Okay, Participant 1, just for clarity, is there a lot of students in your group that struggles with language barrier, I see that we your you speak a lot about the language barrier, and how that will impact on the learning. So, do you find that there is a lot of students that has that barrier?

P What I have, in these few years noticed is that I think it's because of my sites, placement sites that I am currently doing that most of the students who live out of res and living in the areas where my sites are, are normally students who are foreign national, and who do have language barriers. So, over these years, I have noticed that the groups that I seem to be supervising has always got the majority of students who have language barriers. And what I have also noticed during skills lab sessions, maybe because my first language is English, there is a tendency for them also, because they are given a choice sometimes, depending on what is happening in the skills lab. Otherwise, especially now with the lockdown, where only six students can be with a supervisor, and I find myself with students who have language barriers, and who are, I wouldn't say predominantly English, but who have a better understanding of English. So yes, I seem to be more exposed to students who have language barriers.

I So how do you with these students that has the language barrier, how easy or how difficult is it for you to integrate the theoretical component to the clinical component?

P I think it's important that we use our audio-visual skills. And also, what I have made use of now is that we have a lot of modules, if I don't know what we can call it in

the skills lab, which are there, that have not been used, and they are also posters. And of course, we have our sim dolls, or some appliances that we use with the students. But with without those, we have to engage with the students in applying their knowledge with the simulated patients, and also to guide them. So, a lot of scenarios are used, or where you have to create an environment where they can participate, even if it is doing the questions or participating in applying the skill. And you guide. What I have noticed is that the sessions do tend to take a little longer, then the sessions where there are less students who have a language barrier, there is a tendency to take a little bit more time, because one has to go slower. And also, that you need to use all your audio visuals I have, sometimes, I've used my tablet also. And they've also got the PC, especially on second floor at the School of Nursing, where we can put a video on for them, and let them watch the link. Or we can share a link with them and ask them for their contribution with regard to the link. So, it's creating a platform for dialogue. Until I can see by the expression, when the session is taking place, whether the student is able to follow; whether the student is lost. There is a tendency to frown, or to move to the front because it's not a matter of not being able to hear but because they do not understand. So, I have learned also to break down words to make it easier. And also, the way I apply the skill board in such a way that it's easier for them to follow.

I And besides the audio-visual skills is there other visual aids that you use in the simulated environment for them.

P Well, we have the sim dolls, and we have the sim patients who assist us especially when they is history taking and we need someone who actually is able to communicate. And I have to be the interpreter in those instances. So, you have the patient, and they will be the nurse, and I then will be the interpreter. And we do have posters. And what I have been trying to do is gather some of the, I don't know even, you know, we've got like, for instance, one of our sessions we had last week was musculoskeletal. And we had the brain. And in that skills lab, we have a little brain and we also did have a knee joint, which was more for students to be able to visualise, which we then took and let the students touch it, let him touch it; let them look at it. And also they it's easy, especially if you have a language barrier, if they can see the picture. So we would always also go on to Google and get a

picture for instance now between nervous system we will get a picture of the cranial nerves so they understand how the brain and the cranial nerves work. And it is much easier in that way to be able to carry the information over to make it easier for them. But I use a lot of my own props which I made. I even resorted to using a hand puppet with latching to show the student how the procedure is done. Besides using what is at placement or in the skills lab. Sometimes using a different type of prop makes it easier for them to understand. So we'll link up everything that we have at our disposal, and in the facilities, it's easier because they may have some different equipment, which they are then exposed to.

I Okay, so what you have described for me now you're puppeteers and your audio visual and your simulated patients, all of those things are taking place in your skills lab sessions, right?

P Yes, yes. Currently, we when we were on remote we used to… we used the iKamva platform, the Google, not the Google meet the discussion forum, and also the chat room to engage with students. And when we did the skill sessions on the Google meet, we would use PowerPoints, and also new PowerPoints which we had then developed, and also share links with them from Google, on training abroad, which is first country we do know that to compare with the third country, just that Third World countries so that they are aware of the difference and also that things are done differently abroad. And also, that they're exposed to those different ways of doing it. So, we became very innovative, especially now during the lockdown, we were forced to become innovative with regard to doing teaching, and always ending up like I said, giving them some homework so that they can do their own research with regard to certain topics. And we had a register, so it was easy to get the names, and then able to at the next session, call on those students to give their feedback before we engage in the PowerPoint. And also, while engaging in the PowerPoint. We always first asked questions on prior knowledge of that topic, to see how much the students know. And some of them may have already been exposed. And some may have been repeaters or have deregistered and come back on board. So, we have to be aware of those things all the time with regard to students.

I Sandra, with regards to the First World country and the Third World country, is this now with regard to demonstration of skills that you are referring to?

P Yes, I remember two specific PowerPoints we did. One was the nasal gastric tube insertion. And then one was on the insertion of a catheter, that there was some equipment which they have, which we do not have. But we had to show them how we improvise in this side in the Third World country. But we also need to make them aware that even though we are a Third World country, the government sector, and the private sector may be also working with different equipment with regard to those procedures. So, when we could Google some of the information, some of the equipment that was used, the students were not familiar with. And then we had to take them back to our placement skills lab. And the fact that we are still some of the audio visuals, which we are using may not have the new equipment in the video. And we need to work on that. So, some of that information also came up when we were doing the training on the skills lab sessions with the Google meet skills. Because if we look at the old videos, some of the equipment had changed already. And we have to make the students away that there is new equipment in the skills lab currently. And once we got back on board, and we're able to do face to face, we could then show them. But with regard to the First World country videos they would watch had to make it clear that some of the private hospitals may also be using that equipment already. But because it's costly and because the government facilities at placement where they are available a budget, they may still be using the older versions, but the procedure itself can still be carried through with the equipment that they use.

I And then just one more thing before I move on. So you said in the facilities, it's easier than to teach the students or to show them the skills that you've now just explained, that is being demonstrated in the skills lab laboratory, due to the different equipment. So can you give me an example of a skill that you teach in the facility and how does your students interact or participate, because remember, that's now the clinical supervisor and your student and there's a patient?

P Yes, I think that one needs to also be aware that most of the time in any case and placement, they are actually working with actual patients. And it's an integrated service. So, they are exposed to different types of services in that same facility. So, they have a wider exposure of different clinical skills at the same time, because you have to have an integrated approach with the patient. The other area, which they have been exposed to that we may be still using some manual equipment where in placement, they have electronic equipment. And if you look at one of the other things that we used with our skill sessions in skills lab, and what we also used on the Google training skill session, we have a different type, we noticed that our emergency trolley is slightly different to the emergency trolleys is in the unit itself. There are differences in how it is packed, and also in the type of equipment because of having more equipment on the trolley in the facility or at placement than what we have in the skills lab.

I And does that that…

P It goes to more shall I say getting exposed to a variety of equipment that can be used, and also of patients with regard to their objectives that they have to meet.

I Oh, I was about to ask, so does that have an impact on their clinical learning with all the differences that they are exposed to?

P I think that it's important that the clinical supervisor is able to link the two, so the students are able to follow through, because they may have observed and they still working on the one side with the one and not linking up what they have learned on the other side. So, when you… that's why I say prior learning is also important but also prior knowledge is just as important. Before you are going to teach a skill, you first need to find out if the student has already had information with regard to that skill in a theory setup, and then find out so what… how would you apply what you have learned in the theory of setup now in your practical session, or the current skill that we are now doing or try giving you training on at placement. So, you got to do that all the time, so that students realize that it's not just about see you cannot separate your theory from your clinical skill, the two work together and I also tried to teach them when you need to, like I say, you store

knowledge and you need to know when you need to retrieve that knowledge because if you're doing for instance your vitals, you have to then take your theory knowledge out when you have to do the interpretations. So, the skill has to be used with the theory information.

I And the theory information, how is that being relayed to your students? Where do they get that information from?

P The students have the module guides and also, they have iKamva and also students are of course they are now back to face to face. So, the lectures have started taking place and if they're not face to face, some of them are getting the theory on online. But I am encouraging students now especially with what we've just been through on lockdown, let students need to do their self-directed learning. And you can read articles on Google, you don't only have to look at PowerPoints, but it needs to be applicable to their year level. And I have already tried to guide them on how you get to something that is similar to your year level, because when you type in the information, you need to cite not for medical students, for student nurses, second year training, or first year level, or you know, and you'd get that information for that level, so that they don't eventually end up also with too much information, which is not applicable for them. And I also clinic level, there are policy and guidelines, which we also refer them to, like in placement, they've got the EDLs, and they have got like your reproductive health guidelines. So, there are a lot of guidelines that they need to apply with the skill as that skill is being developed. They see these guidelines, but they're not able to use the guidelines. So, one has to make them aware of how the guideline is used to make that to do to enhance the skill which they have been trained.

I And all of this links up with you mentioning before their prior learning before that you demonstrate a skill to them.

P Yes, very important. Also, what I have taken into cognizance is that there are some students who have done some medical training in some other fields, and maybe have come to nursing now, or some are Professional Nurses who were from another country and have to restart because it's not at… their qualification is not

accepted in our country. So, one has to be aware that they have been exposed, but not necessarily completely to the way it is done in South Africa. But one needs to make reference. And also, the one thing that I emphasise that students have to respect each other because we all have areas of ours, where we have strengths and areas where we have weaknesses. So, they must learn to accommodate each other in those areas. And also, I think if I think of placement, students can walk down those corridors and not even look at what's on the walls. And yet, a lot of the information on the walls, the posters and patient information is also applicable to them for their objectives that they are studying.

I And you've mentioned policy guidelines, which is the EDL, the reproductive health guidelines…

P Your IMCI, your (inaudible) guideline. And then I know there's another guideline, I'm not able to get it now. But there are quite a few guidelines which they can use like your schedule for the EPI guideline, that was the other one, in correlation with code chain management. So, there are a lot of things which are accessible to the student, if the student opens up and wants to ask questions, and has an inquiring mind, the information is there. The information can be there and be nothing if you don't apply yourself. So that is what I'm trying to teach them is to be curious, so that the information is given to them. And then they have to put extra time in to read through these articles or read through these policies and guidelines, which are available.

I Okay, thank you, Sandra, it brings me to my second question. When you do engage your students when you are demonstrating a skill for them, how important is following a sequence, if at all, following a sequence when you demonstrate a skill to your students?

P I think that when I'm going to answer this from the point of view that I know that skill has got, if I can put two aspects to it and even three aspects to it. because when you're teaching the skill, there is a theory aspect. And then you the student is going to be assessed and with an assessment at placement and then you're going to have the OSCE so I think the sequence is very important for the student

to be able to remember, but not in parrot fashion. The students must realize that if there is something in the sequence which has been forgotten, that they can always go back to it, as long as they have not started with anything that may affect the health and safety of the patient.

I When you say the three aspects, and then you've broken it down for me in to the theory aspect, the assessment, the OSCE. where does all of this take place?

P The assessment will take place at placement, and the OSCE will take place in the skills lab. So, applying the skills on those three platforms, the other third platform, like I've explained is when they do the exam, or they are tested on that subject or have to do a tutorial, they need to apply those skills all the time. So, I have picked up in the time that I've been marking some of the work in lockdown while I was working remote, how students are not connecting the information that they are getting. So, when you prepare the students in the sequence, you also have to make it clear to them that they must not learn something in parrot fashion, but learn the procedure manner that it needs to be done. So that it is easier for them to follow through and why it is done. You need to understand why it is done in a certain way. Why do you need to identify your patient at the beginning? Why do you need to ensure that certain things are available before you commence? We are currently busy with assessments. And students sometimes don't even put the bin close by. And when it comes to the point where they are now opening and preparing equipment and whatever they're going to need, there's syringes and so on, then they realize that the bin is not close by so you need to use the problem solving or critical thinking how do I now dispose of the things that I need to dispose of. In skills lab we have the plastic bags on either side of the trolley. At a placement that is not available. So, you need to ensure that your bin is close by. But whether it is your bin close by, whether it is your plastic bag, at the skills lab, you need to find an alternative way. Like I've explained to some students, if you are in a situation like we have been mentioning and you are not able to follow the sequence. For instance, you have already put your gloves on and you will have to now take off your gloves if you have to open certain equipment, you then can use your problem-solving skills and ask someone. I have forgotten to open them, can you please open that for me, but not allow that episode to cut you off

completely from the rest of the procedure, because that is what happens when you do it in a parrot form. But if you are able to think out of the box and have critical thinking and problem solving, which we are trying to bring in now, then you will know you have the opportunity to ask somebody to assist you may not get full marks but you can do. What I have also picked up with the assessment, and also, with regard to OSCE, washing your hands in the assessment may cost you [four] marks less than four marks, let's put it but if you maybe don't wash your hands in OSCE, it could be a critical mark and it is actually 50% less. So, we have to make sure that students are aware of these all the time because of the different ways of them being examined to check if the skill is developing and also the knowledge is (inaudible)

I Okay so Participant 1, you spoke about the assessment in placement that is different to the sequence of the skill in OSCE and then you spoke about procedure manner how to do a skill or know the skill by procedure. Do you find that your students can differentiate between the three aspects? Do you follow a sequence with that regard?

P Not always but one has to always go back to your own guidelines so that you stay on track, that is very important that you carry your guidelines also at all times. So that if there is something that has been questioned, or where you need a little bit more information that you can refer to that guide, because we have to also have our preparation that we do and make sure that the students are in line with what the objectives or the expected objectives are. But what I have picked up, especially in placement, is that sometimes because things are not working out exactly the way it is, at skills lab, they have to improvise. So, we have to teach them how to facilitate improvises in their setup without compromising the patient, health and safety of the patient, and also not compromising infection control.

I Does the students know the difference between health and safety and infection control?

P Yes, we are trying our best to be able to bring that across. It's two separate entities. And I think they are gradually getting it in place if I can put it that way. And it

seems to be going easier now after COVID. And after all the PPE and COVID policies and so on. I think students are grasping it better now.

I And when you say that you as the clinical supervisor need your guidelines, what are you referring to?

P We need to also have a copy of the module guide. And also, we have to also go on to iKamva to check what has been put on the iKamva so that we are in line with what the objectives are for the student. And preparation before you go to students at the placement. When we get to placement, we also need to be able to see immediately where the gap is now between what is that skills and what we teach them and what is not available at placement or vice versa. So that we can point those out to the students. But at the end of the day, the principle of the procedure will still remain the same. For instance, we may use a manual otoscope at the skills lab. And in the facility, they got an electronic one, it does make a difference, especially when it comes to assessment because the student doesn't know each and they just need to take it off the wall. If the plug is on. If the plug is off, they need to just put the plug on and your equipment will be in working order. And also, some areas have for instance, we found that out now with our ones even for some facilities are using the stainless-steel speculum, and some facilities are using the disposable stick units, we need to point the difference out to the students. So, we need to have our guides we carry. We are also handed out IMCI guideline we are also given the current (inaudible) guideline, one gap, because I don't know if I can call it a gap in my position as clinical supervisor. I know the coordinators go for training in certain aspects of the clinical skill. But I feel that we should also go on training where government or the City local authorities, they do have training in progress throughout the year. So, if is in line with our objectives we also need to be refreshed with regard to certain things that we are going to carry over to the students. So, I personally feel that when it is that time that maybe somebody needs to do a little research with regard to if there are any spaces and allow those in that specialist area to be able to attend some of the updates, the training so that they are in line…

I …with what is being done.

P Students might seek something differently.

I With regards to what you just told me now, is it being currently done for the clinical supervisors?

P I remember a few years ago you know lockdown has actually impacted a lot on our routine if I can put it that way. And also, some of our guidelines. I know the B. Nur 3, what we did when it was that is that I would link up with the training department of the City, and find out what training is being held in that session of the vac. And we wouldn't take leave. And if it was something related to primary health care or to child health, that we will then attend or EPI or [Code] Chain Management, something different in the schedule, we would ask how many spaces are available, because they would first give preference to the staff of the City. And they do avail any additional spaces for people in the area who also need the training. So, we did attend a few sessions. And I can assure you, it did make a big difference, because when students go out, they would see it the way the person who has been updated is training them. So we went on these sessions, and were updated also with regard to the nutrition the guy you know, a nutrition that the dietitians from Karl Bremmer also the training on, we attended a whole upper (inaudible) and etc. So, we had to learn firsthand from the dietician, how it's done, so that we carry it over to exactly the same way to the students, because that would be the procedure followed.

I Thank you, Participant 1. So, it brings me to the next question that links with what I've just asked with regards to sequence. So, when you do engage your student, and you're teaching clinical skills, what is the substance, if I can put it to you that way? What is the substance that you bring across when you do teach a clinical skill? Substance referring to how deep do you go, when you are teaching a clinical skill?

P I think that's going to differ from skill to skill, if I can put it up depending on if it's invasive, or what skill it is, I am particularly very strict when it comes to little children, because the students, especially those who have not been mothers, or have no

children, do tend to be a little bit afraid to handle the child. So, to me, one needs to be sensitive to the procedure. And I also now with R4 (inaudible), even four have been exposed to the males feeling uncomfortable with the examination of the breast for a cancer. So, and for lumps and so on, and to be teaching a female how to do a breast examination. Because we take it for granted that we are female, it's an easy procedure. So, it like I'm saying that there's a few things that have to be taken into consideration. It's, for instance, the age group that you are dealing with, the culture, and also the diversity, if I can put it that way, because students are not exposed to all of these skills all the time. And sometimes students react differently. So, you will find that when you are teaching the skill, you need to be sensitive to what the students' emotions are, when the skill is being taught, and that you gradually introduce. Sometimes a skill has to be introduced. I do that in three stages, your preparation stage, you know, where you're…when you're planning stage, your preparation, and then your implementation. And I think more time will be spent in the implementation. If I just take, for instance the examination of the lymph nodes with regard to a primary health care client, or patient, I have to then demonstrate and it takes quite a while allow the students opportunity to also demonstrate and then allow some discussion with regard to that. And one of the things that students have to be aware of is the discomfort not allowing the patient any discomfort at any time. And when you are working with the child to remember that the mother is on behalf the child observing you at all times on how you are working with the child. So, it's a lot for students to grasp. So, most of the procedures, we will follow through I've now started my own terminology. When the planning phase, I would say there are certain golden rules, which you need to follow. And then when you get to your preparation, there you need to visualise, before I actually implement, this is the sequence I'm going to work in. If I do not have all those things in place, I cannot implement what, or carry out the procedure that I am going to carry out. It's becoming, I think that lockdown has taught us a lot because of our online teaching, and also being creative and coming up with our own PowerPoints that we have now started to break down things to make it easier for students to follow the sequence. And also, where in the sequence, you need to apply more time and also apply more of the skill.

I I would just like to clarify. So how do you as the clinical supervisor, you've now explained to me, the male students being uncomfortable. For example, when they must examine the breast of the female patient, how they end the culture and the diversity, so how do you as the clinical supervisor manage that situation?

P That is a question which has been coming up quite often now with the R1 to (inaudible), which is the new curriculum, because of what they are exposed to that I now realize that when I started nursing, males were not allowed to do midwifery. When the females went to do midwifery the general the males went to do psychiatry. So, for me, it is easier to understand that concept if I can put it that way. And I am putting myself out there to be able to coach and mentor the students with regard to applying certain things where it's against, I can say to one student last week against your religion, because some Muslim student and he has to observe pap smears. And they are now in the fast. So, for him, is it for him ethical now to be doing that. And one has to be in like I said, separate yourself from the sexual aspect and see it as the reproductive aspect as one of your procedures, which you need to follow through. So, one has to find… one is to how to say, one really has to find your area of how you can make it easier for your students to students to pass that aspect of whatever difficulty they are experiencing. Because your main goal I tell the students is that you want to get your degree at the end of your training. The other one is that according to your clinical objectives, you need to do a certain amount of clinical work before you can move on to the next thing. You need to hand in a portfolio of evidence. And if you have not done any of those, it will show up in the OSCE. So, you need to apply yourself and forget. You're not forgetting your culture, you're not getting your religion, but you need to focus on your goal and your profession that you have chosen and apply yourself so that you can achieve what you have started at the end of the day. Yes, it is very difficult. But it takes a lot of engaging. Sometimes you have to call a student one side and engage with them on their own. Sometimes you have to follow up with the student on their WhatsApp, ask for their number and engage with them on WhatsApp just to not in the in the group to find out what the barrier is for learning with regard to certain procedures. And once you have that information, you would then assist the student in sort of getting over that milestone if I can call it that. And once

they over it's you find them, someone amongst their own peers, to assist them. So I know that a student who had a major issue with the PV, and I wasn't even doing Midwifery, I was in the doing community, but in the same facility where the student was prior B. Nur 3 doing community, and we have to get a buddy who was with him, to buddy him when he does the PV just to make it easier for him to get through the first few so that because of culture, and because he wasn't married, and he was a male, just so that you could get over that, and see it as one of his objectives and clinical skills that needs to be developed for his goal that he needs to achieve.

I Thank you, Participant 1. So, the next question then would be how do you as the clinical supervisor, teach your students to do a risk assessment? How do they manage risk assessment when they are performing a skill?

P That is very difficult for the students currently, I think that the awareness is not 100% developed yet with regard to the risk. But we are slowly getting the end to do it. Like we say, like I mentioned that I now call them if you pass through your 10 golden rules, you have already covered some of your risks. And also, if you consider your patient safety and comfort throughout your procedure, that's another area, and at the end of all procedures will always assist you with regard to the infection control and the health and safety of the patient. So, the end goal is to ensure that when you have done what you've done, that the patient has had a good experience, and also that you've given the best that you could do in under the circumstances that you working under, and have fulfilled the criteria with regard to the health and safety of the patient and yourself. I always mentioned that to them and yourself. And with regard to infection control, especially now for the patient, and yourself. And what the students need to realize is that with every patient that comes in this is a risk. And I mean that is a skill we are trying to develop so that you are also aware of what other risks are, the patient is already undergoing, and or challenges that the patient is experiencing. And sometimes you even have to use an example of someone who you know or someone who is maybe a family member, for instance, we would say to them, somebody that comes in with pain, and is hypertensive now that the vitals may be different. Why would the vitals be different? Because pain affects the vitals, you know, so you

need to get your patient comfortable in a calm position so that the patient can… the vitals can stabilise so and also that if they do not stabilise that you need to then make sure that the general practitioner is notified that the vitals have changed, because that is your indication of a risk factor that can take place. For instance, we were talking the other day about the contraceptive method and if the patient has already told you, there is hypertension in the family, and now with the vitals that it took before your history taking for the method, you now find out that the patient does also have a hypertension but maybe wasn't aware. So you need to exclude all of those risks during all procedures that you are doing, even with regard to a child because when you are assessing for instance, we had a child who was actually coming for an immunisation, but during the procedure, we found the child was sleeping and in a calm state, but when the child got up started coughing, eyes rolling back and foaming, which I then indicated to the student there is a possibility this child is having a chest infection, or this child we then asked if there's any history of epilepsy or convulsions in amongst family members and so on. And they had already excluded fever because the temperature was taken. So yes, risk factors major because at the end of the day, the student, like I always explained to them, we are not with them around the clock. So, they have to be mentored. And certain objectives they cannot do … certain invasive objectives must be observed only because they then put themselves at risk with regard to SANC and, you know, disciplinaries and incident reports, etc. if they have put the patient at risk. We make them aware of the patient rights charter, and the importance of identification of the patient. And the reason for admission, your vitals, your history taking, so that you beforehand already can summarise where your risk areas are with regard to then patient. And then when you end with your documentation is so important. And your reporting, if there is something that may put the patient at risk.

I Thank you, Sandra. Which brings me to the last question. How do you teach your students to maintain the dignity of the client?

P Good question. Especially now that we are busy with R174s, one of the things that I have to emphasise because in community, people, sometimes s barging at the door. Now we are busy with breast examination, not all the facilities have curtains, they need to ensure that the door is locked before the patient undresses. So, we

talk about it in stages, like I am talking, I'm talking to you, like I'm talking to the students, and how different stages of age groups, or a male and a female, what they perceive as respect or disrespectful, and also as having been treated, how can I say with dignity. So, it starts unfortunately, in the front line, and it ends when the patient leaves your facility because we always explain like the patient needs to have a good experience coming and leaving, because at the end of the day, your name is going to go out there. So, one of my ways of explaining also to the student is that every patient you treat must be treated as if it was your close family member or your close friend. So, there's a certain way you treat people who you know, so patients must all be treated that way. And also, they need to be made aware of diversity and also respect the diversity because if you can be aware of diversity, but not necessarily respect it. We spoke about religion and contraceptives and even I had to respect the version of the student with regard to certain family planning methods, because everybody has a different area should I say which is important to them and could be due to the culture or etiquette or a religion. So, dignity and respect of the patient is something that needs to be carried out with all age groups irrespective. We have now started emphasising that if you see a young person in the facility because you are now doing family planning, you are not being judgemental. To remember that when you are busy with the older person, and they have a certain problem that you need to ask for someone to accompany you when you are busy with the procedure, because the old person or the senior may feel uncomfortable. So, there are certain things that we've got to make students aware of all the time whether it is female, or whether it is male. Eeven with a simple procedure, for instance, like examination of the lymph of nodes, which teach students not to automatically think it's okay to stand between the legs of patients when you are doing the examination of the lymph node nodes, but to stand on the side whether it is a male or whether it is a female. A simple thing like examination of the knee. Some people you may need to if they've got a tight pants on, they may need to take the pants off. Ensure that the patient has a gown or is closed before you expect the patient to take their pants off. That is a very important aspect. And I think that we are having a lot of problems at placement at the moment, not necessarily with our students as such, but a general problem or challenge due to people feeling that they are not being respected. And also, their dignity is not

taken into consideration. How you speak about the patient, you know, when you discuss the patient in your prep area, talking loud about the patient, referring to the patient with the patient's complaint, and not on the patient's name. And also, that you don't talk down to your patient, that you always got to make sure that the patient is comfortable. So, you converse, and especially when you are busy with the procedure, which is uncomfortable to talk in a soft manner, and to make sure that you are aware that it is uncomfortable and you are taking, you will try your best to do the procedure as quick as you can. One of the things sorry one of the things with regard to the males, and it's so sensitive with regard to pap smears because they can observe three pap smears and two pap smears, they can under the guidance of the sister be mentored. So, we have to talk about the anatomy of the vagina and the awareness for them with regard to female harassment. So, you have to be cautious in how you do the examination, vaginal examination, etc. So yes, the dignity and respect. And I'm actually very grateful for the new curriculum, because I think there's quite an emphasis with regard to that.

I Just one last thing you've mentioned now that there's a problem in the placement with regards to keeping the patient's dignity intact. And you've, you've given some examples. But who mentors the students in the placement when the clinical supervisor cannot be there 24/7?

P What I have realized is that and I've explained to students, if staff members are absent that unfortunately, they have to make use of locum staff in the kind of the absence of that staff member. So, we do not have a guarantee that it's always going to be a permanent staff member who is mentoring. I know at one stage the School of Nursing did say that locum staff are not allowed to mentor the students. But it's meant those staff members were Professional Nurses in the facility or in other facilities already. So, it is very difficult for the students, but they need to understand and they are actually picking up on that themselves. Because if I asked them, if there was a case where they felt embarrassed, and felt the sister didn't treat the patient correctly, or respect the patient's dignity, then they would say that the sister who works there is off sick, or that the sister works there is on leave, and the sister that de is only there for a short while then I would realize that it is a locum

and that they need to bring it to the attention of the facility manager, which unfortunately some of them have mentioned, they sometimes have never met. Because in the facilities they sometimes somebody who has been put in charge of the students to mentor the students, it's that person's task that has been allocated to them. So, it is not always the facility manager that they have contact with. But that is a loose end which we need to try and deal with. Because then the facility needs to send a report to the locum agency and report if there are incidents where there's disrespect, because it makes it very challenging for the students to be witnesses in an aspect where they know it is incorrect.

I Do you think that that that your students are learning something from the discussion that we just had?

P Definitely, yes, they are. I have been speaking to students because sometimes students prefer to be in the quieter sites, if I can put it that way. But I've explained to them sometimes the goldmine is the busy site, because you are exposed to so much and you learn so much. And there are some times that you have to do your own problem solving and think out of the box. You know because you are placed in a situation maybe where you need to then assist the sister because there is a shortage of staff or there's a little bit of there's masses, you know, it's full, or they've been (inaudible) now, it's a public holiday today so tomorrow, the facility will be full. So, students will find themselves sometimes having to do a little extra. And they need to use that as a learning opportunity, not just see it as they are assisting the sister with a specific task, but it must be in line with their objective, and that it must add value to their objective. So, I can see, especially now that the students were to do a lot of self-directed learning, but then put it that way. Now with lockdown, I do see a bit of a change, there definitely is a bit of change. And also, the communication skills also seem to be improving. And the students are more open to dialogue, if I can put it that way.

I And can your students link that that kind of behaviour, or obstacle or lack of mentorship has an implication on keeping the patient's dignity intact? Can they link the two?

P Well, the students that I've been exposed to who have reported the incident to me, yes, they do. There has been another incident where a student was allowed to do an invasive procedure, and under the mentoring of the sister, but that was not part of the guideline. And if there were any risks, then it would actually be the responsibility of that sister. But when I spoke to the student, you know, called the student aside and explained that you are not allowed to do that procedure, even though the sister was there, the student out of respect for the staff member wouldn't say no, when the staff member said, you were going to do it, and I will mentor you. I said, if it was a medical student, it is a different thing. But as a nursing student, you are not allowed to carry out that specific procedure. It's not it was invasive, but it wasn't anything major. It's just that because it was invasive. And also, it required a special skill, it has to be done by somebody who has a certificate for that skill. The student could have just been there as in somebody assisting to pass on the equipment that was required, but not to carry out the procedure. So, the role was reversed. The sister was passing the equipment, and the student was carrying out the procedure. And for me, I walked in that and was very, very angry and had to contain myself. Because you know, one, like you say with the dignity of the patient, and also not for the patient to feel that there was anything being done, which was unlawful, if I can put it that way. I contained myself and then also speak to the sister and say that it's not allowed, unfortunately, no matter how eager the student is and how good the student is with the skill. Unfortunately, the student has to work under the regulations or the University of the Western Cape. And that is only an observed skill, and not that the student has to carry out the skill.

I Would you say it was another learning opportunity for the student?

P Definitely. And I've heard students who work in trauma, also having had been exposed to procedures, which the medical profession, the practitioner was supposed to carry out, but the sister was there and the student was assisting the sister. So, they are exposed sometimes to things and because of ethical reasons and also because of respect, they don't want to say no, because they feel that they are visitors there and they dependent on the placement and the site for their learning objective. But we need to make the students also aware that when it comes to a …if there's a complaint or there's complications, they will refer back to

the student, you know, and that the student will be held accountable and that is what they need to be aware of. If you carry out the procedure, you are going to be accountable at the end of the day. So even in some of the trauma that is why we are very strict with regard to where the students are placed in this placement, because they got to work according to the objectives. And if it's not the objective to be in the trauma, the students should not be placed in trauma, because that is the areas where they are exposed to things that they shouldn't be exposed to. And out of respect, they cannot say no.

I All right, thank you so much, Participant 1. We've reached the end of our interview, I would just like to take the opportunity to thank you so much for participating and for sharing your value as a clinical supervisor, thank you.

---End of recording---

Appendix E: Project Registration (Ethics Lett16 March 2021

Dear Ms Syme

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT THE SCHOOL OF NURSING, UNIVERSITY *of the* WESTERN CAPE

Name of Researcher: Syme, Beverdene
Student number: 2828761
Research Topic: *Creating A Caring Praxis in Nursing Education and Training: The experiences of Clinical Supervisors*
Ethics Clearance Reference No.: HS21/10/44
UWC Permission Reference Code: UWCRP919538

Validity Period: 22 December 2021 – 22 December 2024
Target population: Clinical supervisors across all the year levels who have been doing clinical supervision for more than one year.

As per your request and evidence provided, we acknowledge that you have obtained the necessary permission and ethics clearance. Permission is therefore granted for you to conduct your research as outlined in your proposal.

Please note that while permission is granted to conduct your research (i.e. interviews and surveys) staff and students at the School of Nursing are not compelled to participate and may decline to participate or withdraw should they wish to.

Should you wish to make use of or reference the School's name, spaces, identity, etc. in any publication/s, you must first furnish the School with a copy of the proposed publication/s so that the School can verify and grant permission for such publication/s to be made publicly available.

As per your letter of permission to conduct research at the UWC from Dr Ahmed Shaikjee, Deputy Registrar, assistance to access staff contact information, must be facilitated by your supervisor. Please note that all COVID-19 protocols have to be observed when on campus.

We wish you success with your research.

Yours sincerely

Prof Penelope Martin

Director: School of Nursing

Faculty of Community and Health Sciences

UNIVERSITY OF THE WESTERN CAPE

021 959 9345

E: pmartin@uwc.ac.za

Appendix F: Permission to conduct study (Ethics)

UNIVERSITY OF THE WESTERN CAPE
PERMISSION TO CONDUCT RESEARCH

DEAR **Beverdene Syme**

This serves as acknowledgement that you have obtained and presented the necessary ethical clearance and your institutional permission required to proceed with the project referenced below:

RESEARCH TOPIC

Creating a caring praxis in nursing education: the experiences of clinical supervisors

Name of researcher	:	Beverdene Syme
Permission valid till	:	31 December 2024
Institution	:	University of the Western Cape
Ethics reference	:	HS21/10/44
Permission reference	:	UWCRP919538

You are required to engage this office (researchperm@uwc.ac.za) in advance if there is a need to continue with research outside of the stipulated period. The manner in which you conduct your research must be guided by the conditions set out in the annexed agreement: Conditions to guide research conducted at the University of the Western Cape.

Please be at liberty to contact this office should you require any assistance to conduct your research or require access to either staff or student contact information.

Regards
Dr Ahmed Shaikjee
Deputy Registrar Academic Administration

Approval status: **APPROVED** 10 March 2022

To verify or confirm the authenticity of this document please contact the University at researchperm@uwc.ac.za.

Appendix G: Proof of editing

Leverne Gething, M.Phil. *cum laude*

PO Box 1155, Milnerton 7435; cell 072 212 5417

e-mail: leverne@eject.co.za

16 December 2022

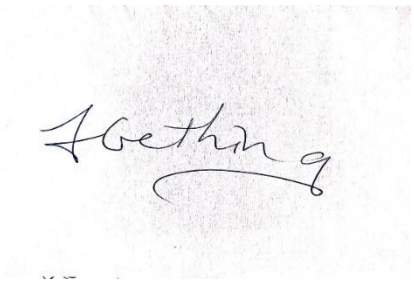
Declaration of editing of a Master's in Nursing thesis for submission to UWC

TITLE: **Creating a caring praxis in nursing education and training: The experiences of the clinical supervisors**

I hereby declare that I carried out language editing of the above thesis on behalf of **Beverdene Syme**.

I am a professional writer and editor with many years of experience (e.g. 5 years on *SA Medical Journal*, 10 years heading the corporate communication division at the SA Medical Research Council), who specialises in Science and Technology editing – but am adept at editing in many different subject areas. I have edited a great deal of work, including academic papers and theses, for various academic journals, universities and publishers.

I am a full member of the South African Freelancers' Association as well as of the Professional Editors' Association.



Yours sincerely

LEVERNE GETHING leverne@eject.co.za