GUIDELINES FOR CLINICAL FACILITATORS TO SUPPORT STUDENT NURSES IN A SIMULATION LABORATORY AT A COLLEGE OF NURSING IN THE WESTERN CAPE

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1.1   ABSTRACT

The main benefit of simulation in nursing education is the ability to teach clinical skills in a non-threatening, safe environment where mistakes can be rectified without harm to any patient. Therefore, it is clinical facilitators who must display the knowledge and skills to impart to the student nurses during their 4-year programme of study. It is unclear how student nurses at a local nursing college view teaching and learning processes in the simulation laboratory. The purpose of this study is to explore student nurses' views of teaching and learning in a simulation laboratory with the purpose of describing guidelines for clinical facilitators to support student nurses in a simulation laboratory at a local College of Nursing in the Western Cape.

A qualitative, exploratory, descriptive and contextual design was used in order to explore and describe the views of student nurses about teaching and learning in the simulation laboratory. The ECP (Extended Curriculum Programme), 1st, 2nd, 3rd and 4th year students (N = 880), who were registered in the R425 programme at the College of Nursing in the Western Cape, had been identified as the accessible student population of this study. A purposive opportunistic sampling population was applied. Two focus groups (20 participants) per year of study were conducted. The size of each focus group was at least 10 participants. The focus group interviews lasted around 60 minutes per group. Data gathering was conducted by the researcher who initiated, prompted, and facilitated these focus groups. For the purpose of data triangulation, voice recordings of the interviews were supported by the taking of field notes. Open coding had been used for data analysis. The credibility of the coding was checked and confirmed by an independent coder.

Trustworthiness was maintained, since credibility was ensured by means of prolonged engagement in the field until data saturation occurred, referential adequacy, and member checks that followed. Dependability was ensured by establishing an audit trail. Ethical considerations were ensured by obtaining written, informed consent from participants of the study, as well as for the voice recording of the discussions. Participants could withdraw at any stage of the study. Confidentiality was explained and the researcher requested that participants do not share the information after the group discussions.

In this study, student nurses experienced both opportunities and challenges with the teaching and learning in the simulation laboratory. Furthermore, the contextual demands between the first and subsequent years of study seemed to play an essential part in their experience.

1.2 DECLARATION

I declare that "Guidelines for Clinical Facilitators to Support Student Nurses in a Simulation Laboratory at a College of Nursing in the Western Cape" is my own work, that it has not been submitted for any degree or examination at any other university, and that all sources I use or quote are indicated and acknowledged as complete references.

Full name: Desiree Jessica Abrahams-Marra

Date: 12 September 2013

Signed: _____

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1.3 ACKNOWLEDGEMENT

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CHAPTER ONE:

INTRODUCTION, BACKGROUND, AND LITERATURE REVIEW

2.1   INTRODUCTION

Nursing education exists for the purpose of acquiring the knowledge and developing the skills students need to function as competent nurses (Rothgeb 2008:108). These skills could be developed in a simulation environment. Nursing simulation laboratories evolve over the past decade in response to the practical learning needs of undergraduate learner nurses (hereafter referred to as 'student nurses' according to the definition of 'learner nurse' on page 16) (Wellard, Solvoll & Heggen 2009).

Simulation laboratories are also known as clinical skills rooms, skills laboratories, and learning resource centres with varying levels of technologies (Childs & Sepples 2006:154). Simulation teaching originates from basic life support (resuscitation) programmes developed by Laerdal, a medical equipment company in Norway. The focus of the company had been to enhance patient safety during acute hospital care. Simulation equipment was developed in anaesthesia to allow for endotracheal intubation (Wilford & Doyle 2006:604), and moved into many other areas of the health profession, that included nursing, with the initial introduction of 'Resusci Annie' and more recently, SimMan®, a lifelike computerised manikin (Alinier, Hunt, Gordon & Harwood 2006:141).

The benefit of simulation in nursing education is the ability to teach clinical skills in a non-threatening, safe environment where mistakes can be rectified without harm to a patient. The nursing students work in peer groups which could enhance teamwork and teaching (Childs & Sepples 2009:107; Granger, Hebb, Lavallee & Murray 2011:82; Hancock 2008:262; Hovancsek, Jeffries, Escudero, Foulds, Husebo, Iwamoto, Kelly, Petrini & Wang 2009:102; Jeffries 2009:104). Simulation is used during both under- and post-graduate nursing programmes and the rationale is to develop and enhance specific nursing skill sets in order to meet the requirements of application of theory in practice, and to replicate the clinical setting that would ultimately assist with achieving safe patient care (Childs & Sepples 2006:154; Jeffries, Bambini, Hensel, Moorman & Washburn 2009:662; Rothgeb 2008:494).

However, nursing students ought to be adequately prepared for carrying out clinical skills competently and efficiently. It is the responsibility of nursing educators and nurse practitioners to display knowledge and skills required to promote integration between theory and practice in order to enhance student nursing education that results in acceptable standards of patient care. Therefore, clinical skills laboratories are necessary to guide student nurses to develop the collaborative skills required for a profession like nursing. (Childs, Sepples & Chambers 2007:58; Freeth & Fry 2005:279; Hovancsek *et al.* 2009:2; Jeffries *et al* 2009:622; Morgan 2006:160). Teaching and training of basic to more complex clinical procedures can be conducted in simulation laboratories, and the more complex skills that require more dexterity can be simplified into smaller steps. The student nurse should be able to practise the skills until they are competent and confident before utilising these skills in the clinical setting with real patients *(*Childs *et al.* 2007:106; Freeth & Fry 2005:279; Jeffries 2006:96; Kardong-Edgren, Starkweather & Ward 2008:13).

Across the globe (in developed, as well as developing countries), simulation laboratories develop over a period of time due to technological changes in the midst of shortages in nursing. It adds to challenges faced by both the student nurses and clinical facilitators (Baillie & Curzio 2008:303; Barry 2009:434; Childs & Sepples 2009:107; Jeffries 2006:96). Simulation laboratories develop at colleges of nursing in the Western Cape since 2005. The need arises from an increase in student nurse enrolment numbers, a decline in clinical site placement opportunities (Jeggels, Traut & Kwast 2010:85), as well as a shortage of skilled nursing personnel in certain clinical areas.

Shortages of skilled nurses, both in clinical areas and at nursing colleges, are creating challenges that student nurses and clinical facilitators encounter in the simulation laboratory during the learning and teaching process (Howard, Englert, Kameg & Perozzi 2011:e9). This also seems to be the case at a College of Nursing in the Western Cape, South Africa.

2.2   PROBLEM STATEMENT

There is an increase in student enrolment at a local College of Nursing and shortages of trained nursing staff at clinical sites. Furthermore, in-patient stay in hospitals is shorter with decreasing opportunities of acquiring practical nursing skills at clinical sites. It leads to the recruitment of more clinical facilitators in order to meet the practical learning needs of the student learners (Morgan 2006:158; Jeffries 2006:96; Jeggels *et al.* 2010:85; Nehring &

Lashley 2009:248). A study by Morgan (2006:160) indicates that clinical facilitators seem motivated to utilise the simulation laboratory for basic skills development. However, they are experiencing technological challenges with some of the equipment, while being exposed to large groups of student nurses. At the time of this study, it was unclear how student nurses viewed the teaching and learning processes in the simulation laboratory at a College of Nursing in the Western Cape.

From the problem statement, the following research questions were posed:

- How did student nurses view teaching and learning in the simulation laboratory?
- What actions did students suggest for describing guidelines for clinical facilitators i to support them in the simulation laboratory?

2.3   PURPOSE OF STUDY

The viewpoints of student nurses were explored and described with the purpose of developing guidelines for clinical facilitators to support students in the simulation laboratory at a College of Nursing in the Western Cape.
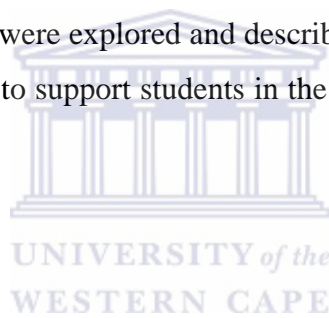
2.4   OBJECTIVES

This study's objectives are:

- explore and describe the viewpoints of student nurses about teaching and learning in the simulation laboratory at a College of Nursing in the Western Cape; and
- describe guidelines for clinical facilitators with the purpose of supporting student nurses in the simulation laboratory at a College of Nursing in the Western Cape.

2.5   RATIONALE OF THE STUDY

Positive simulation laboratory learning enhances the acquiring of basic nursing skills in a safe and non-threatening learning environment. It minimises students' anxiety and stress levels and increases their levels of confidence in "knowing and being able to do" the skills they require, prior to clinical placement (Rothgeb 2008:494). The simulation laboratory provides each learner with a similar learning opportunity where theory is applied in practice and group work is improved (Limoges 2010:60). Therefore, exploring and describing the viewpoints of student nurses about learning and teaching in the simulation laboratory may inform the crucial

guidelines for clinical facilitators to support students in the simulation environment at a nursing college that is consistently informed about changes in policy and procedure.

2.6 LITERATURE REVIEW

While simulation laboratories are evolving in several countries across the globe, teaching and learning methods are questioned with regard to its efficacy and whether student nurses could make the necessary transition from an artificial learning and teaching environment to one of reality, that is the clinical setting (Childs & Sepples 2009:5; Hovancsek *et al.* 2009:3; Freeth & Fry 2005:279; Jeffries 2005:103; Jeffries 2006:351; Howard *et al.* 2011:e9; Haigh 2007:101; Hosoda 2006:484; Kaakinen & Arwood 2009a:17; Lisko & O'Dell 2010:108). This process requires resources. Simulation laboratories across the world vary in levels of technology and the usefulness in developing nursing skills as part of undergraduate nursing programmes. Its success is dependent on financial and human resources to manage the facility (Jeggels *et al.* 2010:85).

Kaakinen and Arwood (2009a:14) reviewed nursing simulation literature between 2000 and 2007. Subsequently, they consider simulation more as a teaching model rather than a learning model. Most of the studies approach the complexity of practice as the acquisition of skills that are taught by "doing". However, none of the studies use research about how the brain acquires or learns concepts. Even in relation to student thinking, students' preferences, beliefs, or perceptions of beliefs; which are all components of self-efficacy; are measured, and not conceptual learning.

However, Kaakinen and Arwood (2009a:14), state that Kolb's (2004) works support the purpose of designing simulation to match a student's needs and preferences for learning. Learning style categories are developed based strictly on observations about what people are doing while learning is assumed to be taking place. For example, some people move around all the time or fidget while paying attention (assumed learning is taking place). Therefore, they are assigned to the kinaesthetic learner style.

During the past decade, there is a steady growth in the technological sophistication of simulation laboratories in nursing education (Childs & Sepples 2009:5; Jeffries 2009:S6; Jeggels *et al.* 2010:85; Nehring & Lashley 2009:248; Reese, Jeffries & Engum. 2010:36; Stark & Fortune 2003:305; Wellard, Solvoll & Heggen 2009:233). That level of technological development is dependent on several factors:

- Increased enrolment of students at colleges of nursing;

- Diminishing clinical site placement, as well as diminishing learning opportunities; and

- Having a safe learning environment.

Literature indicates limitations in the scope of learning settings that simulate patient care. It is found that there is a tendency to design the simulation laboratory as an acute hospital care setting and little or no design includes other forms of nursing and patient care (Rothgeb 2008:493; Wellard *et al.* 2009b:234; Stark & Fortune 2003:305). Wellard *et al.* (2009b:233) state that there is a lack of knowledge about how student nurses could benefit from gaining knowledge while they are moving between the lecture theatre, simulation laboratories and clinical sites for preparation to become nurses. Appropriately supervised clinical site placements, as well as decreasing learning opportunities at clinical sites create the need for simulation laboratories to provide the required psychomotor skills training that integrates theory with practice (Morgan 2006:160).

Limoges (2010:110) states that understanding how the simulation laboratory experience is theoretically integrated with the current teaching paradigm and exploring areas for change are important concepts for consideration by nursing education providers. Wellard *et al.* (2009b:233), as well as Lisko and O'Dell (2010:108), state that traditional approaches to nursing education, including didactic lectures, memorisation, and return laboratory demonstration might indicate technical mastery, but these techniques do not facilitate the development of critical thinking.

Student nurses learn best by means of experiential learning. Kolb's Experiential Learning Theory and Model (2000) is a foundation of the practice integration method designed to provide a critical thinking experience. Introspection methodology, as used by Benner, expect expert nurses to conduct a task analysis or to explain everything they remember they are doing and why they are executing that particular action through reflective practice (Kaakinen & Arwood 2009b:17).

2.7 THEORETICAL ASSUMPTIONS

Kolb, Boyatzis and Mainemelis (2000:2) provide a holistic model of the learning process and a multi-linear model of adult development. This process and model are consistent with what we know about how people learn, grow, and develop. The theory is called "Experiential Learning" to emphasise the central role that views and experiences play during the learning process.

Subsequently, the following assumptions are made by the researcher:

- It is assumed that this learning theory fits clinical skills training well;
- Experience plays a central role in the learning process;
- The learning cycle begins with a concrete experience that the student encounters (Jeggels *et al.* 2010:85); and
- The student observes all the aspects of the experience and reflects on it. It gets followed by a conscious effort to gain insight and form generalisations (theory) about the experience.

Kolb *et al.* (2000:3) state that the learner student ought to continually choose which set of learning abilities he or she would use in a specific learning situation. In acquiring experience, some of us perceive new information by experiencing the concrete, tangible, felt qualities of the world while relying on our senses and immersing ourselves in concrete reality.

According to the theory, learning gets enhanced when students are actively involved in gaining knowledge by experience that includes problem solving and decision making.

2.8 DEFINITION OF TERMS

Simulation laboratory: A simulation laboratory is an on-campus facility that aims at simulating health care settings and allows students to rehearse clinical skills, surrounded by the artefacts of clinical environments (Wellard *et al.* 2009b:40). In this study, the simulation laboratory is located at the local College of Nursing, and it has the artefacts of a clinical environment.

Views: A personal opinion about something; an attitude towards something. (Oxford Advanced Learners Dictionary 2005:1640). In this study, the views of the student nurses

about learning and teaching in a simulation laboratory at a local College of Nursing in the Western Cape are explored.

Teaching: Teaching is what the educator provides the student with in terms of goals, methods, objectives and outcomes (Kaakinen & Arwood 2009b:17). In this study, teaching is what the clinical facilitator provides the student nurses with in terms of goals, methods, objectives and outcomes as determined by their curriculum at a College of Nursing in the Western Cape.

Learning needs: Learning refers to the processes that enable the student nurse to change skills, knowledge and dispositions by means of a planned experience (Kaakinen & Arwood 2009a:12). In this study, learning refers to the views of the student nurses' learning and teaching in a simulation laboratory at a College of Nursing in the Western Cape.

Learner nurse: It refers to a person who is duly registered in terms of Section 32 of the Nursing Act 33 of 2005 (SANC 2005):

- A person undergoing education or training must apply to the Council to be registered as a learner nurse or a learner midwife;
- The Council must register as a learner nurse or a learner midwife any person who complies with the prescribed conditions and furnishes the prescribed particulars for a training programme at a nursing education institution; and
- In terms of Section 2 (n) of the South African Nursing Council Programme Objectives, a learner nurse or a learner midwife has the cognitive, psychomotor, and affective skills to serve as a basis for effective practice and for continuing education (Government Notice No. R425).

In this study, the term student nurse, refers to learner student nurses who are registered in the R425 programme, and are currently studying at a College of Nursing in the Western Cape.

Nursing education: It exists for the purpose of acquiring the knowledge and developing the skills students need to function as competent nurses (Rothgeb 2008:490).

Guidelines: It is an official recommendation that indicates how something should be done or what kind of action should be taken in a particular circumstance (Encarta Dictionary 2008).

Clinical facilitator: Nurse practitioners / educators who reinforce the theoretical component of the programme while teaching practical procedures in the clinical skills laboratory (Morgan 2006:159).

CHAPTER TWO:
RESEARCH METHODOLOGY

2.1 INTRODUCTION

Methodology refers to the coherent group of methods that complement one another and that have the "goodness of fit" to deliver data and findings that will reflect the research question and suit the research purpose (Henning, Van Rensburg & Smit 2007:36).

Henning *et al*. (2007:15) continue to state that methodology does not only include how we come to know, but it also is much more practical in nature – it means that we come to know by inquiring in certain ways. Methodology is concerned with the specific ways, the methods that we can use to try and understand our world better.

A discussion of the research design, the study population, the sample, the sampling procedure, data collection methods, data analysis, trustworthiness, and ethics are included in this chapter.

As stated by Mouton (2005:124), methodological assumptions are assumptions about the nature of the research process and the most appropriate methods to be used, about the relative worth of qualitative methods, about interpretation versus explanation, and about the ideal of universal statements versus specific and 'local' generalisations.

As defined by Polit and Beck (2010:562), a paradigm is a way of looking at natural phenomena that encompass a set of philosophical assumptions and that guide one's approach to inquiry. Henning *et al*. (2005:31) concur that the way the researcher perceives the world and knowledge, i.e. the ontological and epistemological position of the researcher, influence the research phenomena and the design of the inquiry. In this study, the questions were directed at the meaning of participants' experiences, feelings, beliefs, and convictions about the theme in question (De Vos, Strydom, Fouché, & Delport 2011:317), namely their views' of teaching and learning in a simulation laboratory at a College of Nursing. Student nurses learned best by means of experiential learning, and Kolb's Experiential Learning Theory and Model was a foundation for the practice integration method designed to provide a critical thinking experience. The introspection methodology, as used by Benner, expects expert nurses to conduct a task analysis or to explain everything they remember about their duties by reflecting on their actions (Kaakinen & Arwood 2009b:117).

2.2   RESEARCH DESIGN

Denzin and Lincoln (2011:36) state that a research design situates researchers in the empirical world and connects them to specific sites, persons, groups, institutions, and bodies of relevant interpretive material that include documents and archives. The authors further describe a research design as a flexible set of guidelines that connects theoretical paradigms, firstly to strategies of enquiry and secondly to methods for collecting empirical material. Researchers select methods and a research genre / design that will not only suit the research question optimally, but will also indicate the researchers' (reflexive) knowledge of how language makes meaning, and what role Kolb's theory plays.

Polit *et al*. (2010:203) concur that the research design of a study provides the basic strategies that researchers adopt to develop evidence that is accurate and interpretable. The research design incorporates some of the most important methodological decisions that researchers make.

In this study; a qualitative, exploratory, descriptive, contextual design was used to explore and describe the student nurses' view of learning and teaching in the simulation laboratory. The purpose was to develop guidelines for supporting the learner in the simulation laboratory at a local College of Nursing in the Western Cape.

Henning *et al*. (2007:16) state that in qualitative studies the "variables" are usually not controlled because it is exactly this freedom and natural development of action and representation that qualitative researchers wish to capture. A **qualitative study** is a study that is presented largely in language and deals with the meaning constructed from the language that presents the data.

Du Plooy (2009:33) states that qualitative researchers hold the opinion that there is no one objective reality which can be observed and neutrally quantified. Gravetter *et al*. (2009:158) state that the primary distinction between quantitative and qualitative research is the type of data they produce. Quantitative research typically produces numerical scores, whereas qualitative research is typically a narrative report that is a written discussion of the observations. However, qualitative researchers believe that human beings are unique and that they cannot be simply categorised (Du Plooy 2009:33).

In this study, the phenomenon being studied was student nurses' views of learning and teaching in a simulation laboratory. It included the actions that student nurses were suggesting to clinical facilitators, in order to support students in the simulation laboratory. Plus assisted with describing guidelines for clinical facilitators with the purpose of supporting student nurses in the simulation laboratory at a College of Nursing in the Western Cape. Henning *et al*. (2007:3) emphasise that qualitative researchers want to find out not only what happens but also how it happens and, importantly, why it happens the way it does.

Babbie and Mouton (2005:80) state that **exploratory studies** are most typically conducted to:

- satisfy the researchers' curiosity and desire for better understanding;
- explicate the central concepts and constructs of a study;
- determine priorities for future research; and
- develop new hypotheses about an existing phenomena.

The authors continue by stating that because exploratory studies usually lead to insight and comprehension rather than to the collection of detailed, accurate, and replicable data; these studies frequently involve the use of in-depth interviews (Babbie *et al*. 2005:80).

According to Polit *et al*. (2010:22), like descriptive research exploratory research begins with a phenomenon of interest. Instead of simply observing and describing the phenomenon, exploratory researchers investigate the full nature thereof, the manner in which it is manifested, and the other factors to which it is related; including potential factors that might be causing it.

Gravetter *et al*. (2009:160) state that a **descriptive research design** is intended to answer questions about the current state of individual variables for a specific group of individuals. This design is not concerned with relationships between variables but rather with the description of individual variables. The goal of a descriptive design is to obtain a snapshot (description) of specific characteristics of a specific group of individuals.

Polit *et al*. (2010:552) agree that descriptive research has as its main objective the accurate portrayal of the characteristics of persons, situations, groups, and / or the frequency with which certain phenomena occur. This study described the narratives of the student nurses experiences of learning and teaching in a simulation laboratory; and what actions student

nurses suggested to clinical facilitators in order to support students in the simulation laboratory, at a College of Nursing in the Western Cape.

Babbie *et al*. (2001:272) state that a **contextual study** aims at describing and understanding events in the concrete, natural context in which they occur. The authors add that the qualitative researcher argues that one can truly claim to "understand" events when the background of the whole context and how such a context confers meaning to the events are taken into consideration.

The researcher entered the setting with an open mind, prepared to immerse them in the complexity of the situation and to interact with their participants. Categories (variables) emerge from the data that lead to "**context-bound**" information, patterns and / or theories that explain the phenomena under study. Therefore, data analysis is more subjective in nature (De Vos *et al*. 2011:64).

The purpose of this study was to explore and describe the views of student nurses in the natural context of the simulation laboratory with the view to developing guidelines for clinical facilitators to support students in the simulation laboratory at a College of Nursing in the Western Cape.
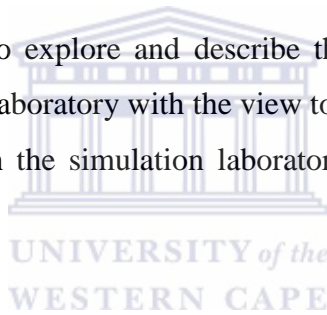
2.3   POPULATION

Babbie *et al*. (2005:100) affirm that the population of the study is that group from which a researcher wants to draw conclusions. A researcher is almost never able to study all the members of the population, nor can every possible observation of them be made. A population is the entire aggregation of cases in which a researcher is interested. A population may either be broadly defined when thousands of individuals are involved, or may be narrowly specified when the population only includes a small number of people. The accessible or source population is the aggregate of cases that conform to designated criteria and that is accessible as participants for a study. Researchers usually sample from an accessible population (Polit *et al*. 2008:238). In this study, the accessible population was the student nurses (N=880) at the campus of a College of Nursing in the Western Cape.

Vicki, Plano and Cresswell (2010:252) agree that the qualitative researcher selects sites and people that can best assist with developing an understanding about a central phenomenon. This understanding emerges through a detailed exploration of the people or sites. It provides

information that is useful, that helps us learn about the phenomenon, or that gives a voice to individuals who are not heard. In qualitative research, where there is a need to collect detailed data from participants, it is often important to select a small sample of individuals who are both able and willing to provide the type of data the study seeks (Oliver 2010:77). In this study, a sample was selected from those student nurses at the campus of a College of Nursing in the Western Cape.

Table 2.1:   Number of students

Year of study	Total number of students per year of study
Extended Curriculum 1st Year	40
First Year	350
Second Year	220
Third Year	180
Fourth Year	90
Total	**880**

2.4   SAMPLING

Sampling is the selection process of research participants from a population that includes decisions about the observation of people, settings, events, behaviour, and / or social processes (Terre Blanche *et al*. 2007:49).

Wheeler *et al*. (2010:146) believe that there is rarely justification for a large sample in qualitative research, since it is unnecessary and might result in less depth and richness. The researcher's intention usually is to thoroughly research a purposive sample in a specific setting. An oversized sample might not capture the meanings participants ascribe to their experiences, and it could result in the loss of the unique and specific contributions.

According to Vicki *et al*. (2010:253), the research term that is used for qualitative sampling is purposive sampling. **Purposive sampling** means that the researchers intentionally select sites and individuals with the purpose of learning about or understanding the central phenomenon. Patton (2002:169) explains that the logic and power of purposive sampling lies in selecting

information rich cases for an in-depth study. Vicki *et al*. (2010:253) describe purposive sampling as information-rich cases from which one can learn a great deal about issues of central importance to the purpose of the research. They further elaborate that purposive sampling is important for good qualitative research because it demonstrates that the researcher tries to identify the best sites and participants with the purpose of learning about the central phenomenon.

According to Patton (2002:173), homogeneous sampling is the strategic picking of a small, similar sample. The purpose is to provide an in-depth description of a particular subgroup. The author continues to state that focus group interviews are typically based on homogeneous groups. Focus group interviews involve conducting open-ended interviews with groups of people about specially targeted or focused issues. It is important that sampling for focus groups typically involves the gathering of people with similar backgrounds and experiences to participate in a group interview about major programme issues that are affecting them. Terre Blanche *et al*. (2007:139) state that purposive sampling implies that sampling depends not only on availability and willingness to participate, but that typical cases of the population are selected.

The purposive sampling group in this study was those student nurses from the (ECP) Extended Curriculum Programme, 1st, 2nd, 3rd and 4th year groups at a College of Nursing in the Western Cape. It was planned that two groups of 8 student nurses of each year of study would be selected to participate in focus group interviews (Table 2.1). In this study, purposive sampling was utilised and the researcher sought suitable participants for the focus group interviews. Polit *et al*. (2010:341) state that focus group interviews ideally need to be conducted with groups of about six (6) to ten (10) people whose opinions and experiences are solicited simultaneously. The interviewer guided the focus group discussions according to an interview guide.

Table 0.2: **Planned focus group interviews with student nurses at a College of Nursing in the Western Cape**

Year of study	Focus Groups	Participants
ECP 1st year	2	16
1st year	2	2
2nd year	2	8
3rd year	2	8
4th year	2	12
Total	**10**	**46**

2.5   SAMPLE

Polit *et al*. (2008:395) postulate that groups of four or fewer may not generate sufficient interaction, particularly because not everyone is equally comfortable with expressing their views. Botma, Greeff, Mulaudzi and Wright (2010:211) agree that deciding on the size and the right number of participants' means striking a balance between having enough participants to generate a discussion without having too many participants, since some valuable contributions may get lost during a crowded interview. Six (6) to ten (10) participants are preferable when they have to share in-depth, intense, and lengthy experiences.

The bigger the group, the more experienced the facilitator needs to be to ensure participation and discipline. In this study, the number of participants per focus group was five (5) to eight (8).

Inclusion criteria for the sample

For this study, nursing students in their ECP, 1st, 2nd, 3rd, and 4th year of study at a College of Nursing in the Western Cape; who were registered for the four year Diploma in General Nursing Science, Community Nursing Science, as well as Psychiatric and Midwifery Nursing Science; were included. The qualification should enable them to register as professional

nurses according to the South African Nursing Council Regulation 425, as promulgated by the Nursing Act 33 of 2005 (SANC 2005).

The sample was selected from the student nurse population, who were currently registered in the R425; for a Diploma in General Nursing, Community Nursing, as well as Psychiatric and Midwifery Nursing Science who were attending classes and / or residing on campus at a College of Nursing in the Western Cape.

Eight focus group interviews were conducted (see Chapter 3).

2.6   DATA COLLECTION

The phenomena in which researchers are interested must ultimately be captured and converted into data that can be analysed. Without high-quality data collection methods, the accuracy and robustness of the conclusions are subject to challenge. In developing a data collection plan, the researcher needed to carefully consider the kind of evidence they want to provide to their colleagues in settings of practice (Polit *et al.* 2008:367). The decisions about inclusion and exclusion depended on the research topic, the emerging data and the experience of the researcher (Holloway *et al.* 2010:158).

Holloway *et al.* (2010:158) believe that in qualitative studies, the researcher is the major research tool by taking note of everything they see and hear as well as interviewing members to gain their interpretation. They further state that health researchers commonly observe behaviour in clinical or educational settings. In this study the participants and their actions were observed, as well as the ways in which they interacted with one another. The site and the use of space and time were also observed. Where the researcher did not understand what she saw or heard she asked participants to explain these instances to her.

The interviews were formal and unstructured, but the researchers asked follow-up questions on the spur of the moment. Often a researcher uncover discrepancies between the words and actions – what people do and what they say – a problem originally discussed by Deutscher (1970). On the other hand, there may be congruence between the spoken word and behaviour. If any discrepancies exist, they must be explained and interpreted.

Alasuutari, Bickman and Brannen (2009:361) state that specific issues that the researcher is expected to deal with include disagreement and arguments between members of the groups, noticing when participants are uncomfortable with a discussion and dealing with this

discomfort appropriately, and ensuring that the essential topic is covered in the available time. As Sim in Alasuutari *et al*. (2009:361) state, the researcher tried to ensure that discussion took place among participants rather than between participants and researcher. De Vos *et al*. (2011:368) agree that the researcher needs to direct discussions, encourage participation, and probe participants without expecting biased responses.

Patton (2002:372) state that probes are used to deepen responses to a question, to increase the richness and depth of responses, and to give cues to the participants about the level of response that is desired. Probing questions were used by the researcher and were conversational, offered in a natural style and voice, and used to clarify initial responses (Patton 2002:372).

Probing is a skill that originates from knowing what to look for during an interview, listening very carefully to what is said and what is not said, and being sensitive to the feedback needs of the participants who are being interviewed (Patton 2002:374).

As De Vos *et al*. (2011:368) state, the researcher needed to keep the discussion flowing by encouraging everyone to be an active participant. Patton (2002:374) concurs that the researcher needs to maintain awareness of how the interview is progressing, how the participants are reacting to questions, and what type of feedback is appropriate and helpful for the purpose of sustaining the flow of the discussion. Probing was done to obtain clarity and validation of what the participants said. In this study, data were collected from participants' discussions during focus group interviews by using the appropriate interviewing, listening, observational, and communication skills.

2.7   FOCUS GROUP INTERVIEWS

As defined by Alasuutari *et al*. (2010:358), a focus group is generally understood to be a group of 6 – 10 participants, with an interviewer or moderator who asks questions about a particular topic. The authors continue to state that focus group interviews are in-depth group interviews consisting of relatively homogenous participants to provide information about topics that are specified by the researchers.

Polit *et al*. (2010:395) state that the researcher plays a critical role in the success of focus group interviews. An important job of the researcher was to solicit input from all group members, and not to allow a few vocal people to dominate the discussion. Bless, Higson-

Smith and Kagee (2009:123) support this point of view by explaining that group facilitation is aimed at ensuring that a safe environment for uncensored communication is created. In particular, the researcher/facilitator should ensure that everyone in the group has real opportunities to contribute, and that the group does not prevent some members from freely expressing their ideas. Some members of the group might tend to dominate and they would need to be disallowed by the facilitator. Some participants might find it extremely difficult to express their thoughts and they would need to be encouraged (Bless *et al*. 2009:123).

Polit *et al*. (2010:395) state that focus group sessions are carefully planned discussions that take advantage of group dynamics for accessing rich information in an efficient manner. Typically, the people selected for a group are fairly homogeneous to promote fairly comfortable group dynamics. People usually feel more at ease expressing their views when they share a similar background with other group members. Therefore, when the general sample is diverse, it is usually best to organise focus groups for people with similar characteristics, e.g. in terms of race / ethnicity, age, gender, or experience. This approach does not rely merely on the ideas of the researcher and a single participant. Instead, the members of the group generate new questions and answers through verbal interaction. Holloway *et al*. (2010:127) continue to state that through these group interviews, researchers are able to discover the experiences of the participants. They further elaborate that focus groups are characterised by interaction between the participants while researchers are discovering how people think and feel about particular issues, such as the views student nurses at a local College of Nursing, had about learning and teaching in a simulation laboratory. Focus groups members responded to the interviewer and to one another. Before the question was posed, participants were put at ease without wasting time before starting the discussion. In this study, the opening question of each focus group interview was, *"What are your views of teaching and learning in the simulation laboratory at the Western Cape College of Nursing?"* Different reactions stimulated debate about the topic because group participants responded to one another. Discussions in the groups helped not only in the development of ideas about problems and questions which the researcher did not think about before, but also with finding answers to some of the questions and solutions to problems.

Polit *et al*. (2010:395) state that a major advantage of a group format is the fact that the researcher efficiently obtains the viewpoints of many individuals in a short period of time. They state that focus groups encourage participants to react to what is being said by other

participants, thereby potentially creating a richer or deeper expression of opinions. Also, focus group interviews are usually stimulating to participants. Holloway *et al*. (2010:127) concurs that the ultimate goal for the researcher is to understand the reality of the participants, and not to make decisions about a specific issue or problem, although future actions may be determined by the findings of the focus group interviews. The second question posed to the focus groups was *"What actions they could suggest to clinical facilitators in order to support the student learner in learning in the simulation laboratory?"*

Focus groups differ from individual interviews, since they depend on the stimulus that participants gain from one another by discussing both unique and shared perceptions and experiences. For this reason, the researcher chose to conduct focus group interviews with the student nurses who were registered in the R425 course that led to registration with the South African Nursing Council with a Diploma in General, Midwifery, Psychiatric, and Community Nursing Sciences.

Polit *et al*. (2008:395) continue to state that it is a disadvantage of focus group interviews when some people are uncomfortable about expressing their views in front of other group members. The fact that the dynamics of the sessions may allow a group culture that could inhibit individual expression is also of concern, since collective thinking inhibits the expression of individual thinking. However, the researcher noted that the topic of this study was not a sensitive issue and the students could freely air their views. Furthermore, Bless *et al*. (2009:123) state that many African cultures make constant use of small groups to address concerns within the community. For this reason, the focus group method of data collection was the method of choice, since participants seemed to be extremely comfortable with sharing their views. In this study, therefore, focus groups were used to capture student nurses' views of teaching and learning at a College of Nursing in the Western Cape and the actions the student nurses suggested for clinical facilitators to use in order to support them with learning in the simulation laboratory.

2.8   PREPARATION OF THE FIELD

Polit *et al*. (2008:395) state that the setting for the focus group sessions should be selected carefully and, ideally it should be a neutral space. The location was planned to be comfortable, easily accessible, and free from intimidation. Focus group interviews should be conducted in a non-threatening setting. Since the sessions in this study lasted between 45 to

60 minutes, the comfort of participants was important. The location of focus group interviews needed to meet the needs of the researcher and the participants alike. The primary concerns for the researcher are the ability to hold the discussion and to capture the data. However, for the participant comfort is the main concern (De Vos *et al*. 2011:370). Conducting effective focus group interviews required careful planning with regard to participants, the environment, and equipment.

Recruitment of participants for the focus group interviews required a systematic process, thus it was important to set dates, times, and locations before establishing contact with participants. The following specific tasks were taken into account during the recruitment phase of this study:

- Know the segments of the target population;
- Identify the appropriate composition of each group;
- Apply inclusion and exclusion criteria for each participant;
- Invite potential eligible participants; and
- Determine the follow-up procedures that will encourage attendance.

The right group composition generates free-flowing discussions that contain useful data (De Vos *et al*. 2011:365). In this study, the campus library at a College of Nursing in the Western Cape had a private meeting room that was easily accessible for both the participants and the researcher and was utilised for the focus group interviews. The meeting room allowed for privacy and enhanced the use of audio-recording equipment.

2.9 FIELD NOTES

Definition of field notes: It refers to the notes that are taken by researchers to record the unstructured observations made in the field, and the interpretation of those observations (Polit *et al*. 2010:555). Field notes as described by Field and Morse in De Vos *et al*. (2011:372) are a written account of the things the researcher hears and sees during the course of collecting or reflecting on the data obtained during the study.

The most important forms of record keeping for participant observation are field notes. A log (field diary) is a daily record of events and conversations. Field notes are broader and more interpretive, and represent the observer's efforts to record information and to synthesise and understand the data (Polit *et al*. 2010:354). In focus groups, the notes should include:

- Seating arrangements;

- The order in which the people speak for voice recognition purposes;

- Non–verbal behaviour; such as eye contact, posture, gestures among group members, and fidgeting;

- Themes that are striking; and

- Emphasising as much of the conversation as possible (De Vos *et al*. 2011:372).

In this study, field notes were used to record the seating arrangement of participants in each focus group. For voice recognition purposes, notes were made about the order in which the participants spoke. Participants' behaviour was also noted and striking themes that had emerged from the discussions were highlighted.

2.10 AUDIO-RECORDING OF INTERVIEWS

As stated by De Vos *et al*. (2011:359), informed consent to audio record the interview must be obtained from all participants. The venue of the focus group interviews should be acoustically suited for audio-recordings (Polit *et al*. 2008:395). Audio-recording of interviews allows for a more complete record when compared to notes that are obtained during the interviews. It also gives the researcher the opportunity to concentrate on the development of the interview and to facilitate the direction of the discussion. It is recommended that both an electronic and battery-operated voice recorder are used to ensure that data are captured without fail. The quality of the voice recordings influences the accuracy of the transcription and analysis of the data. Audio-recorders should be placed inconspicuously, since its obvious use will unnerve the participants or the novice researcher. Some participants may feel uncomfortable with being audio-recorded and may withdraw from the focus group (De Vos *et al*. 2011:359).

In this study, audio recordings were used to capture the discussions of the focus group interviews during which the student nurses expressed their views about learning and teaching in the simulation laboratory and what actions student nurses suggested to clinical facilitators in order to support their learning.

2.11 DATA SATURATION

As defined by Polit *et al*. (2010:531), saturation is the collection of data in a qualitative study to the point where a sense of closure is attained because any new data yield redundant information.

Sometimes, the only way to find out whether more focus group meetings are required is to assess the need while the interviews are being conducted. The more diverse the responses, the more groups will be required in order to know what people are saying. Fewer groups are needed when there is a similar range of responses. If the discussion reaches saturation and becomes repetitive after two or three groups, there is little to be gained from increasing the number of groups (De Vos *et al*. 2011:367). Particularly with interviews and observations, there comes a point where no new categories emerge when more sets of notes or transcripts are examined. The categories are considered to be "saturated" and it indicates that the next stage of the research process may commence (Costley *et al*. 2010:98).

In this study, data saturation was reached when similar responses and themes were noted in the discussions during the focus group meetings. *Data saturation occurred with the seventh focus group interview*. However, eight focus group interview was conducted to ensure data saturation.
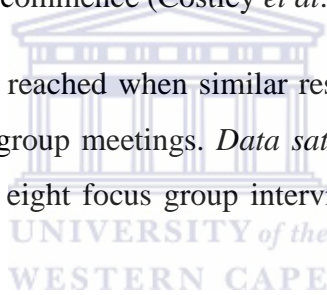
2.12 PILOT FOCUS GROUP INTERVIEW

Bless in De Vos (2011:237) defines a pilot study as a small study conducted prior to a larger piece of research to determine whether the methodology, sampling, and analysis are adequate and appropriate. The pilot study forms an important part of the research process. Its function is the exact formulation of the research problem, and tentative planning of the method and range of investigation (De Vos *et al*. 2011:236).

Sarantakos in De Vos *et al*. (2011:236) states that researchers should never start the main inquiry, unless they are confident that the chosen procedures are suitable, valid, reliable, effective, and free from problems that might arise during the study. De Vos *et al*. (2011:237) continue to state that probability does not play a role in qualitative pilot studies, since the findings are not generalised.

Although the researcher may plan his / her investigation very carefully and logically, the practical situation remains an unknown factor until it is entered, thus modifications can be

made to the interviewing process after the pilot focus group interview (Vos *et al*. 2011:237). The authors continue to state that during the pilot study the researcher may already form an opinion about the openness of the participants, the willingness to co-operate, and the number of participants likely to be involved until saturation of data is achieved.

De Vos *et al*. (2011:370) state that piloting in focus group interviews can be difficult, since the questions used these interviews are difficult to separate from the environment of the focus group. Therefore, the true pilot test is the first focus group interview with the participants.

In this study, a pilot focus group was conducted to determine whether the methodology, sampling, and analysis were adequate and appropriate. The data obtained from the pilot study were included in the analysis of this study.

2.13 TRUSTWORTHINESS

Streubert and Carpenter (2011:47) state that it is critical for qualitative researchers to clarify 'to outsiders' what qualitative research is, by stressing the use of qualitative findings and addressing the quality in qualitative studies. Holloway *et al*. (2010:302) describe the cornerstones of trustworthiness in qualitative research as methodological soundness and adequacy. Researchers make judgements of trustworthiness possible through developing dependability, credibility, transferability, and confirmability. The most important of these qualities is credibility. Polit *et al*. (2008:768) concur that trustworthiness is the degree of confidence that qualitative researchers have in their data that are assessed by using the criteria of credibility, transferability, dependability, confirmability, and the fifth criteria as authenticity.

2.13.1 DEPENDABILITY

The term dependability as opposed to reliability is used by Lincoln and Guba (1985; 1989) and replicated in Holloway *et al*. (2010:768). If the findings of a study are to be dependable, they should be consistent and accurate. This means that readers will be able to evaluate the adequacy of the analysis by following the decision-making processes of the researcher. The context of the research must also be described in detail. To achieve some measure of dependability, an audit trail is necessary. This helps readers follow the path of the researcher and demonstrates how she / he achieves their conclusions. It also guides other researchers

who wish to carry out similar research. Although this study cannot be replicated, in similar circumstances with similar participants, it might be repeated.

In this study, dependability was achieved by narrating the analysed data (quotes) as voiced by the study participants.

2.13.2 CREDIBILITY

Holloway *et al.* (2008:303) state that credibility corresponds with the notion of internal validity. This means that participants recognise the meaning that they attach to a situation or condition and the "truth" of the findings in their own social context. The researcher's findings are, at least, compatible with the perceptions of the people under study. Polit *et al.* (2010:751) concur that credibility is a criterion for evaluating integrity and quality in qualitative studies by referring to confidence in the truth of the data, i.e. analogous to internal validity in quantitative research.

In this study, the focus group participants were able to discuss their views about learning and teaching in the simulation laboratory and suggested actions that clinical facilitators could use to support the learning and teaching of students.

2.13.3 TRANSFERABILITY

Lincoln and Guba use transferability instead of generalisability (as cited in Holloway *et al.* 2008:303). This means that the findings in one context can be transferred to a similar situation or participants. The knowledge acquired in one context could be relevant in another, and those who carry out the same research in another context will be able to apply certain concepts originally developed by other researchers.

2.13.4 CONFIRMABILITY

Holloway *et al.* (2010:303) assert that, confirmability takes the place of the term objectivity. Since the research project is judged by the way in which the findings and conclusions achieve their aim and not by the results of the researcher's prior assumptions and preconceptions. They further explain that, in turn, this focus needs an audit or decision trail where readers can trace the data to their sources. Readers follow the path of the researcher and the way he or she arrives at the constructs, themes, and interpretation. To this end, details of the research and the background and feelings of the researcher should be open to public scrutiny.

2.13.5 AUTHENTICITY

A study is authentic when the strategies used are appropriate for the true reporting of the participants' ideas. Authenticity consists of the following elements, as outlined by Holloway *et al*. (2010: 304).

Table 0.3   Authenticity strategies

Strategy	Description
Fairness	• The researcher must be fair to participants and gain their acceptance throughout the study. • Continued informed consent must be obtained. • The social context in which the participants work and live need to be taken into account.
Ontological authenticity	This implies that those people involved, readers as well as participants, will be assisted to understand their social world and their human condition through the research.
Educative authenticity	Through understanding, participants improve the way in which they understand other people.
Catalytic authenticity	The research needs to enhance the decision-making skills of the participants.
Tactical authenticity	The research should empower participants.

In this study, all focus groups were facilitated by the researcher and audio recordings and field notes of each focus group interview were obtained. Also, all participants were afforded the opportunity to voice their views about teaching and learning in the simulation laboratory and suggested actions to clinical facilitators in order to support students in the simulation laboratory at a College of Nursing in the Western Cape The data were transcribed and coded by independent professionals.

2.14 DATA ANALYSIS

Immersion in the setting helps researchers to use a thick description (Holloway *et al*. 2010:7). Geertz in Holloway (2010:7) explains that the term "thick description" was first used by the philosopher Gilbert Ryle. Geertz explains that this process involves detailed portrayals of the participants' experiences by going beyond a report of surface phenomena to their interpretations, as well as uncovering feelings and the meanings of their actions. This also means that researchers create and produce another layer that is constructed from the contributions of the participants. A thick description develops from the data and the context. The task involves describing the location and its people, giving visual pictures of setting, events, and situations; as well as verbatim narratives of individuals' accounts of their contextual experiences and ideas. Denzin (1989:83) supports this view by defining thick description as: "deep, dense, detailed accounts of problematic experiences. It presents detail, context emotion, and the webs of social relationship that join persons to one another." Polit *et al*. (2010:550) concur that a thick description refers to a rich, thorough, and vivid description of the research context, the people who participated in the study, and the experiences and processes observed during the inquiry. The prevailing sentiment is that if there is to be transferability of the findings, the burden rests with the investigator to provide sufficient information to permit judgements about contextual similarity. Lucid and textured descriptions, with the judicious inclusion of verbatim quotations from study participants, also contribute to other quality criteria; including authenticity of a qualitative study.

Holloway *et al*. (2010:7) emphasise that the description of the situation or discussion should be thorough. This implies that writers need to describe everything in vivid detail.

In this study, the transcription of data collected from student nurses interviews in relation to learning and teaching in the simulation laboratory and what actions they suggested to clinical facilitators in order to support their learning in the simulation laboratory at a College of Nursing in the Western Cape was conducted by an independent professional

2.15 CODING

According to Denzin and Lincoln (2000:823), an alternative approach treats interview data narratives from the perspective of people's description of their worlds. This narrative approach claims that, by abandoning the attempt to treat respondents' accounts as potentially

"true" pictures of "reality", we open up for analysis the culturally rich methods through which interviewers and interviewees collaboratively generate plausible accounts of the world.

According to Henning *et al*. (2007:101), the trustworthiness of a competent qualitative researcher is evident in the analysis of the data, a process that requires analytical craftsmanship and the ability to capture understanding of the data in writing. In "showing the workings of the data" (Holliday 2001:99), a researcher also needs to demonstrate an understanding of design logic. The researcher is able to match the analysis procedures and the methodological position of the study, and consistently and coherently manages the analysis (and interpretation) process according to the principles of the study design. The analysis process represents the "heartbeat" of the research. The description of this process determines the analyst's quality of thinking (Holliday 2001:99).

Henning *et al*. (2007:102) continue to state that initial procedures of coding and categorising are just that – initial procedures – and that they lead to no more than a "thin description".

Holliday (2001:79) states that: "A thin description simply reports facts, independent of intentions or circumstances". Therefore the following comprehensive steps were conducted in the study to obtain rich data (Figure 2.1) on next page.
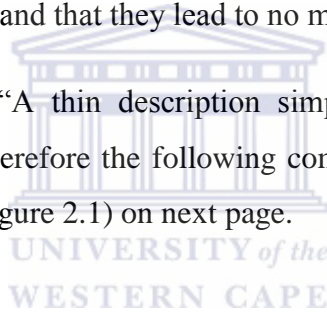
Figure 0.1:   Coding from texts


```
┌─────────────────────┐      ┌─────────────────────┐      ┌─────────────────────┐
│ Write down text of  │      │ Separately describe │      │ Classify each unit of│
│ single interview.   │ ───▶ │ units of meaning in │ ───▶ │ meaning in a        │
│ Read set of data    │      │ one or more         │      │ descriptive phrase. │
│ to form impression  │      │ sentences or        │      │ Indicate this       │
│ of context of       │      │ phrases. A          │      │ classification in   │
│ every comment.      │      │ highlighter can be  │      │ the margin with an  │
│                     │      │ used to show the    │      │ arrow pointing to   │
│                     │      │ end of each unit.   │      │ the text.           │
└─────────────────────┘      └─────────────────────┘      └─────────────────────┘
```

Search for possible groupings of the codes.

Tabulate a list of all the codes and then READ the whole text again to see whether the codes make sense and whether there is some agreement. Ensure that codes can be related to the research question.

 (Adapted from Henning *et al*. 2007:104)

In this study, the coding was done by the researcher, and a qualitative researcher after which a consensus discussion was held.

2.16 TRIANGULATION OF METHODS

Holloway *et al*. (2010:308) state that another important strategy to establish validity is to adopt triangulation procedures. Triangulation is the process that examines the phenomenon or topic under study from different perspectives. Triangulation in research means that the findings of one type of method (or data, researcher, theory) can be compared with the results of another method. Although researchers do not necessarily have this aim, triangulation provides a way of establishing whether the findings of the research can be generalised. They believe it is more common to check observations with answers from qualitative interviews or documents by maintaining the same methodology; this is called within-method triangulation. In this study it included the interviews, observational notes and tape recordings. Triangulation does not automatically demonstrate the trustworthiness of a study. It is used to give more depth to the analysis and to enhance its validity, although it cannot guarantee it. Polit *et al*. (2008:196) agree that in a qualitative study, triangulation might involve attempting to

understand the full complexity of a poorly understood phenomenon by using multiple means of data collection to distil the truth, e.g. having in-depth discussions with study participants, as well as watching their behaviour in natural settings.

In this study, data triangulation was further enhanced by analysing all the data of the interviews and field notes together. Two focus group interviews were conducted with ECP, 2nd and 4th year student nurses. One focus group of the 1st and 3rd year student nurses was done. All student nurses are studying in the R425 course that leads to a Diploma in General, Community, Psychiatry and Midwifery Nursing Science. The responses requested from all focus groups were about student nurses' viewpoints of learning and teaching in the simulation laboratory and what actions student nurses suggested to clinical facilitators in order to support students in the simulation laboratory.

2.17 REFLECTION OF THE RESEARCHER

- In relation to the design, the researcher explains why certain methods are used and what type of data he / she aims at capturing. The cohesion of data collection methods, analysis procedures, and the way in which the meaning of the findings is constructed indicates the research tradition that the researcher adopts.

- Henning *et al*. (2010:36) state that methodology refers to the coherent group of methods that complement one another and that have the "goodness of fit" to deliver data and findings that reflect the research question and suit the research purpose. The methods of data collection and analysis in this study were coherent because the researcher ensured that they were compatible.

- The methods selected to capture and process the data were chosen according to the needs of the research question and the concomitant unit of enquiry or of analysis. Thereafter, they were situated in format of a qualitative design (Henning *et al*. 2010:33). In this study, audio-recorded focus group interviews were conducted in conjunction with obtaining field notes. The audio-recorded data were transcribed and coded into themes, sub-themes and categories.

2.18 BASIC ETHICAL PRINCIPLES

Ethics in research has its basis in certain philosophical assumptions. The term originates from the Greek work 'ethos' that, according to Aristotle, means character and refers to the credibility of a speaker or writer. It is a branch of philosophy that addresses values. There are

two approaches in ethics: the normative approach, namely what we should do and the descriptive approach, namely what we are actually doing. (Holloway *et al*. 2010).

According to the Belmont Report (1979:2), the expression "basic ethical principles" refers to those general judgements that serve as a basic justification for the many particular ethical prescriptions and evaluations of human actions. Three basic principles, among those generally accepted in our cultural tradition, are particularly relevant to the ethic of research that involves human subjects, i.e. the principles of respect for persons, beneficence, and justice:

2.18.1 Respect for persons

Individuals should be treated as autonomous agents. An autonomous person is an individual who is capable of deliberation about personal goals and of acting under the direction of such deliberation. To respect autonomy is to give weight to the autonomous considered opinions and choices of people while refraining from obstructing their actions unless such actions are clearly detrimental to other people.

In most research that involve human subjects, respect for persons demands that subjects take part voluntarily and with adequate information.

Costley, Elliott, and Gibbs (2010:28) state that universities require a research proposal to be approved by the university and benchmarked with ethical standards of organisational and professional codes of good practice, such as the health care and education. These codes include taking appropriate action, such as gaining approval from ethics committees both at the university and location where research is to be conducted. The Senate Research Committee of the University of the Western Cape approved the methodology and ethics of this research project (Ethical clearance registration number 12/3/24).

Approval had also been requested from the Research Ethics committee of the Western Cape College of Nursing. Once the research proposal had been endorsed by the committee, proof of evidence was provided. De Vos *et al. (*2011:127) state that an ethical clearance number relating to a specific study is usually provided by the organisation. This number should be mentioned in all future correspondence with regard to the study. Ethical research practice is a continuing process and does not cease when an external body endorses the research proposal with a favourable opinion (Costley *et al*. 2010:30).

2.18.2 The principle of beneficence

Persons are treated in an ethical manner, not only by respecting their decisions and protecting them from harm, but also by making an effort to secure their wellbeing. The term beneficence is often understood as covering acts of kindness or charity that go beyond strict obligation. In the Belmont Report (1979:2), beneficence is understood in a stronger sense as an obligation. Two general rules are formulated as complementary expressions of beneficent actions in this sense: (1) do not harm, and (2) maximise possible benefits while minimising possible harms. This is confirmed by Holloway *et al*. (2010:55). The principles of beneficence and non-malfeasance (do good, do no harm) demand that benefits should outweigh the risks for the individual and the wider society. In this study, all participants were treated ethically and they were ensured that information would be protected and secured by the researcher.

2.18.3 The principle of justice

This principle requires that the research strategies and procedures are fair and just. In a multicultural society, this includes proper representation in research samples and respect for diversity; age, gender, disability, and sexual orientation. (Holloway *et al*. 2010:55). Botma *et al*. (2010:19) agree that the principle of justice means that participants should be treated fairly. Therefore, a researcher needs to adhere to the research protocol and information that is supplied in the information leaflet. No new interventions, procedures, or techniques that are not described in the information brochure should be executed. If a new intervention, procedure, or technique has to be used; new informed consent must be obtained. In this study, participants were selected according to the inclusion criteria as noted in this Chapter.

2.19 ANONYMITY AND CONFIDENTIALITY

Qualitative health care research might be more intrusive than quantitative research. Therefore, the researcher needs to be sensitive and should acquire excellent communication skills. Usually, anonymity is guaranteed, and a undertaking is given that identities will not be revealed. Qualitative researchers work with small samples and use thick description; it is not always easy to protect identities (Holloway *et al*. 2010:60). They recommend that only the researcher should be able to match the real names and identities with the audio recordings, and report descriptions; participants are given numbers or pseudonyms to avoid identification. Audio recordings, notes, and transcriptions – important tools for the qualitative researcher – must be kept secure and participants' names need to be stored separately from the voice

recordings. When other people, superiors, supervisors, or typists have access to the information, however limited this might be; names should not be disclosed, participants' identities must be disguised and they should be asked for permission before any disclosure. Although undertakings of confidentiality are given, participants need to know whether other people might have access to the voice recordings for the purpose peer reviews to verify the data analysis. Patton (2002) suggests that audio recordings should be erased a year after the research has been concluded, but many ethics committees require that they are kept for ten years; universities keep these records for five years.

Holloway *et al*. (2010:61) believe that although confidentiality is a separate issue from anonymity, also it is equally important. In research where words and ideas from participants are used, full confidentiality cannot be assured, especially since qualitative research contains quotations from the interview data. In these studies, confidentiality refers to researchers who keep records confidential when the participant does not wish to disclose the information it contains to other people.

In this study, anonymity and confidentiality were maintained by using alphabetical lettering to identify the focus groups and no mention of any participant's name occurs in this study.

2.20 CONCLUSION

This chapter described the methodology used by the researcher to explore and describe the viewpoints of student nurses about teaching and learning in the simulation laboratory at a College of Nursing in the Western Cape. The research findings are presented in the next chapter.
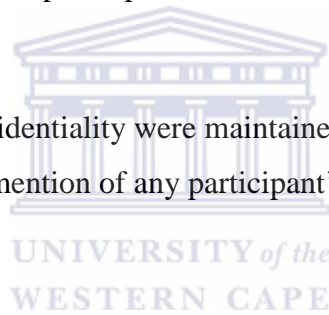
CHAPTER THREE:
RESEARCH FINDINGS

3.1 INTRODUCTION

This chapter presents the details of the data analysis. Polit and Beck (2008:507) state that the purpose of data analysis is to organise, provide structure to, and elicit meaning from research data. Patton in De Vos *et al*. (2011:397) state that qualitative analysis transforms data into findings. This process involves reducing the volume of raw information, sifting important from irrelevant information, identifying important patterns, and constructing a framework for communicating the essence of what the data reveal.

The first objective of the study was to "describe student nurses views of learning and teaching in the simulation laboratory".

3.2 OPERATIONALIZING THE FIELD OF RESEARCH

Eight focus group interviews were conducted with the R425 registered student nurses at a College of Nursing in the Western Cape. Most focus groups had 6 to 8 purposively selected participants. Eight focus group interviews were conducted with 46 participants (Table 4.1). The participants were selected from all 5 levels of study of the R425 programme for the Diploma in General, Community, Psychiatric and Midwifery and Nursing Science, including the foundation phase. The foundation phase refers to the extended curriculum programme (ECP).

Table 0.1:   Participants

Date of Focus Group	Focus Group	Year of Study	Female	Male	Number of Participants (n)
25/06/2012	A	ECP 1st	8	0	8
05/07/2012	B	ECP 1st	8	0	8
16/07/2012	C	1st	0	2	2
03/07/2012	D	2nd	3	0	3
04/07/2012	E	2nd	3	2	5
18/07/2012	F	3rd	6	2	8
08/06/2012	G	4th (Pilot)	4	2	6
20/06/2012	H	4th	2	4	6
TOTAL			**34**	**12**	**46**

Participants for the focus groups were recruited from those students who were attending lectures on campus. Focus group interviews took place after the day's lectures, in the meeting room of the campus library. This room was ideal to audio-record the focus group sessions. Only one focus group interview was conducted during the lunch break at a venue on campus; the participants were allowed to have their meal during the focus group session.

In this study, the participants responded enthusiastically, once there was clarity of the study purpose and how the information would be managed to ensure confidentiality and anonymity of information that was being shared during the focus groups. Saturation of data was reached when several of the issues were repeated during the eighth focus groups interviews and no new data emerged in relation to the questions that were asked.

3.3   PROFILE OF THE PARTICIPANTS

The pilot focus group consisted of six 4th year participants. Of these participants, four were women and two were men. The data of the pilot study were included in the data analysis,

since the outcomes did answer the research questions of the study, and the main research questions were the same as in the main study. Of the 46 participants in the main study, 34 were men and 12 men. Nineteen of the 46 participants were over the age of 25 years, and the remaining 27 were between 18 and 25 years of age.

3.4   THE PROCESS OF DATA ANALYSIS

Babbie and Mouton (2008:270) state that instead of focusing on counting and quantifying patterns in behaviour, the emphasis in qualitative description is on 'thick description'. The authors further state that a thick description is usually a lengthy description that captures the sense of actions like they occur. It places events in contexts that are understandable to the target audience of the research outcomes. Morse and Field in Polit *et al*. (2008:507) note that qualitative analysis is a "process of fitting data together, of making the invisible obvious, and of linking and attributing consequences to antecedents. It is a process of conjecture and verification, of correction and modification, of suggestion and defence". Audio-recorded data and field notes were transcribed. It was subsequently coded by the researcher and an independent expert in qualitative research after which consensus was reached during a consensus meeting. Qualitative analysts develop categories that are based on the scrutiny of actual data. Developing a high-quality category scheme involves a careful reading of the data, with an eye to identifying underlying concepts and clusters of concepts with the purpose of facilitating the coding process. (Polit *et al*. 2008:510). Data obtained in this study were structured into themes, sub-themes, and categories (Table 4.2). The central storyline dealt with how students were experiencing the learning and teaching in the simulation laboratory as providing both opportunities and challenges. The contextual demands of the first and subsequent years of study seemed to play an essential part in their experience.

Table 0.2: **Themes, sub-themes, and categories**

Theme	Sub-themes	Category
Contextual demands of first and subsequent years of study	• Changing pace of self-directed learning	• Greater expectations of 2nd and 3rd year participants leading to an increase in perceived pressure • Less structure provided during teaching and practice
	• Challenges for the student	• Greater and faster adapting required • Greater independent and self-directed learning required • Greater clinical demands
Opportunities experienced	• The positive outcomes of simulation laboratory teaching	• Builds confidence • Facilitates integration and internalisation of theory and praxis • Teaches correct methods • Enhances 'real time' learning • 'It is fun' • Enhanced 'preparedness' for clinical practice
Challenges experienced	• Programme demands	• Demands of the programme (full) • Lack of programme and service alignment • Large student numbers
	• Practice demands	• Theory – practice gap • Simulation laboratory – practice gap: transitional difficulties • Use of automated equipment • Lack of time to support students
	• Personal attitudes of facilitators / tutors / mentors	• Negative personal attitudes (not approachable, negative body language, intimidating) stifle their approachability • Lack of clear communication and expectations • Lack of uniformity

Theme	Sub-themes	Category
	• Attitudes of permanent staff at practice facilities	• Lack of support in the clinical setting • Lack of time to teach and demonstrate • Take 'short cuts' • Unrealistic expectations • Rigid expectations • Language issues (speaking Afrikaans) • Ridicule students • 'Get upset' with students • 'Tension with other categories of staff members'
	• Student related matters	• Differences in personality types (introvert vs. extrovert) when asking for assistance • Language difficulties, English second language • Individual learning styles (not everybody learns in the same way or at the same pace) • Cognitive dissonance: don't understand, need for reinforcement • Emotive dissonance: frustrated, shocked, fear, simulation laboratory is exhausting, 'feeling down'
	• Simulation laboratory facility	• Lack of resources and space • Lack of time and opportunity to practise • Availability of mentors and educators • Difficulty in organising additional access

3.5   FINDINGS

Three main themes emerged from the data analysis:

- Contextual demands of first and subsequent years of study.

- Opportunities experienced.

- Challenges experienced.

3.5.1   Theme One: Contextual demands of first and subsequent years of study

In this study, contextual demands referred to how the students of a College of Nursing in the Western Cape view teaching and learning in the simulation laboratory during their foundation year and the subsequent years of study in the R425 programme Diploma in General, Midwifery, Psychiatry, and Community Nursing Science.

Contextual demands as suggested by Rhodes and Curran in Limoges (2010:60) is that a simulation laboratory is a place where clinical judgement is learnt and where the novice nurse gets advanced to the beginner stage of nursing practice, guided by the clinical facilitators.

Two sub-themes emerged in Theme 1, namely "changing pace of self-directed learning" and "challenges for the student".

3.5.1.1 Sub-theme: Changing pace of self-directed learning

Procedure-based activities do not prepare the student learner adequately for the reality of the clinical setting, since it does neither take into consideration the learning needs of the individual student learner nor does it facilitate the attainment of integrated knowledge, skills, and attributes (Jeggels *et al*. 2010:53). During the subsequent years of study after the student learners' first year, some of them do experience difficulties in managing the changing pace of self-directed learning. Under the sub-theme of changing pace of self-directed learning, two categories emerged namely:

- Greater expectations of second and third year student learners that lead to an increase in perceived pressure.

- Less structure provided during teaching and practice.

Category: Greater expectations of second and third year leading to an increase in perceived pressure

Haigh (2007:101) states that a simulated environment can provide the space, time, and learning opportunity in a non-pressured learning setting. However, participants in their 2nd and 3rd year of study at a College of Nursing in the Western Cape expressed their views of clinical facilitators who had greater expectations from them while they were exposed to new nursing skills of the R425 programme in the simulation laboratory. This led to an increase in perceived pressure amongst the participants of this study when they were comparing their current year of study to that of their first year.

In a focus group (FG-D), it seemed that after being demonstrated a procedure, students experienced pressure to execute it. *"It is difficult to show somebody a thing once and expect that when you go to hospital, you just have to know it. It is really difficult… not everybody can adapt so quickly…"* Students need to adapt to their new learning environment as soon as possible. Jeffries in Kaakinen *et al*. (2009:1) states that simulation was used as a teaching strategy to facilitate integrating concepts that engage students in the learning process by assisting the student to become a useful member of the nursing team in the clinical setting.

In a focus group (FG-E), it was affirmed that in the clinical setting there was a greater expectation by clinical staff members in relation to student nurses' abilities to perform advanced nursing procedures, *"They* [hospital staff] *also expect us to know about the wound dressings. We didn't do any other dressings and they* [clinical facilitators] *didn't show it to us yet"*. In a UK study conducted by Baille *et al*. (2009:303), learners who were exposed to simulation teaching at a pace that met their learning needs prior to clinical placement appreciated the fact that they were thrown in at the deep end. During this study, this principle was confirmed, *"It is new to us, we haven't done it in class but now we must go and do it in the services and be assessed on it… I personally feel they threw us in at the deep end, of the physical assessment."* It could be interpreted that this participant (FG-D) felt pressured to perform practical procedures before being exposed to the theory. However, Freeth *et al*. (2005:278) note that one is made aware of the fact that simulation laboratories should accelerate learners' attainment of competence and confidence in key skills in order to quickly become useful members of the team.

A participant (FG-D) raised her concern about the skill of suturing wounds that most students experienced difficulty, *"We are expected to suture in a very sensitive area of the woman and that is when we need that skill…".* Another participant (FG-H) reflected on his second and third year of study and stated that it was important for them to know how to perform particular procedures prior to clinical placement, *"They don't see it as important, but it is important to us, because we are the people who need to know how to do the procedure".* Haigh (2010:101) concludes in a study that the students need far more simulated practice where they could work with peers to increase their understanding, particularly of the anatomy and physiology underpinning practice. Haigh (2010:101) emphasises that learning is reinforced and extended by means of repetition. In this study, participants expressed an opinion that they were not well prepared for clinical practice placement and the increased pace of self-directed learning during their 2nd and 3rd year of training led to escalated pressure for them in the clinical placement area.

Category: Less structure provided during teaching and practice

Kaakinen *et al*. (2009:1) state that simulation is purported as the vehicle for translating classroom knowledge into a safe learning environment. Kaakinen *et al*. (2009:17), in their systematic review of nursing literature between 2000 – 2007, show that simulation is more frequently considered as a teaching model rather than a learning model. In their study, Wellard *et al*. (2010:43) find that the time spent in the simulation laboratory is dominated by teacher activity with a mechanistic approach to teaching and learning. Participants voiced their concern that before attending simulation laboratory, they were not informed of the structure of their teaching programme for the first semester. Some of the teaching sessions were completed in a short period of time, depending on the clinical facilitator that they had for that session. One of the participant's said and several other group members agreed by nodding their heads, *"I didn't understand it at all because sometimes in sim lab, uhm… in thirty minutes… they just show us in thirty minutes. Then they are finished. I mean, those procedures that they say are simple, like how to clean tracheostomy"* (FG-D). A participant (FG- E) added that the stipulated time for simulation laboratory learning and teaching was not utilised optimally, *"They just show you briefly as we know already the things; it is no more like teaching. You learn on your own and then the time is not… they don't use all the time that we have for a period. It is just roughly, roughly."* Another participant (FG-E) confirmed that the stipulated simulation laboratory time was not utilised effectively for learning and teaching, *"Very quick. We were there one hour and then we were done because now they know we are*

already exposed to the hospital, now they just doing it already because they told us it is already signed in our practical books. So just doing it because they know they just…" A participant agreed with what was voiced and confirmed that the learning and teaching as viewed by student nurses were not as effective in 2ⁿᵈ and 3ʳᵈ year of study, *"but I know it is gonna* [sic] *be a procedure during the year, but should actually have done it before we do it for the first time" (FG-E).* A study by Strand *et al.* (2009:21) discusses the students' request for sufficient time to be allocated for demonstrating the complexities of nursing skills and the opportunity for practising the skills. However, Haigh (2012:101) states the nature of simulation means that time can be manipulated to suit student learning needs to allow time for discussing and critiquing theory, as well as articulating explicit knowledge. In this study, participants voiced that from the 2ⁿᵈ year of their programme of study, simulation laboratory teaching and learning were less structured when compared to their foundation year.

3.5.1.2 Sub-theme: Challenges for the student

Challenges for the student are adapting to the increased pace in learning new skills and being able to apply these skills in the clinical setting. The most frequently mentioned comment from students' evaluations was that scenario-based evaluation served as an integrator of learning, amalgamating theoretical knowledge obtained in the classroom and the psychomotor skills learned in the laboratory and clinical practice, while requiring students to think critically (Lisko *et al*. 2010:108). The challenges were further categorised into three categories, namely:

- greater and faster adapting required.
- greater independent and self-directed learning required.
- greater clinical demands.

Category: Greater and faster adapting required

In this sub-theme, a category emerged that greater and faster adapting was required after the first year of the R425 study programme. Maginnis *et al*. (2010:5) assert that novices have no experience with scenarios that they encounter in the clinical setting and, therefore, they have a lack of understanding of how to apply what they learned to the real situations that arise. In this study, the participants (FG-D, -E, -F, -G and -H) voiced their opinion that there is a greater and faster pace of adapting required of them to grasp the learning and teaching in the simulation laboratory in this year of study when compared to the previous year of study. The following quotations revealed this sentiment when a participant (FG- E) said*, "You learn on*

your own..." Another participant (FG-D) shared her view with the group that being shown a practical procedure once was not adequate for her to grasp the learning of a new skill and added, *"it is difficult to show somebody a thing once and expect when you go to hospital, you just have to know it, it is really difficult, it is not everybody that can adapt so quickly."* In a study by Wellard *et al.* (2009:42), it is noted that laboratories can provide some basic instruction and familiarisation with psychomotor techniques. However, there is a difference between injecting a real patient as opposed to a practice device. They continue to state that the complexity associated with injecting a real patient cannot be taught in a laboratory. The participants in this study echoed this principle.

Category: Greater independent and self-directed learning required

In this study, the next category that emerged in the sub-theme of challenges that students experienced was that greater independent and self-directed learning was required of them, especially after their first year of the R425 study programme. Ramani and Leinster (2008:357) state that students should be active participants in the session. Merely telling the students the facilitator's view of the situation or having them observe the expert in action does not lead to learning. Several participants from a few of the focus groups mentioned that from their second year of study the workload and the need for independent learning increased.

A participant (FG-E) voiced her concern that the amount of work per simulation laboratory session was overwhelming, *"For me the physical assessment, it was a lot for us to do, because the previous students, I heard that they only did one part, but we had to do all three parts... this year we had to do all these things at the same time."* Another participant (FG-D) agreed that greater independent and self-directed learning was expected of them and that it was vastly different from their experience during their first year of study, *"For me, it is different from 1st year because last year, they like showed us exactly and they let us do exactly what they shown us, but now it is like you are on your own".* A study by Jeggels *et al.* (2010:57) concludes that limited clinical learning opportunities and inadequate clinical skills development support in the service settings may be challenges that would lead to nursing colleges having to customise their clinical skills training programmes to suit their specific contextual situations. In this study, it is obvious that learners' needs needed to be taken into consideration when designing simulation laboratory teaching programmes.

Category: Greater clinical demands

This category gave a voice to the participants who experienced greater clinical demands in the clinical facilities, after the first year of study. Watkins and White in Freeth *et al*. (2005:277) suggest that simulation laboratories should accelerate learner's attainment of competence and confidence in key skills to enable them to become useful members of the team more quickly. Strand *et al*. (2009:21) state that those learners who practise learning skills in a laboratory adapt more readily to the clinical field. However, in this study, it emerged from several of the participants, who were in their 2nd to the 4th year of study, that the expectations of hospital staff members were incongruent to their level of experience and scope of practice.

During this study, it emerged that hospital staff members assumed that the nurse training programme was the same as the one that they had experienced during their training which led to inappropriate comments, like one participant (FG-D) stated, *"Sometimes they will tell you, okay you are in second year, you have to now do wound dressings and if you explain to them, but you not sure, it is like you are… 'What are you doing in second year, you don't know! But it is the beginning of second year, yeah, or you lazy, you don't want to do that' or stuff like that. It is the exposure that we experience".* Since a participant (FG-E) experienced that the simulation laboratory teaching of the physical assessment of the adult patient was overwhelming for her, she said, *"We are in second year now, I know we must be into the process of learning, but for me it was just too much because it was so easy to forget and the classes was in the first three weeks of the first semester".* Nursing psychomotor skills are taught and practised in the simulation laboratory to enable the learner to be competent and confident prior to clinical site placement *(*Morgan 2006:159; Reilly & Spratt 2007:20).

A participant (FG-G) agreed with a fellow participant that there was a greater demand in the clinical setting for them to competently perform advance nursing skills, especially in their 3rd year of nursing when they are expected to be able to suture episiotomies, *"The suturing procedure, in second year we do the removal of sutures, but in 3rd year, we have to suture episiotomies."* Another participant (FG-H) expressed the need for the simulation laboratory facilitators to provide realistic materials and equipment when teaching learner students how to suture wounds and this procedure needed to be repeated in subsequent years of study. She said, *"In third year that is really the time that you must know how to suture because it is such a sensitive part of the woman that you need to suture, therefore, you must know what you need to do."* In the discussion of a study conducted by Strand *et al*. (2009:20) it is clear that

nursing students report the irresponsibility of being sent into practice during the first and second year of training without having learnt the basic skills in advance. As voiced by several participants of this study, there appeared to be a lack of understanding by service personnel of the capabilities and skills capacity of the learner at varying phases of their study programme, namely the R425 study programme for a Diploma in General, Midwifery, Psychiatry, and Community Nursing Science.

3.5.2 Theme Two: Opportunities experienced

The second theme that emerged was opportunities experienced and this was divided into the sub-themes of confidence, fun, teaches correct methods, integration and internalisation of theory and praxis. Maginnis *et al*. (2010:5) state that simulation laboratories offer simulated situations and activities that allow students to consolidate their knowledge, skills, and problem solving strategies in a controlled and safe environment that reflects the clinical setting before they face the reality of clinical practice.

3.5.2.1 Sub-theme: The positive outcomes of simulation laboratory teaching

The sub-theme that emerged was the positive outcomes by student learners in the simulation laboratory at a College of Nursing in the Western Cape. Kolb (1984:28) states that any experience that does not violate expectations is not worthy of the name experience. Kolb (1984:28) continues to state that, somehow the dents that these violations cause in the fabric of his experience are magically repaired, and he faces the next day a bit changed but still the same person. The following categories emerged:

- Builds confidence.
- Facilitates integration and internalisation of theory and praxis.
- Teaches correct methods.
- Enhances 'real time' learning.
- 'It is fun'.
- Enhanced 'preparedness' for clinical practice.

Category: Builds confidence

This category emerged that one of the positive outcomes of simulation laboratory teaching was that it built the student learners' confidence prior to placement at clinical facilities. Clinical nursing skills are taught and practised in simulation laboratories to develop the learners' competency and confidence prior to clinical site placement. The simulation laboratory provides the learner with a replica of the clinical ward setting, including the equipment and materials used (Morgan 2006:160). Several participants in all of the focus groups expressed that during their 1st year of study at a College of Nursing in the Western Cape, they had positive experiences of the simulation laboratory learning and teaching.

A male participant (FG-H) reflected on his 1st year of study and voiced a feeling of confidence after simulation laboratory learning and teaching that took place prior to clinical practice placement, *"When I came across something called sim lab I was actually more confident in my approach when I went to the hospital, because now you have an idea of the environment that you are to be placed in"*. This sentiment was shared by another participant in the same focus group who voiced feelings of being scared of first time clinical practice placement, *"sim lab was like a small hospital… I'm gonna* [sic] *become use to this in the hospital even though there are dolls (manikins), but at least the environment was therapeutic… I was scared of going to hospital… but sim lab lowered my fears of going to hospital"*. Morgan (2006:18) concludes in his study that the teaching of psychomotor skills in the simulation laboratory is done in order for the learner students to know what they may encounter in the clinical area, thus minimising their levels of anxiety and enhancing their confidence levels. Reilly *et al*. (2007:542) indicate that undergraduate nursing students value the opportunity of practising nursing activities in a safe environment prior to clinical placement, since it promotes confidence. In this study, the participants expressed their satisfaction with being exposed to the required 1st year learning and teaching in the simulation laboratory, since they voiced the opinion that it gave them a good idea of what was expected of them when they entered the clinical practice placement area.

Category: Facilitates integration and internalisation of theory and praxis

The simulation laboratory is a place where clinical facilitators can level the learning experience in order for all students to have an opportunity to observe nursing practice informed by nursing theory (Limoges 2009:62). Another category that emerged in this study

was that the learning and teaching in the simulation laboratory at a College of Nursing in the Western Cape facilitated the integration and internalisation of theory and praxis. A participant (FG-A) mentioned that she appreciated the integration of theory and practice as seen in the simulation laboratory and clinical placement area, *" Ja* [yes]*, we did that theory and we already did that in hospital before we even did that in sim lab"* Simulation laboratories offer teaching and training of basic to more complex clinical procedures as required by nursing; the more complex skills that require more dexterity can be simplified into smaller steps to accommodate the learner's need. The learner students are able to practise the skill until they are competent and confident before utilising the skills in the clinical setting with real patients (Childs *et al*. 2006:158; Freeth & Fry 2005:279; Jeffries 2005:103; Kardong-Edgren *et al*. 2008:13). In this study, participants explained that in their current year of study, the simulation laboratory learning and teaching experience was positive and assisted with internalising the theory to praxis prior to service placement.

Category: Teaches correct methods

Simulation creates an environment where important teaching and learning principles can be applied by means of a standardised learning experience (Rothgeb 2008:491). In this study, it emerged from some of the participants that they appreciated being taught the correct method of performing nursing skills. The following quotations are from (FG-A and -B) participants who were confirming that the teaching in simulation laboratory was the correct method. *"...like they have been teaching us properly…"* This was confirmed by another participant who mentioned that they watched a visual example prior to practising the skill and that enhanced learning new nursing skills, *" …you saw the video, you practice it… it is not easy to forget that".* Jeffries *et al*. (2009:615) state that novice students memorise 'rules' and practise following those rules in a context-free environment. In this study, several of the participants experienced the correct method of teaching in the simulation laboratory and learning was facilitated by seeing, doing, and repeating the process until they were comfortable performing the skills.

Category: Enhances 'real time' learning

Lupien and George-Gay in Broussard *et al*. (2009:8) state through simulation, a predictable environment can be created to allow health care providers to practise under realistic conditions in 'real time' using actual clinical supplies. In this study, it emerged that

simulation laboratory teaching enhanced 'real time' learning. A participant (FG-B) shared her view with her group that as a novice nurse practitioner she found teaching and learning in the simulation laboratory to be useful, *"I can say the teachings of the sim lab… I can say that for me it was fruitful… because from my background … I never been in the hospital industry to know all these things and I can say for a student who is the first time in this facility, it is good to get this practice in the sim lab first before she or he can go to practice on a human being".* What simulation laboratories offer the educational community is a model of teaching, which appears to offer benefits (Stark *et al*. 2003:305).

Category: 'It was fun'

Boud *et al. (*1988:19) state that experiential learning is one of the easier ways to incorporate play into the classroom and is widely used in informal educational settings. Findings of an Irish study of learners' view of learning in a controlled environment, such as a clinical skills laboratory, is essential and can be fun, while assisting students to learn more efficiently (Morgan, 2006:158). In this study, another category indicated that learning new skills was a positive experience due to the pleasant learning atmosphere created by clinical facilitators. The findings indicated that the learning atmosphere was pleasant in the simulation laboratory as expressed by a participant (FG-A), *"The thing about sim lab, they show us a video, explaining it and then we go to practical. What we are about to do, maybe a baby bath... everything... step-by-step… and then we go practise it. They got baby dolls… that makes the classes fun... that is nice".* Learners acquire unique learning experiences and request time with adequate equipment to have hands-on and visual pre-clinical experiences (Strand *et al*. 2009:18). Another participant (FG-A) added that they felt comfortable with the learning and teaching in the simulation laboratory, *"Yes, the activities we do, it is fun, they must apply it more, the TPR, BP, we did a lot and that I enjoyed. And everybody is comfortable with it".* Feeling secure is fundamental to the learning processes; severe anxiety restricts learning whereas moderate anxiety can promote learning, as noted in a study of Strand *et al.* (2009:20). In this study, participants express their satisfaction with being guided step-by-step through the teaching and learning process of new nursing skills in the simulation laboratory plus learning new skills in a comfortable and pleasant environment.

Category: Enhanced 'preparedness' for clinical practice

Enhanced preparedness for clinical practice can be facilitated in a simulated environment, where the student is the centre of the action. The teaching and learning process can be stopped at any point, allowing deliberation and rehearsal until knowledge is sufficient and actions are fluent (Eraut in Haigh 2007:100).

A participant (FG-A) explained that clinical facilitators accommodated the learning needs of students and would reiterate teaching material by repeating the lesson and ensuring that they were able to apply the theory to practice in the simulation laboratory, *"More than once, a couple of times… If they explain something on the board and then they ask us, 'Do you understand it?'… and if we practising it, if they see we are not sure, we will practice it until we can do it"*. Maginnis *et al*. (2010:5) informs us that the simulation laboratory is one strategy where collaboration can occur that provides the opportunities to practice the required skills by means of simulation activities. Another participant (FG-F) added that there was additional teaching and learning support from the lecturers in the clinical placement area in her second year of the course; they were able to contact both the clinical facilitators and lecturers when they required additional academic support, *"Like in second year, you have that support totally, like lecturers were there. You can go to their offices for intervention. Please, I need help with… and they will say: 'fine, we will meet you there, at that time. Be sure that you will be there'. They will even phone the wards and say students of that specific year, we gonna* [sic] *meet there please to practise"*. A participant (FG-H) shared his reflections of his first year of study where he experienced being well-prepared by the clinical facilitators and lecturing staff for clinical practice placement, *"First year, that really helped us, motivated us and prepared us well"*. Nursing skills are not merely technical, they are situational and relational. It is clear that learning in the simulation laboratory is limited and the importance of learning in the complexity of the real world becomes central (Wellard *et al*. 2009:42). In this study, participants voiced their satisfaction with their clinical facilitators and lecturers who were easily accessible to assist and guide them with their learning needs, both in the simulation laboratory and in the clinical placement area.

3.5.3 Theme Three: Challenges experienced

Challenges experienced was the third theme that had emerged from the data analysis with the sub-themes of programme demands, practice demands, personal attitudes of facilitators,

attitudes of permanent staff at practice facilities, student related matters, and simulation laboratory facility.

3.5.3.1 Sub-theme: Programme demands

In this study, the participants found that they were encountering many challenges in the simulation laboratory and in the clinical area, particularly from the 2nd year to their final year of study. The fact that learning is a continuous process based on experience has important educational implications (Kolb 1984:28).

Category: Demands of the programme

It is essential that students are adequately prepared at the required level of their training programme with the purpose of enabling them to link theory to practice during clinical placements with the aim of ensuring quality patient care (Morgan 2006:159). In this study, the category emerged that the full programme was demanding. Participants expressed their views that the programme demands were poorly aligned in relation to their programme and the clinical services. Student numbers were increasing while the clinical staff complement was decreasing; it created a non-conducive teaching and learning environment.

A participant (FG-A) expressed that she thought there was a gap in their programme due to lack of communication between the lecturing, clinical facilitators and hospital staff members, *"I think that there is a gap in the programme… there is a lack of communication between the lecturers, mentors and hospital… which makes life very difficult for the students".* Maginnis *et al*. (2010:5) report that student perceptions are insightful, since it identifies gaps between the simulation laboratory skills training and what is occurring in the clinical setting.

A participant (FG-E) articulated that the hospital staff members expected them to know the second year nursing procedures, however, it was only the start of a new academic year and they were not exposed to many of the second year nursing skills in the simulation laboratory, *"They expect us to say, for instance, you are second year, they expect from us to know the medication and to know all the procedures we still need to do. Say, for instance, the beginning of the year, then they expect from us to know this procedures and we… mmm… but we do not know, we weren't exposed to that thing, ja,* [yes] *but you are already second year. They expect from us to know, even if you explain to them".* Haigh (2007:101) finds in her study that current clinical skill sessions are predominantly about increasing manual dexterity.

This notion is noted in the study of Wellard *et al.* (2010:43) that recommends the need for research about the link between teaching and learning in the lecture theatres, including the skill laboratories, and the clinical sites.

Category: Lack of programme and service alignment

- When students do not have the opportunity to link theory to practice during placement, it will have an effect on their learning needs and, more importantly, affect the level of care provided to the patients, which would be of concern to both the nurse practitioner and nurse educators (Morgan 2006:159). In this study, the category of a lack of programme and service alignment had emerged. A participant (FG-C) expressed that there were some basic procedures that he encountered in the clinical placement area that was new to him, since he had not been exposed to the nursing procedure in the simulation laboratory, **"***For me, in surgical I come in there and I was kind of lost because there weren't so many procedures that I had to do, because the patients can wash themselves... They never showed me how to shave a patient before he is going to operation and all of those stuff to prepare the patient, taking in valuable goods, they never showed us that and how..."* Hosoda (2006:1) states it is well recognised that the clinical placement setting can be a source of stress and anxiety for students. One of the participants (FG-A) pronounced her surprise at encountering documents that were new to her, however, the hospital staff were willing to guide her, *"...because when I saw the form* [admission forms] *I was like, what is this! Yes, in hospital you ask and they will help you"*. Hosoda (2006:2) continues to inform us that creating a good atmosphere and relationships in the clinical setting is regarded as essential. A (FG-B) participant shared the following concept with her group that some nursing procedures were new to her, *"Intake and output. We did it first in hospital... then when we came to college we did it here"*. Another participant of that group raised her concern about complex nursing procedures that were new to her, *"like some things we didn't learn there, that we have not learnt yet... to teach us the discharge plan and the admission, things that are complicated so then... they apologised for everything when we came back from hospital"*. Psychomotor nursing skills are taught and practised to make sure that the learner is competent and confident prior to clinical site placement (Morgan 2004:160; Reilly & Spratt 2007:542). However, learning and practising a clinical

skill can be successfully carried out in other suitable contexts, provided there are opportunities for observation and feedback (Stark *et al*. 2003:305).

- A participant (FG-A) recommended that their theory, simulation, and clinical placement programme needs to be co-ordinated and several members in her group nodded in agreement when she said*, "So, they must rearrange our programme and take the services into consideration".* In the discussion of a study by Baillie *et al*. (2008:304), they emphasise a further benefit of simulation, i.e. prepares lecturers with placement skills, particularly when programmes occur at the start of clinical placement.

- It emerged from the dialogue that a participant (FG-A) suggested that the basic nursing procedures needed to be taught in the simulation laboratory prior to practice placement in the hospitals, *"I like to suggest the sim lab class to teach us first the basics, as a first year, you have to do TPR* [vital signs]*, how to do bed making and how to do full washes."* Wellard *et al.* (2009:43) note in their study that staged laboratory learning must be complemented by participation during learning in the actual patient area in the presence of other nursing personnel. In this study, due to poor alignment of the learning and teaching programmes, the participants identified the gaps and their experience in the clinical area was a source of tension and frustration.

Category: Large student numbers

Adequate supervision during simulation requires small groups in the presence of appropriate staff members (Ballie *et al*. 2008:303). Another category that emerged in this study when the participants in the focus groups indicated that, due to large numbers of learners per group in the simulation laboratory, effective learning was challenging.

A participant (FG-F) shared the opinion that several sessions in the simulation laboratory in a large group did not ensure that learning and teaching was effective, since she experienced difficulties while performing the skill in clinical placement, *"Going to sim lab to practise there before we going to do the real thing is not enough, by saying that we have been to sim lab two or three times and then we were like how many students?"* Kilmon *et al.* (2010:316) conclude that accommodating smaller groups of students could be an asset to clinical educators during teaching and training of clinical nursing skills.

Another participant (FG-G) reflected on his experience of being part of a large student learner group. It was a distraction to the learning and teaching process in the simulation laboratory, *"Like for me, if it is a large group and my friend is standing next to me, I don't take notice of what is happening. I sometimes talk to my friend that is next to me. So, if it was a smaller group of about five, I would pay more attention and there would be enough time for all of us to practise".* Large, noisy groups of learners diminish the learning experience for many members of that group (Childs *et al.* 2006:157). This sentiment was affirmed by another participant (FG-G) who reflected on the first year experience of smaller student learner groups*, "Two classes combined going for one simulation, it is too many, whereas in first year it is only that one group that attends sim lab at a time".* In this study, it emerged that subsequent to the first year of study, the group size in the simulation laboratory increased and many participants found learning and teaching a challenge in such a situation. One of the lessons from a study of Childs *et al.* (2006:158) suggests that group sizes need to be kept small. In future planning, more groups need to be added in preference to increasing group size.

Smaller groups of learners per clinical facilitator enhance the teaching and learning experience for both the learner and the clinical facilitator. A participant (FG-C) affirmed, *"It is not too many and each mentor get like nine or eight students and those students do everything in the sim lab for themselves. So, that is a very good thing that we got so few because if you got quantity you not gonna* [sic] *get quality, and the less you got the better the quality".* In this study, it emerged that there were positive aspects about the entire teaching and learning experience in the simulation laboratory when the group size was small. Simulation works best when there are 5 – 10 learners who are participating in the experience; this enables learning in a safe and supportive learning environment Rothgeb (2008:483) and endorsed by Maginnis *et al.* (2010:5).

Those participants who compared their first year with their second and third year of study were dissatisfied with the larger number of learners per group. Weaker students in a large group could become less interactive during group participation (Childs *et al.* 2006:157).

In this study, participants were generally satisfied with the simulation laboratory learning and teaching that occurred in smaller groups in the first year of their course, however, in the subsequent years of their studies the larger group sizes were a challenge to many of the participants.

3.5.3.2 Sub-theme: Practice demands

Childs *et al*. (2010:37) state that well-designed simulation based on the Nursing Educational Simulation Framework is effective learning tools to prepare competent nurses and can be integrated into the curriculum to improve problem solving abilities of students. Simulation facilitates the application of theory in practice. The following categories emerged in this sub-theme:

- Theory-practice gap.
- Simulation laboratory practice gap – transitional difficulties.
- Use of automated equipment / lack of time to support students.

Category: Theory-practice gap

At the beginning of the clinical placements of students, they may experience dissonance between the academic ideal of expected nursing practice and the reality of the clinical setting (Maginnis *et al*. 2010:2). This dissonance emerged in this study as another category, since it was voiced by a few participants. A participant (FG-C) expressed the opinion that one of the basic skills taught in the simulation laboratory, namely urine testing, lacked the integration of theory and practice, however, he had the opportunity to learn more about this in the clinical placement setting, *"The urine testing. Yes the urine testing because I learned that from a sister* [professional nurse] *and she explain there are so many ketones,…… why is this,.....why is it that I never knew ph, alkaline… so, they explain, that they didn't explain that in sim lab. We just say... you have to pee. You just look and that is over… they didn't explain why... not in the class room or in the sim lab…"* Wellard *et al.* (2007:8) indicate in their study that there is limited direct integration found between theoretical and practical aspects of the undergraduate nursing programme.

However, a participant (FG-A) said that the learning and teaching was similar in the simulation laboratory and in the clinical placement setting, but only when the clinical facilitator was present, *"Yes, it is exactly the same. Yes, TPR* [temperature, pulse, and respiration] *is exactly the same because we done a practical competency… everything that you done in the sim lab. You must, but as soon as the mentor is not there, we don't do it the same way because…"*. In a discussion, Landers in Morgan's study (2006:159) states that for qualified nurses the familiarity of carrying out clinical skills and low staffing levels, often are reasons why these skills are not executed in the correct manner and this may obstruct the

teaching and learning of these skills. A participant (FG-B) explained that the hospital staff members were not able to teach skills in the same manner as the clinical facilitators, *"Normally, the sisters* [professional nurses] *in the hospital, but they not trained to teach the method as a mentor, who would have been… they just do it and then they… and when the mentor comes then she says no, no you can't and you have to do it like that".* Far reaching staff development is an essential part of this strategy to ensure compliance with the educational philosophy and outcome objectives of the curriculum (Stark *et al.* 2003:302).

Another participant (FG-D) suggested that the simulation laboratory programme should focus on teaching the basic nursing skills that were needed in the clinical placement setting before teaching those skills that occurred less frequently, *"Focus* [clinical facilitators] *on the things that is most important that everyone has to deal with in hospital. Then afterwards the extra things can come… because we don't do that as soon as we walk in".* Broussard *et al. (*2009:9) note that nurse educators are challenged to provide the necessary learning opportunities for learners to obtain expertise in patient-monitoring functions and effective patient management skills in a rapidly changing patient environment. A (FG-D) participant expressed the view that new simulation laboratory teaching had to be conducted in the clinical placement setting for assessment purposes while the accompanying theory was lacking at that time, *"…it is new to us, we haven't done it in class but now we must go and do it in the services and be assessed on it".* There was limited direct integration found between the theoretical and practical aspects in the undergraduate nursing programme (Wellard *et al.* 2007:7). From the discussion (FG-F), it emerged that there is a gap between theory and practice in their programme, *"We don't get the perfect guidance to do the things and then all the procedures or the things that we need to do we don't get them all in sim lab".* The findings in the study of Strand *et al.* (2009:20) indicate that learners appreciate a clinical teacher who follows up, stimulates understanding, and provides concise and tangible feedback with the aim of satisfying their learning needs.

It emerged that the link between theory and practice in the simulation laboratory was not evident for this particular participant (FG-E) and several members of the group agreed, *"…It was the theory* [pathophysiology]*, because we haven't done it, we weren't exposed to it, we couldn't give,… I couldn't give the necessary information that was needed, there wasn't a good understanding of it because we haven't done it".* In a third year undergraduate nursing course, the module combined pathophysiology, pharmacology, and nursing care and students reported an increase in confidence and skills to deal with sick patients in the clinical setting

(Rice *et al*. 2009:301). Another participant (FG-E) suggested that visits at clinical sites by lecturing staff members would be appreciated because they needed to be exposed to the conditions that prevailed at clinical sites, *"So, we would like to see not only our clinical facilitators, but the lecturers in the clinical services, so that they can see what is happening and they can witness what is actually happening there… the shortage of staff and procedures aren't been done as it is in our book."* All students require equal opportunities to learn how to practise the skills safely and competently (Stark *et al*. 2003:298). However, when there are deficiencies, the feedback should include suggestions for improvement (Ramani *et al*. 2006:358).

In this study, a (FG-F) participant said that to do a vaginal examination on a patient was complex and she was uncertain about what she needed to detect when conducting this procedure, and several group members nodded in agreement with her, *"…but they never show us in the real person, we do not know what to feel in a PV* [per vaginal examination]*…"* The dialogue in this group continued and the following emerged, *"I mean a PV* [per vagina examination]*, you can't do on a doll. You can't work on a doll, that you have to do in a hospital, but the information given in the sim lab must be sufficient and the equipment to do the procedure should be there…"* Haigh's study (2007:99) states that there learners need to experience real life scenarios and to interact with real clients as part of their educational process.

This confirms the need for learners to experience some of the nursing skills activities in the clinical setting in the presence of skilled nursing practitioners. A particular (FG-F) participant stated that some of the nursing skills could be demonstrated on a manikin, such as foetal positions, *"The positions* [foetal position in utero]*, they can show you on the doll, then we can understand"*. Hovancsek in Broussard (2009:8) reports that learners report that there is a decreased level in their performance anxiety with a concurrent increase in self-confidence of their psychomotor skills and critical thinking abilities after experiencing simulation-based learning.

In this study, the participants were able to distinguish between those nursing skills that could be readily taught in the simulation laboratory and those nursing skills that had to be taught in the clinical placement setting. A study by Maginnis *et al*. (2010:5) confirms that students had identified the gap between simulation laboratory and the clinical setting.

Category: Simulation laboratory practice gap – transitional difficulties

Nurse educators' strive to mimic reality in traditional skills laboratories; learners often experience difficulties when moving from the simulation laboratory to the clinical placement area (Broussard *et al*. 2008:6). Another category that emerged from the collected and analysed data was the gap between simulation laboratory and practice that manifested as transitional difficulties for participants. Several participants in this study encountered transitional difficulties between teaching and learning that occurred in the simulation laboratory and practice in the clinical setting. A participant (FG-A) felt that washing a manikin was completely different from washing a real patient, *"Ja* [sic]*, sometimes it is totally different when you wash a doll and then when it comes to a hospital you wash a real patient".* Maginnis *et al.* (2010:4) report that learners find washing a manikin is different to washing an actual patient due to the personal interaction that is needed. The participant continued to share that she experienced some difficulties with knowing how to manage the emotional state of a patient, since this could not be simulated in the simulation laboratory, *"For me, who is the first time to be in nursing, sometimes it is a bit difficult, because here it is just a doll, but you pretend as this is a human being and then in the hospital, this is a real patient and sometimes she is angry, or he is angry with you and then you see, sometimes it is a bit difficult when it comes to dolls and, but shame..."* Maginnis *et al.* (2010:4) note that it is hard to replicate a full wash on an adult to include the emotional aspect of care in the simulation laboratory. This point of view was confirmed by another participant (FG-B), *"The dolls are not interacting with you. In the clinical services the human being has feelings, and how are you going to interact with that person".* Wellard *et al.* (2009:43) state that learners experience difficulties with plastic manikins, since they were not real persons. One of the participants (FG-C) compared his experience of the learning and teaching in the simulation laboratory with the clinical placement setting where the change from working with a manikin was vastly different to working with a patient who had dissimilar emotional needs, *"uhm… well most cases it is quite a change... because you don't work with a doll, you working with a person and every person has its own needs and then this…"* Another participant (FG-D) added that administering an intramuscular injection was very different when given to an object, such as a sponge, when compared to injecting a real patient*, "Just the fact that the person is alive. You feel confident when you do it on the sponge, because there is no… like feelings! But when it is a person you must be calm, so that the person can be calm, that you can reassure the patient… but with a sponge, you can just inject it".* Simulation laboratories can provide basic

instruction and familiarising with psychomotor techniques; however, there is a difference between giving a practice device an injection and giving a patient an injection (Wellard *et al.* 2009:43*). Another (FG-H) participant reflected on his experience and said that there was a difference teaching nursing skills in the simulation laboratory and the clinical placement setting, and this created confusion for him, *"In sim lab we are shown one way of doing procedures and when we are in hospital then the staff there would do it differently... it is so confusing! Which is the correct way?"* Yet another participant (FG-H) reflected on his experience of being scared while washing and dressing a baby for the first time; he felt uneasy dressing an agitated crying baby, *"It was so different doing a baby bath in the hospital to the practice we did in the sim lab, when I dressed the baby he was crying with the arms going up and down... it was scary".* Kardong-Edgren *et al.* (2008:2) inform us that the simultaneous use of cognitive, psychomotor and psycho-social skills sets can be particularly challenging for the novice learner. However, Maginnis *et al.* (2010:5) reinforce the use of simulation laboratories as an effective teaching strategy, since it prepares learners for the clinical placement. In their study, they highlight the inconsistencies between what is taught and what is practised. In this study, it emerged from several focus groups that there was a difference in the teaching of nursing skills in the simulation laboratory and how these skills were practically applied in the clinical placement areas.

A participant (FG-A) pointed out that the inconsistencies observed in relation to the learning and teaching in the simulation laboratory and in clinical placement areas were due to resources that were different and found that she needed to use her initiative to adapt to the current clinical situation, *"...but sometimes like if you in sim lab, they do procedures like in this manner and you go to hospital and then you see now there is a change here because you have to adapt to that and then that change that you have to adapt... you have to actually use your own initiatives to take what you know and use it to that situation."* This was confirmed by another participant of that group, since she echoed what the clinical placement staff expressed that some of the nursing procedures were done differently to the simulation laboratory, *"They* [hospital nursing staff] *kept on saying some of the procedures aren't the same so you have to adapt to the way that in that hospital too. So, you have to follow the orders of that hospital…"* To enhance the quality of teaching in practice and the quality of placements, nurse educators must spend time in clinical practice placements to ensure that clinical skills are carried out correctly (Morgan 2006:159).

A participant (FG-C) experienced great difficulty in dealing with his first encounter of the death of a patient. He shared the experience with his group, *"Dead and dying, where you drop off the dead patients, yes… Sjoe...* [SIC] *Yes, yes, just see the dead… for the first time"*. The participant was asked whether he performed the procedure of caring for the dead patient on his own and he said, *"No... no... What was happening in fact, I was at hospital so I had to help because… one of the staff, there were three of us… during that time I was sad when I was just seeing it for the first time… It is something that I had to go through... like a first time experience"*. Tanner in Kardong-Edgren *et al.* (2008:2) emphasises that the use of experiential teaching and learning that addresses the overarching disciplines of health, namely the physical, psychological, and spiritual environment within the context of the patient and family is proposed as the ideal way to enhance the integration of skills sets among nursing learners.

Another participant (FG-F) voiced her experience of time spent in a post-natal ward where it was challenging for her to work with the mother who had difficulty breastfeeding and new-born infant, *"Theoretical, and also here in the sim lab with the doll!"* The use of manikins is not new in maternal-child education (Jeffries *et al.* 2009:616). The participant continued, *"No, we talking about the real person, and the child, and the mothers they will leave their babies there saying, 'the child doesn't want to suck!'…"* Jeffries *et al.* (2009:617) report in their study that 63% of staff nurses working in a maternal-child unit prefer a 'hands-on demonstration and review' and 'live demonstration and question and answer session' as the most effective learning styles for them.

Another participant (FG-D) shared her experience of giving an intramuscular injection for the first time to a patient, *"Uhm… scared because you are thinking, I might hurt the patient when I am inserting the injection* [needle]. *The patient might move… so… something might happen; the needle might break inside the muscle of the patient. Uhm… the challenge…"* Simulation laboratories do provide limited nursing skills training, since there is a difference between injecting a practice device and injecting a real patient (Wellard & Heggen 2009:43).

 In this study, it emerged from several focus groups (FG-F, -G, and -H) that there was great difficulty with mastering the skill of suturing a wound, particularly in their 3rd year of study. For example, one of the participants shared an experience with the group that was acknowledged by several other members in the group, *"...suturing a sponge is so different to suturing human tissue… and the needles that we use in the sim lab is so big, the needles we*

use in the services are smaller plus you have to use a forceps to hold the needle…" Baillie *et al.* (2009:299) state that the realism of simulation is often questioned and some learners experience that the simulation laboratory lacks realism.

In this study, it emerged that several participants experienced transitional difficulties from simulation laboratory teaching and learning to the clinical placement area. As noted in the study by Wellard and Heggen (2009:42), laboratories cannot replace the real world of practice. However, it is equally problematic in learning the skills of practice when these laboratories provide a stereotyped view of nursing and minimise complexity. Jeffries *et al.* (2006:18) state that the acquisition of relevant knowledge, the development of psychomotor skills, and the ability to apply the knowledge and skills appropriately in a given context are all required for nursing competency.

Category: Use of automated equipment

The next category that emerged in this sub-theme was the use of automated equipment; this is equipment is used in the clinical setting, such as electronic and / or digital equipment used to monitor and measure vital signs of patients in a general and / or an obstetric placement unit or ward. The simulation laboratory resources at a College of Nursing in the Western Cape were dissimilar to the equipment that was available in the clinical area and learners were initially uncertain about how to manage the situation they found themselves in.

The equipment in the simulation laboratory was limited and not as sophisticated as the equipment in use in the clinical placement areas, confirmed one of the participants (FG-C)*, "...the first time that I come to the hospital and I saw the digital thermometers… like! What is this!... and then sister explain what they use it for and... so, now! I got... okay… now... I know now what it is!"* The participant continued by saying that it would be useful to see the same equipment in the simulation laboratory prior to clinical placement,, *"If they showed us that there are digital and you get manual equipment in sim lab, you actually would have known what you do with it".* Maginnis *et al.* (2010:6) conclude in their study that the concept of parity and consistency between what is taught and what is experienced is imperative in ensuring safe practice for novice nursing students.

Another participant (FG-F) highlighted the fact that an important piece of equipment used in the monitoring of the foetal heart rate and maternal contractions were not demonstrated to them prior to clinical placement, *"Especially the mentors should be there with that CTG*

[cardiotachography] *machine, because here you just seeing it in the text book, then there in the hospital… it is something different…"* Jeffries *et al.* (2009:619) state that providing a realistic simulation environment allows the students to apply the textbook "rules" to a situation that contains unknown conditions. In this study, the participants voiced the challenges that they experienced while using automated hospital equipment for patients and that they would like the simulation laboratory to acquire similar equipment for purposes of teaching student learners how to use it prior to clinical placement, since it would diminish some of the challenges they encountered in their training.

Category: Lack of time to support students

Eraut in Haigh (2007:101) states that the nature of simulation means that time can be manipulated to suit student learning needs, thus there is time to discuss and critique theory and to articulate implied knowledge. It emerged in this study that the time in the simulation laboratory was not optimally utilised for learning and teaching purposes.

A participant (FG-C) expressed the opinion that time was always a concern, since their programme seemed not to make provision for sufficient learning and teaching sessions in the simulation laboratory, *"it is more the way the programme is managed and time is always a concern"*. Strand *et al.* (2009:20) explain in their study that time and space arrangements should be collaboratively established by fellow learners with the purpose of leading to an enhanced understanding of learning.

Another participant (FG-D) echoed that the teaching session in the simulation laboratory was brief*, "They just show you briefly… it is no more like teaching... And then the time is... over!"* This sentiment was confirmed by another participant (FG-E) who also stated that the learners were reluctant to admit that they were not understanding what was being taught, since the clinical facilitator would claim that there was insufficient time for any further discussion, *"I think that also contributes towards the situation that they don't want to tell the facilitator: 'I don't understand or can you explain this again', because some of the facilitators they will tell you about the time… or something like that"*. Haigh (2007:101) informs us that by allowing learners to express their understanding of a particular situation through discussion with their peers, prior knowledge is resituated and integrated with newly attained knowledge by means of participation in the simulation. In this way, effective learning occurs. Another participant (FG-E) suggested that the officially allocated time slot for simulation laboratory learning and

teaching ought to be fully utilised, *"And there is not much time, you know, because we got so much work to do, so at least that two hours that is supposed to be, it should be used for that procedure…".* The concern within this group that the allotted time for simulation class was underutilised, *"There is time because our periods are like two hours and they only spend thirty minutes with us."* Nehring *et al.* (2004:248) state that efficient and effect use of simulation in nursing education requires time and effort from nursing educators. Maginnis *et al.* (2010:6) conclude in their study that the articulation of the use of simulation laboratories and the effectiveness will lead to improved learning experiences both in the simulation laboratory and in the practice setting. In this study, it was noted that there several concerns were raised by participants about the utilisation of the stipulated time in the simulation laboratory, and there was also a concern that learners were reluctant to voice their opinions when they were uncertain about a particular topic, however, further research was needed about the effective utilisation of simulation laboratory time.

3.5.3.3 Sub-theme: Personal attitudes of facilitators / mentors / tutors

The starting point for any good teacher must be enthusiasm for the subject that is being taught. This has to be complemented by an eagerness to transmit this enthusiasm to other people that may result in a positive attitude of learners (Ramani *et al.* 2008:362). In this sub-theme, the following categories emerged:

- negative personal attitudes (not approachable, negative body language, intimidating) stifle their approachability.
- lack of clear communication and expectations.
- lack of uniformity.

Category: Negative personal attitudes, (not approachable, negative body language, intimidating) stifle their approachability

Cross in Lambert *et al.* (2005:668) believes that to allow the actual process of facilitation to occur a learning situation, the motivation of a learner, and the facilitator's qualities of realness, caring, and empathy must be present.

Negative body language conveys a message of not wanting to communicate with another person and stifles the teaching and learning process for both the learner and the clinical facilitator.

A participant (FG-D) remarked about the non-verbal communication of some of the clinical mentors when in the simulation laboratory, *"Yes, it is the body language. They will be like… ok… is he stupid... but they won't say it in that manner. You can see in the body language"*. Strand *et al.* (2009:21) conclude that learners want a teacher who challenges them, but at the same one who time instils trust and confidence. This participant (FG-D) shared with the group that there were those clinical facilitators who made one feel comfortable by their positive body language and then there were those ones who were unapproachable, *"Some mentors you automatically feel comfortable with because they smiling and they just like give off warmth, so you not scared; but then some of them you just like, okay… just let us get it done and move on"*. Most clinical teachers go about their business of teaching with very little feedback about their strengths and weaknesses as a teacher (Ramani *et al*. 2008:358). Another participant (FG-E) expressed the opinion that some clinical facilitators were strict and others were intimidating, *"You can be strict but there is a difference between being strict and intimidating..."* During the discussion, a fellow participant (FG-E) animatedly explained the intimidating behaviour of a clinical facilitator, *"The way they greet, because they will come in to the sim lab and then it is like 'do not even speak with me!' Then I just uhm… I am gonna* [sic] *greet because I need to greet and I am gonna* [sic] *get this finish and done with. Some! They don't ask if there are any questions"*. Dialogue with the student is an important part of clinical teaching (Ramani *et al*. 2009:357). Simulation is a teaching strategy that is used to facilitate establishing networks among concepts that actively engages students in the learning process (Jeffries in Kaakinen *et al*. 2009:1).

Another (FG-E) participant shared her experience of seeking clarity about what was being taught and her encounter with a curt response from the clinical facilitator, *"...and then, you feel like, oh, I didn't see that. I don't understand that. Can you repeat that? Then it is just like… really nurse, come on, where is your head?"* Students need a clinical facilitator who would encourage learners to ask questions, since asking questions is a key activity of their learning process (Strand *et al. 2009*:21).

Another participant (FG-F) suggested that repetition of procedures, while clinical facilitators were simultaneously rotated, may be a way of improving the learning and teaching in the simulation laboratory, *"The procedure needs to be repeated, but the mentors need to be rotated as we ask the same questions and she gives the same answer, she will get bored. In first year they rotate the mentors and that helps with understanding some of the answers to your questions…"* The teacher's goal must be to develop deep learning. Since students have

different learning styles, the material to be learnt must be presented in a variety of ways. (Ramani *et al.* 2008:356).

A participant (FG-D) said that it appeared that the learners and the clinical facilitators were surprised to see one another in the simulation laboratory, since the clinical facilitator seemed to be disinterested in teaching that session, *"Sometimes, it looks like we kind of surprising each other. It is only the show and off you go…"* Freeth and Fry (2005:278) conclude that there may be a possibility that senior learners are outgrowing the simulation laboratory experiences they offer. The dialogue in this group continued and they claimed that some clinical facilitators rushed through the learning and teaching session while some of them managed their session thoroughly, *"…but the way the mentors explain, some mentors just run over the stuff and other mentors will do it in detail, everything... for me, to know detail is actually better…"* Freeth and Fry (2005:278) note in the discussion of their study, that learners and clinical facilitators value teaching when the facilitators provide expert demonstrations before learners are given an organised, structured opportunity to practise with the necessary assistance of the facilitator. Another participant (FG-B) shared her view with the group that there were those clinical facilitators who provided the required learning and teaching and she appreciated that, *"they* [clinical facilitators] *do care about us that is why it is so easy"*. The teacher functions as a 'guide' and a 'pathfinder' and should formulate questions that make the students aware of their own thought processes. Several students find themselves to be more creative and eager to ask questions while they are engaging in dialogue (Strand *et al.* 2009:21). It is reported that faculty attitudes and approaches toward the facilitation of critical thinking development changes as a result of the integration of theory and practice during scenario-based teaching. Many report personal rewards, since they notice students who experience the "light bulb" effect while interacting during the scenarios (Lisko *et al*. 2010:108). In this study, it emerged that there were student-friendly clinical facilitators who were receptive to questioning and dialogue about skills that were being taught. However, there were some other clinical facilitators who were unapproachable and unfriendly towards the learner students, thus creating barriers to the teaching and learning processes in the simulation laboratory at a College of Nursing in the Western Cape.

Category: Lack of clear communication and expectations

Simulation allows the educator to add complexity by creating a context in which the rules need to be applied. The educator then creates the learning objectives and educational practices

that support the objectives. These objectives must be communicated clearly to the students (Jeffries *et al.* 2009:615). In this study, it emerged that participants from all of the focus groups experienced a lack of clear communication and expectations. They were unsure about their learning needs, particularly in the clinical setting.

A participant (FG-A) shared with her group that she was unaware that during her clinical placement the trained nurses in that ward could evaluate her skills performance and assess her competency level, *"I didn't know they can… I must call her and she will come and watch me and then she will sign, but I didn't know that, it was my last day of clinical placement that I found out!"* Another participant (FG-F) shared her view that the clinical facilitator was responsible for clearly communicating the learning objectives in the clinical placement setting, *"But then, it is our mentor's responsibility. They know they are responsible for us. It is their choice to help us".* Orientating learners and preparing them for the clinical setting can assist to ease the transition from the classroom to the clinical setting, and to ensure that partnerships with mentors and allocations are included as part of the preparations (Wood, Harben-Obasuyi, & Richardson 2011:527). In this study, most of the participants agreed that they were uncertain about their learning goals and objectives, as well as available guidance, particularly when they were at the clinical facilities.

Category: Lack of uniformity

In the discussion of a study by Wellard and Heggen (2009:42) it is noted that teaching in the simulation laboratories in both Australia and Norway is based mainly on tradition and the experiences of the clinical facilitators, or what might be called a 'personal curriculum'. The authors continue to highlight a certain amount of naivety about the way in which the clinical nurse facilitators' 'personal curriculum' relates to the official curriculum of their undergraduate nursing programme. In this study, it emerged that there was a lack of uniformity in the simulation class, simulation laboratory, and in the clinical areas.

A participant (FG-A) stated that some clinical facilitators would read from the board and that communication was one-sided which she found boring and tiresome, *"…but the other lecturers they just reading from the board and just read and they talk and it was boring especially for me, having a two hour class".* Learners find it appealing to be active participants in simulation (Broussard *et al.* 2009:8).

Another participant (FG-A), highlighted that there were inconsistencies when doing the full wash in the clinical area. She had practical experience and knew what needed to be done, however, there were other student learners who did not know how to perform the procedure correctly, *"...There was one of the fresh matriculants with me and she was… it was so confusing the time when we wash the patient. I knew what to do, but so, said to her, you can do the first part. By the time we finished the top part of the patient and both of us… we were nervous by the time… she went straight to the back, but you not supposed to go straight to the back, you must first…"* Morgan's (2006:15a) study informs us that nurse educators must spend time in practice placement to ensure that clinical skills are carried out correctly, and this would enhance the quality of teaching in practice and the quality of placement for the learner. One of the senior participants (FG-E) suggested that it may be useful if the method of teaching during their foundation year could be carried through to the subsequent levels of their course, *"If they stuck to the process of the first year, have a discussion and give you a fair idea what you going to do; maybe have an audio-visual presentation and then do the demonstration".* Uniformity among clinical facilitators in teaching practical skills may reduce confusion among the learners. As Lana in a study by Limoges (2010:62) indicates, the simulation laboratory is a place where we can level the learning experience to give all students an opportunity to observe nursing practice informed by nursing theory. Limoges continues to state that the simulation laboratory has the potential to provide a space where nursing-specific knowledge can be taught and practised.

A participant (FG-E) raised the point that there were differences observed in the method of teaching among their clinical facilitators, *"The mentors, they didn't do the same way when they do the procedure…"* Ramani *et al.* (2008:357) inform us that failure to engage with the learner is more likely to result from poorly constructed teaching sessions, rather than learner motivation. A participant (FG-H) reflected on his clinical teaching in the simulation laboratory that was different from his placement in a clinical placement setting due to presence of a different clinical facilitator, *"Now, you get three different hospitals, and then the clinical facilitator in this hospital and the clinical educator you were with at the sim lab, now that one says one thing, this one says another thing…"* Standardised teaching, that is all teachers agree to teach in the same way by using the same resources and feedback policies that are part of the teaching strategy (Stark *et al.* 2003:301).

In this study, the learners found the non-uniformity in teaching rather challenging and many of them agreed that uniformity in teaching among clinical facilitators in the simulation class,

simulation laboratory, and clinical areas would enhance the learning process for them. Ramani *et al.* (2008:357) continues to state that the learner should be an active participant in the teaching session. Merely imparting the teacher's view to the learners about a situation or expecting them to observe the expert in action does not lead to deep learning.

3.5.3.4 Sub-theme: Attitudes of permanent staff members at hospitals

Creating a good atmosphere and relationships in clinical settings are regarded as essential, therefore, qualified nurses should be required to strive towards making students feel a part of the team and should provide support to students during the learning process (Hosoda 2008:2). In this study, it emerged that the attitudes of permanent nursing staff members at hospitals were at times a barrier to effective learning in the clinical placement setting. The following categories emerged under the theme related to:

- lack of support in clinical setting.
- lack of time to teach and demonstrate.
- taking 'short cuts'.
- unrealistic expectations.
- rigid expectations \ language issues (speaking Afrikaans)
- ridiculing students.
- 'getting upset' with students.
- 'tension with other categories of staff members'.

Category: Lack of support in clinical setting

Gerrish in Morgan (2006:160) argues that the role of ward managers is a multifunctional one that includes maintenance of the quality of nursing care delivered to patients, oversight of the daily functioning of the clinical learning environment, and the responsibility for the education of practitioners and learners.

Many agreed (FG-A) with what was said about novice nursing students who were denied the opportunity to practice the nursing skills in the clinical placement area as taught in the simulation laboratory, *"Yes, we know our work. They don't give us a chance. They always say we taking too long and they would say, 'You are not at school now, we want to finish'".* Morgan's (2006:159) study informs us that it is mandatory for learners to have their clinical

facilitator in the clinical area to limit the exposure of novice learners to shortcuts and incorrect clinical skills practices.

This participant (FG-E) shared her view with the group and stated that the clinical staff were not willing to share their experience with them, *"And the services are there for us to learn from their experience, but they do not see it like that"*. Savage in Baillie *et al.* (2009:304) notes that clinical staff members are unwilling to teach learners in the clinical placement setting.

Another participant (FG-F) expressed dissatisfaction with the situation at the time where they were good enough to do basic nursing procedures, however, learning more complex nursing skills were not encouraged, *"So, we are there to do the observations, but we are there for the hands–on experience; We don't do it… and we are not satisfied with this"*. In Haigh's study (2007:101), learners request more simulation teaching of a relatively simple form of basic midwifery skills. In this study, the learners explained that they were utilised to do ward routine activities only, and those specific midwifery learning opportunities that they needed to be exposed to, were denied due to staff members who were too busy or unwilling to assist and guide the learners.

However, another participant (FG-F) shared her experience about a ward where a particular professional nurse was keen to assist and guide the students, thus most of the students would seek her guidance. When she was not around, there was no other professional nurse who was willing to assist them, *"They totally have an attitude and if you… uhm… there is this sister, one who is nice; all the students they will go to her… if that sister is not there… there is no one to go to…"* Several members of the group agreed with what she had said. In this study, some participants found that there was insufficient learner support in the clinical area by the qualified nursing staff members. Strand *et al.* (2009:21) emphasise that learners express the importance of feeling secure while training and developing nursing skills.

Added to their distress, another participant (FG-F) said that when their clinical facilitator was on site and called them to attend a learning and teaching opportunity, they had been denied the opportunity to attend, since the participants could not be released from the ward duties. The participant felt that the clinical facilitator needed to intervene on their behalf, *"and then sometimes the mentors, they will call us... then you tell them, the sister-in-charge... don't want me to come. She will say, 'it is fine…' Why is she saying it is fine, but other students are there*

to learn, but what about me?". Lambert and Glacken (2005:665) state that there is an identifiable gap that exists about whose prime responsibility is clinical teaching. In this study, there seemed to be a few professional nursing staff members in the clinical facilities that were willing to guide and assist the student learners in achieving their learning goals and objectives of their current level of training. Further research may assist with identifying the underlying reasons for the current situation.

Category: Lack of time to teach and demonstrate

Quinn in Lambert *et al.* (2005:665) refers to experiential learning throughout the literature that learning through placement experience is often considered more meaningful than classroom learning. Lambert states that teaching, learning, and assessing are crucial aspects in the clinical placement area, since it generates the evolution of knowledge and skills by ensuring the development of competent practitioners. In this study, the views held by many of the participants emphasised insufficient permanent nursing personnel in the clinical areas that led to insufficient time to teach and demonstrate the required nursing skills that the learners require. A participant (FG-C) shared her experience that she was unable to perform the nursing skills as taught in the simulation laboratory after placement in a particular clinical area*, "I am learning to do the vital signs the manual way, but they don't give you the opportunity"*. Hosoda (2008:2) states that learners should perform their duties in an authentic domain, since it is considered to be a useful experience for the professional socialisation of the learner.

Another participant (FG-A) expressed her view of staff shortages in the clinical area that were impacting the experiential learning opportunities, *"It depends on the permanent staff, if there is a shortage of permanent staff then we have to rush to help them get their work finish."* Landers in Morgan (2006:159) states that often for qualified nurses the familiarity of carrying out clinical skills and low staffing levels are reasons why clinical skills are not carried out in accordance with prior learning.

Several (FG-F) participants experienced difficulties in the clinical placement area to access support from the nursing staff in that clinical*, "The staff at the hospital… they always busy… they always have their own things to do. You ask, and they say yes, I will, but give me time; by the end of the week when you finished there, that time never comes…"*Another participant (FG-F) said that there was no guidance in relation to a post-natal ward and she felt unsure and

uneasy about applying skills in this busy ward, *"In post-natal, there is no one telling you if you are right or wrong… if she is not doing anything, she will help, but if she is busy she will tell you it is busy…"* Another participant (FG-F) voiced her concern about her time in a labour ward where she observed the professional nurses' reluctance to demonstrate any of the relevant nursing skills for that clinical placement area, *"The labour ward is nice, there are professional nurses… but when it comes to demonstrating, then like everybody said, there is no time… They can't help you or they can't show you this…. They would ask, 'Did your mentor show you this?'"*. Savage in Baillie *et al.* (2008:303) establishes that students report nursing staff that are unwilling to teach them, while they are needing to focus on patient care within an unpredictable changing environment. Wood *et al.* (2011:527) state that learners welcome the support and presence of a qualified nurse who is available and approachable, and who is willing to help them achieve their competencies and training needs. In summary, the staff in the clinical placement areas experienced challenges with staff members who were too busy and clinical areas that were short-staffed. As a result, there was not enough time to teach and guide student learners; however, some of the clinical staff displayed a reluctance to share their nursing expertise with student nurses.

Category: Taking 'short cuts'

Student nurses must become competent and efficient whilst carrying out clinical skills. However, this may be threatened when learners observe several different practices of qualified nurse practitioners (Morgan 2006:159). In this study, participants from all focus groups articulated that it was difficult for them to perform nursing procedures as required due to being rushed in the clinical areas and they observed the permanent staff doing these nursing procedures differently.

A participant (FG-A) indicated that taking a patient's temperature with a manual thermometer that took two minutes to measure was considered time consuming, therefore, the ward staff wanted the student learners to use digital thermometers, *"…time-wise, you can't just go and use the manual one because everything in hospital is a rush. So, there is no time for the manual thermometer, waiting for two minutes for the reading!"* During the discussion, another participant clarified by adding, *"I think I understand what she is trying to say because when they are not there, and then they rush you to get done with the patient because the other patients are waiting, so then you just have to rush"*. This feeling of being rushed in the clinical placement area to perform basic nursing skills was reaffirmed by another (FG-A)

participant who felt lonely and excluded from the nursing team, *"Yes, I feel that they don't want me to do things there because when I come with my things, they say, No, Mum… this is wasting time and then they do everything. I just feel lonely".* Yet, another (FG-A) participant expressed her dismay at the clinical site's atmosphere of rushing to execute nursing procedures by taking shortcuts, thus leaving little opportunity for them to perform their nursing skills as taught in the simulation laboratory, *"I can't practise with the staff at the hospital, they do the assessments, but they don't do it the way we were taught to do it. The shortcuts… so…"* Maginnis *et al.* (2010:5) inform us that the skills learned in the simulation laboratory setting are further developed during clinical practice. Hughes in Morgan (2006:159) concurs that to enable students to link theory and practice, qualified practitioners must be supported with their continued professional development to enable them to guide and support student learners. In summary, it seemed that due to staff shortages, the staff members had to hurry through the work routine in the clinical facilities, therefore, student learners were unable to practise basic nursing skills as it had been taught in the simulation laboratory.

Category: Unrealistic expectations

Moyne in Moulle (2006:23) believes that the quality of mentorship on learners' ability to link theory and practice is exacerbated by the increasing number of nursing learners that is making it more difficult to guarantee learners exposure to relevant learning opportunities and mentor support. In this study, it emerged that the permanent nursing personnel had unrealistic expectations from the learner students who found these expectations unsettling. A participant (FG-E) claimed that the previous graduates at a College of Nursing in the Western Cape, who were practising professional nurses in the clinical areas would reflect on their training programme and expect the current learners to be exposed to the same theoretical and practical learning and teaching opportunities as they would have during their training, *"Some of the trained staff who trained at our college, think that the programme is as it was when they were students".* Another participant (FG-D) said that the permanent trained nursing personnel in the clinical areas were uncertain about their learning needs, *"There is actually a lack of knowing things that have to be done in hospital"*. The sentiment was affirmed by another participant (FG-E) when she claimed that the ward staff expected them to know what the expectations in that ward were on their first day of their clinical placement, *"The ward staff expect us to know when we get there the first day".* However, there was agreement with a statement by other group members who said that there was more pressure on students at a College of Nursing in the Western Cape to perform nursing tasks when compared with

learners from other nursing schools, *"Like the other colleges, they won't put so much pressure on you… it is an old story… they expect you must know… Give me a break it is only my second week!"* In summary, there seemed to be undue pressure placed on student learners in the clinical areas, since many of the permanent nursing personnel were graduates of a College of Nursing in the Western Cape. Limited clinical learning opportunities and inadequate clinical skills development support in the service settings might be challenges that would lead to the college having to customise their clinical skills training programmes to suit their specific contextual situations (Jeggels *et al.* 2010:57).

Category: Rigid expectations

It is argued that, while the past few decades have borne witness to various clinical support roles to facilitate the fusion of theory and practice, an identifiable uncertainty exists about who has the principle responsibility for clinical teaching (Lambert *et al.* 2005:665). Another category that emerged in this sub-theme was the rigid expectations of permanent staff at practice facilities / hospitals. A participant (FG-D) claimed that it was their first semester of the second year of study; on arrival in the clinical area, the permanent nursing staff had difficulty understanding that the learner was new to 2nd year nursing procedures and competencies, *"The hospital staff expect a lot from us on a shift and we must know procedures that we have not done in sim lab as yet, it is the beginning of our 2nd year!"* A study conducted in Norway and Australia reports that timetabling and limited synchronicity with academic classes are concerning to them (Wellard *et al.* 2007:6).

The permanent trained nursing personnel seemed unappreciative of the keenness of learners who wanted to participate in new nursing activities, however, it seemed that the lecture theatres, simulation laboratories, and clinical practice areas were viewed as separate entities. A participant (FG-F) shared her experience, *" 'Why do you come to the services but you can't do the things?' So, I was telling her, in class we do the theory, and in the sim lab we don't do cold testing. We were told we will learn that in the services".* In summary, the participants expressed their dismay at the permanent staff in the clinical facility for not being aware of their scope of practice and their learning needs and objectives for that particular practical placement period. Wellard and Heggen (2009:43) agree that the value of staged laboratory learning must be linked to learning participation in the actual patient area in the presence of other nursing personnel. The authors continue to state that "The fellowship of nurses is vastly

different from a fellowship of students, where the expertise and culture influences the ways that nurses practice".

Category: Language issues (speaking Afrikaans)

Language in a social context, provide an important foundation for thinking and awareness (Strand *et al.* 2009:20). The use of Afrikaans in the clinical facilities emerged as another category in this sub-theme. Some of the participants experienced that the use of a language different to their mother tongue or the language of instruction (English) stifled their learning and teaching process. One participant (FG-B) voiced her experience in the clinical placement setting where the language of instruction was foreign to her, *"They* [permanent hospital staff members] *write in Afrikaans… you get lost, when they do that… all the wards use Afrikaans… They told us, this hospital is for Afrikaans, not for English".* This participant's mother tongue was isiXhosa, and she was literate and conversant in English as a second language. Therefore, the use of Afrikaans was a challenge that created a barrier for learning in the clinical facilities. Strand *et al.* (2009:20) note in their study that the learners learn that there is an interaction between feelings, the body, and language. The learner who scores well on social learning benefits by comparing, listening, networking, and interacting with other people (Fountain *et al.* 2009:98). In summary, several participants experienced difficulty with integrating theory and practice due to the clinical facility staff members who were using a language that the learner students did not understand.

Category: Ridiculing students

The interpersonal aspects associated with educating learners cannot be ignored, therefore, qualified nurses must create an atmosphere and relationships that are conducive to teaching and learning for student learners in the clinical placement area (Hosoda 2006:20). In this study, it emerged that nursing personnel at the clinical facilities ridiculed several of the participants.

A participant (FG-F) explained that the enrolled nursing assistants in the clinical placement setting expected them to know the nursing skills for that area and would pass derogatory comments about them, *"And the way the nurses treated it as the… most of the ENAs* [enrolled nursing assistant]*, they treat us like you have to know it. Some of them, they told us, you are stupid, 'julle is onnosel'… Some of them".* Another participant (FG-F) concurred by adding that the permanent staff ridiculed their inability to perform the required nursing skills in an

ante-natal ward, *"You know the way, sometimes laughing at us. 'You don't know how to count the contractions?' They will talk about this in the tea room and you there! Or some of your friends are there!"* Lambert *et al.* (2005:665) inform us that the clinical learning placement area is not without its problems. It can be erratic and energetic with unforeseeable changes, lacking reliability, and matching experiences.

Another participant (FG-F) shared her experience of being ridiculed and saw some learner students crying because of inadequate clinical support in the ward, *"They* [clinical staff] *laugh, they didn't even show us what to do. Others* [learners]*, they even cried in the hospital because the sisters* [professional nurses] *they just… no, we busy, we don't have time, just go and do the urine… There is a cold test… I didn't even know what is a cold test!"* Penman and Oliver in Maginnis *et al.* (2010:5) refer to the need for tertiary institutions and service areas to collaborate to increase the learning opportunities for students and to create a feeling of security to create an environment that is conducive to learning and teaching. Benner in Maginnis *et al.* (2010:5) asserts that novices have no experience with scenarios that they encounter in the clinical setting and, therefore, they lack an understanding of the application of theory in real situations. In summary, the participants in this study experienced being ridiculed in the clinical placement area and that was due to several factors that need further research to establish the underlying causes and to find ways of mitigating the interaction with learner students.

Category: 'Getting upset' with students

It is argued that while the past few decades borne witness to various clinical support roles to facilitate the fusion of theory and practice, an identifiable uncertainty exists about who has prime responsibility for clinical teaching (Lambert *et al.* 2005:665). In this study, one of the participants (FG-G) identified that the clinical environment was challenging, since it was not always learner-friendly and several other participants in the focus groups raised the same concern, *"Yes, we are in hospital to learn, but it is not always learner-friendly."* Morgan (2006:159) states that managers and educators must support practitioners to enrol for preceptorship courses that will enable them to fulfil their role as preceptors, therefore, helping students to meet their agreed learning outcomes, have the ability to link theory to practice, and provide high standards of patient care. In summary, it was unclear how qualified professional nurses in the clinical facilities viewed their role and their obligation to learner nurse students and further research is needed.

Category: 'Tension with other categories of staff'

Dean and Kenworthy in Lambert *et al.* (2005:665) acknowledge that clinical learning is chiefly spontaneous and unforeseen. It demands planning to enable the maximising of learning opportunities and minimising the risk of haphazard information and education. In this study, it emerged that there was tension between participants and the other categories of nursing staff members in the clinical facilities. The enrolled nursing assistants and enrolled staff nurses were reluctant to share their knowledge and expertise with the learners. In a few years' time, the learners would qualify as professional nurses; it implied that the learners might be in a higher category of nursing. One of the participants (FG-B) said that they were readily summoned to attend to the basic nursing needs of new patients after their arrival in the ward. Several participants agreed with her, however, when complex nurse-learning opportunities arose, often they would be disregarded or given incorrect information, *"When the patient arrives in the ward, the first thing they will do is call the student, but when we have to learn, they do not help us to learn. They will not give us the right information"*. Another (FG-B) participant shared her experience and said that she was denied the opportunity to perform a bed bath procedure as taught in the simulation laboratory, since the staff hurried her along, *"When you want to wash the patient as we were taught in sim lab, they don't give you the option to do so... Four minutes is enough to wash a patient. In four minutes! Is it really enough?"* Maginnis *et al.* (2010:5) affirm that there are discrepancies between what is taught and what is practised. Their study identifies that the students are insightful in noticing the gaps between clinical laboratory simulation skills and what occurs in the reality of the clinical setting.

Another participant (FG-F) said that there was conflict and tension with other sub-categories of nursing personnel in the wards due to their learner student status, *"They think because we studying, then they teaching us, then in a few years to come, you are a sister* [professional nurse]*, you higher than them... They don't like it and sometimes we tell them we appreciate what you teaching us... The ENAs* [enrolled nursing assistant] *and staff nurses... there is a problem... because they just close the doors* [sic] *for you and they will say: 'Why can't you understand but you will be a sister* [professional nurse]*?' "* Lambert *et al.* (2005:666) note in their study that if learners are to acquire knowledge and skills in clinical practice, there must be a designated person available to demonstrate how theoretical knowledge can be integrated with practice; otherwise the significance of opportune experiential learning experience may be lost or diminished. In summary, participants in this study expressed the tensions that existed

in the clinical facilities among them and other categories of nursing personnel and that created a barrier to learning and teaching in the clinical facilities.

3.5.3.5 Sub-theme: Student related matters

One's job as an educator is not only to impart new ideas but also to dispose of or modify old ones. In many cases, resistance to new ideas originates from the conflict with old beliefs that are different. If the education process begins by exposing the learner's beliefs and theories, examining and testing them, and then integrating the new, more refined ideas into the person's belief system, the learning process will be facilitated (Kolb 1984:28). In this study, several student related matters emerged:

- Differences in personality types (introvert vs. extrovert) asking for assistance.
- Language difficulties, English as a second language.
- Individual learning styles (not everybody learn in the same way or at the same pace).
- Cognitive dissonance: don't understand, need for reinforcement.
- Emotive dissonance: frustrated, shocked, fear, simulation lab is exhausting, 'feeling down'.
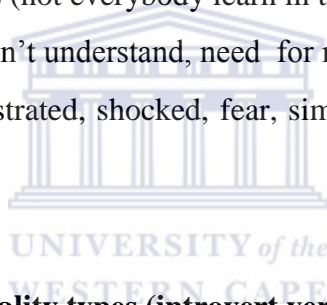
Category: Differences in personality types (introvert versus extrovert) – asking for assistance

Students represent a wide variety of ages, life stages, talents and experiences (Rothgeb 2008:483). Spouse in Strand *et al.* (2009:20) states that socio-cultural theories are helpful in understanding the complex interactions associated with supervising and learning professional craft knowledge. In this study, several of the participants spoke of their particular way of learning and how they differed in dealing with their challenges in the simulation laboratory. These challenges depended on whether they viewed themselves as introverts or extroverts.

Several of the participants explained that they had dissimilar personalities and that needed to be accommodated during the teaching and learning processes in the simulation laboratory. A participant (FG-A) said, *"Some of the students aren't open… there are lots of people and maybe they are shy".* The needs and learning styles of different generations of learners should be considered when implementing any instructional strategy within the curriculum (Howard *et al.* 2011:9).

The same participant (FG-A) said that she coped with learning in the simulation laboratory by doing the procedures and when she was unsure of herself, she would not hesitate to ask the clinical facilitator for assistance, *"I learn hands on and if I don't understand it, I am gonna* [sic] *say I don't understand"*. Learners felt comfortable with making mistakes and having the ability to rectify those mistakes with guidance and they found it created a safe learning space for them (Baillie *et al.* 2008:301).

Yet another participant (FG-A) who voiced her discomfort with learning in a group, while several other participants were nodding in agreement, originated from fear that her peers might laugh at them or be judgemental about their incorrect answers to questions, *"You not sure of the answer and then the problem starts because you gonna* [sic] *think what if I am wrong, are they gonna* [sic] *laugh at you or they gonna* [sic] *judge me or something like that"*. Teaching sessions with similar psychomotor skills and complexity levels should be sufficient for engaging learners, without overwhelming them (Garrett *et al.* 2010:311). Students learn not only with and from one another, but also by teaching one another (Daley in Strand *et al.* 2009:21).

A participant spoke on behalf of the group (FG-H) and raised her concerns about the change in processes that occurred during their four year period of study, *"And we as students, we are not the same. Others they are shy, they don't want to say something wrong in front of other students like in others years, we used to phone them* [clinical facilitators] *and make an appointment so that I can get a practice alone, but now it is not like that"*. Nehring *et al.* (2004:248) find in their study that learners experience anxiety when demonstrating skills in front of their peers, however, they embrace this form of interactive learning.

To set the stage for effective teaching and learning, the teacher has to create an atmosphere that is conducive for stimulating the learner to learn and feel comfortable when they are identifying and addressing their challenges without fear of ridicule (Ramani *et al.* 2008:349). In summary, participants appreciated that they had different personalities and that it would play a role in their way of learning in the simulation laboratory, however, the atmosphere in the simulation laboratory was not always conducive to learning.

Category: Language difficulties, English as a second language

Students reported that there was a need for more simulated practice to increase their understanding, particularly of the anatomy and physiological concepts (Haig 2007:101 &

Nehring *et al.* 2004:245). Another category that emerged in this sub-theme was language difficulties that participants experienced in the simulation laboratory. Clinical facilitators needed to be mindful to the fact that the language of instruction at the College of Nursing in the Western Cape is English. However, English is a second or third language for a majority of the student learners, and they would appreciate the use of nursing terminology as taught in the lecture theatres, to be used in the simulation laboratory as well. This would be very useful to them, since it would assist with the pronunciation and usage of new terminology. A participant (FG-A) shared her concerns about mastering new terminology and concepts that were used in nursing theoretical classes, *"I prefer sim lab to the lecture theatre, because BNS [biological nursing science] I sometimes get bored because of the words in the textbook… they not so easy to pronounce…"* Strand *et al.* (2009:19) report similar findings, where the learners experience that team work gives them a good basis not only in executing practical skills but also in becoming aware of important terms and concepts. This sentiment was also voiced by another participant (FG-B) who informed the researcher that being taught in a second language added to their learning challenges, *"We have two subjects; it is BNS and sim lab. In sim lab we don't have a problem, it is fine, but the other one... I am just comparing, because I prefer sim lab lecturing… You can use your own English, not a problem… unlike the other one. The other one you have to choose the language…"* Morgan (2006:156) states that it is important that clinical educators reiterate the theoretical component of the programme whilst teaching practical procedures in simulation laboratories.

Another (FG-B) participant reaffirmed the need to hear the theoretical terminology used in the simulation laboratory to assist with knowing how to pronounce these words, *"But the terms, the words we need to hear often, especially for the pronunciation, otherwise we are lost".* To enhance learning and understanding of concepts, the student has the opportunity to apply abstract concepts learned in the classroom during simulation laboratory classes (Howard *et al.* 2011:e2)

A participant (FG-A) explained to the focus group that they were from a multi-lingual society and that needed be taken into consideration with teaching and learning in the simulation laboratory, *"Especially in our class, nobody in our class, has English as a first language. All of us are either Xhosa, Zulu, Sotho, Tswana or Afrikaans. Nobody's first language is English. So, that makes it even more difficult"*. It is essential that educators reiterate the theoretical component of programmes while teaching practical procedures in a simulation laboratory, since it enhances the integration of theory and practice (Maginnis *et al.* 2010:3). In summary,

it was evident that the use of nursing terminology needed to be used not only in the lecture theatres, but also in the simulation laboratory and clinical placement setting to assist student learners with grasping the concepts and integrating them with their nursing practice.

Category: Individual learning styles (not all learn in the same way or at the same pace)

Ramani *et al.* (2008:362) state that it is evident that different individuals have different approaches to learning. There is a variety of attempts to describe these different approaches or learning styles. Some classifications focus on the cognitive aspects of learning, some focus on the modalities of learning preferred by the learners, a third group focuses on the outcomes of the learning. In this sub-theme, another category emerged when several participants identified their individual learning styles and also that everyone learned at a different pace. One of the (FG-D) participants explained that the amount of information in some of the simulation laboratory sessions was too much for her to cope with, *"...but for me, it was just too much because it is so easy to forget something"*. It is a good idea to revisit concepts learnt at an earlier stage of the programme, where learning is reinforced and extended through repetition (Haigh 2006:101).

Another participant (FG-D) identified her need to be comfortable with a group for learning to be effective, *"...people that you not familiar with... Make it more difficult because the thing..."* and suggested, *"We! Just do our own grouping! Because that makes it easier in terms of learning."* Kilmon *et al.* (2010:316) state that planning flexibility and accommodating small groups of learners could be rewarding to both the learner and the clinical educator.

However, this particular participant (FG-C) communicated that he managed the teaching pace well, but was empathetic towards slow learners, *"Just to give those students that are slow learners, just to get them in and boost them before joining a bigger group..."* In larger groups, it is easier for weaker students to step back and take a less active role than their peers (Childs *et al.* 2006:157). This participant (FG-C) suggested that those who learn at a slower pace could have the first exposure to the practical teaching in a smaller group, *"....for or maybe, they can get the first exposure to the procedure"*. Learners need sufficient time to observe and practice nursing skills (Garrett *et al*. 2010:311).

A participant (FG-F) held the opinion that due to the differences in learning styles of students learners, the college could accommodate those learners who needed additional simulation

classes as soon as the lecture had been completed to demonstrate the application of theory in practice, *"We learn in different ways; what I was wishing for the college to do, after every lecture, those that do not understand the theory, can go to the sim lab and a demonstration of that, particular skill is done! … if you do not understand, they can show you on the doll".* In the discussion of Haigh's study (2007:101), midwifery learners identify the need for more simulated practice sessions where they could work with peers to increase their understanding particularly of the anatomy and physiology underpinning midwifery practice.

This particular participant (FG-A) identified her success with learning in the simulation laboratory as having previous experience in basic nursing procedures as a care giver, *"I found sim lab very interesting because in the past three years I worked as a carer* [care assistant]*, the work was familiar and interesting".* Kolb's approaches learning as a continuous process in which knowledge is created by transforming experience into existing cognitive frameworks, thus changing the way a person thinks and behaves (Lisko *et al.* 2010:108).

Lastly, a (FG-A) participant explained her negative feelings about some of the teaching in the simulation laboratory, since she had left the formal schooling system a while ago, and she shared the following with her group, *"…To do the practical and also the lab classes because sometimes really… you get bored in the classroom because, you left the school long time ago…"* Interactive*,* focused, energetic laboratory teaching proved to be valuable experiences for learning psychomotor skills and developing critical thinking (Childs *et al.* 2006:157). In summary, many participants found that different teaching strategies could be useful for learning in the simulation laboratory and that would enhance the understanding of nursing theory.

Category: Cognitive dissonance: Don't understand, need for reinforcement

According to Maginnis *et al.* (2010:2), cognitive dissonance describes the concept of the academic ideal of nursing taught in the tertiary sector that clashes with the reality of clinical practice. Some of the participants from all of the focus groups in this study shared the experience that they did not always understand what was being taught in the simulation laboratory, and expressed the need for reinforcement of the skills, since that would enable them to grasp the concepts that were being taught.

This participant (FG-B) stated that for her to grasp how to develop a nursing care plan, the clinical facilitators could utilise visual aids and a more interactive method of teaching this

particular skill, *"They explain to us how to do care plans in the sim lab. So, now when the patient comes in; you have to like ask the patient… Can he eat by himself? Is he physically impaired? You have to work out a care plan for that specific patient. So, they don't show us like in sim lab… How to communicate with patients… but I think it will be better in the sim lab if we got like a scenario and this was role played… I would like to work with scenarios, they are very important"* . Lisko *et al.* (2010:108) conclude in their study that learners identify scenario-based teaching to be the integrator of learning that unite the classroom, laboratory, and clinical experiences with the purpose of facilitating critical thinking. The sentiment was affirmed by a participant (FG-B) who described the ability to communicate correctly with patients when shown on a video may be advantageous in learning the art of effective communication in nursing, *"I feel that if they can show us videos on 'how a nurse speaks to the patient?' So that we can also know how to address patients in hospital to find out more information from them. Then we also know how to speak to them and how to draw up care plans"*. A recent study pointed out that the focus of laboratory learning could be procedural and could lack communication skills during offering of teaching (Wellard *et al.* 2009:42).

Another participant (FG-B) shared her view with the group*, "When you first see on a video then it would be easier to understand what they teaching in the class"*. Engaging learners in satisfactory learning activities while supporting their learning style can be enhanced by technology (Kilmon *et al.* 2010:316).   The group discussion continued with another participant (FG-B) who said, *"We are suggesting that if you can do it in the role play to get a better understanding of the care plan"*. Confucius in Childs *et al.* (2008:155) says "I hear and I forget, I see and I remember, I do and I understand". Another participant (FG-B) shared her view with the group and there were a few participants that nodded in agreement, *"...because they only watching and they went to the hospital, they actually forgot, because they don't physically do it on the dolls. So, it is better to physically do it, then you remember when you with the patient"*.

One of the participants (FG- A) said that she had seen student nurses from another School of Nursing having their clinical facilitators guide them with basic nursing procedures in the clinical facility*, "What I am trying to raise is… in hospital I saw the students from the other university, they were with their facilitator, and that facilitator teach them how to do the full wash on the real human. That is nice, they did the full wash on a doll and then in the hospital, this gives them confidence, yes… before they doing the test* [competency]*"*. Kolb and Fry in

Hosoda (2006:3) state that the experiential learning model emphasises that the learning process is occurring as a result of concrete emotional experiences that accompany cognitive processes.

Suggestions to accommodate learners and their different learning styles came from a participant (FG-E) who said, *"Decrease the time and separate the groups, two hours. I think if they can decrease the information, you can go slowly, you understand and then… when you go out you going to lose some of the information… but not all"*. The simultaneous use of cognitive, psychomotor, and psychosocial skills sets can be particularly challenging for novice learners (Kardong-Edgren *et al*. 2008:2).

Another participant (FG-F) added that the visit from the lecturers as experienced during her previous year was appreciated since the lecturer highlighted the application of theory to practical nursing, *"I would love to sometimes see our lecturers in the services… I know they don't have time, they have to mark… but if they visit us in the services, what they teaching us and what they will point out to us at the patient's bedside will help with understanding the theory to practice"*. Wellard *et al.* (2007:8) suggest that academics who are engaged in teaching undergraduate students should examine their practices to ensure a theoretical basis is present when teaching in laboratory, clinical, and classroom settings. In summary, participants would appreciate the teaching to be reinforced by both clinical facilitators and lecturing staff members in the clinical facilities in order to facilitate the connection between nursing theory and clinical nursing practice.

Category: Emotive dissonance - frustrated, shocked, fear, simulation laboratory is exhausting, 'feeling down'

The simulation laboratory is a place where learning clinical judgement takes place and where the novice nurse is moved to the advance beginner stage of nursing practice (Rhodes & Curran in Limoges 2010:60). However, Freeth *et al.* (2005:278) conclude in their study that senior students are less positive about teaching and learning in the simulation laboratory. In this study, emotive dissonance emerged as one of the categories. A participant (FG-A) said that sitting and listening to the clinical facilitator talking for most of the period made it difficult to remain interested in what was being taught. Therefore, she preferred interactive teaching sessions, *"Okay, the classes we get, we enjoyed the videos, but sometimes the classes can be so boring because of it is just talk and talk and talk and you sit there and you listen.*

There is little action. So, I think there should be more interaction with the students…" Teacher talk is more dominant than the hands-on practise of skills by students (Wellard *et al.* 2007:8).

A (FG-E) participant expressed her dismay about the fact that they only had a two week period of theory and simulation laboratory teaching before clinical practice placement, *"The same thing happened this year. We had two weeks of class and then we had to go and then I was shocked!"* However, Strand *et al.* (2009:18) note in their study that learners express anxiety and worry about their perceived lack of preparation for practice.

One of participants (FG-F) said that after watching a thirty five minute video, she felt exhausted and fearful of the simulation practice session, *"We watch a video of a woman in labour, maybe 35 minutes, you are exhausted, there is no practice after the video… or if there is a practice you are tired and you are fearful of what to do next… "* Alinier in Wellard *et al. (*2007:3) notes that confidence and level of performance do not correlate with simulation laboratory learning. Another participant of that focus group suggested that for learning to be effective, the simulation classes should be prior to and not after their lunch break, *"It is better to have sim lab before lunch time and your lectures after lunch time, then we are fresh…"* The sentiment of morning sim laboratory sessions was echoed by another participant (FG-H), *"You are already tired and it is hard to attend sim lab after lunch time… concentration is not good."* Rothgeb (2008:493) finds in her study that learners often experience high anxiety levels related to their performance in the presence of their peers and clinical facilitators.

A participant (FG-H) reflected on his experience of simulation laboratory teaching and learning over the past few years and suggested that more visual aids to demonstrate the practical procedures plus doing the procedures more than once would be useful, *"We need more visual aids, when you take the injection for instance, it was the first time! …I felt scared and all alone… if they can show us in preparing us a bit more for stuff like that, then it will be easier, or you would have been more comfortable giving the injection… They just show you once off… they show you all the pieces and stuff and that's it"*. Strand *et al.* (2009:18) state that learners acquire unique learning experiences with adequate equipment to get hands-on and visual pre-clinical experiences.

Kaakinen *et al.* (2009:12) find in their systematic review of nursing simulation literature that a majority of simulation studies do not consider student learning as cognitive and social

processes that occur on the basis of a planned experience. In summary, several participants vented their anxieties, fears, and insecurities about the   teaching and learning processes in the simulation laboratory.

3.5.3.6 Sub-theme: Simulation laboratory facility

Simulation laboratory facilities currently simply reproduce the hospital ward as the site of clinical practice (Wellard & Woolf 2007:8). In this study, the simulation laboratory at a College of Nursing in the Western Cape replicates a hospital ward with the equipment and supplies as found in the acute hospital placement setting. In this sub-theme the following categories emerged:

- Lack of resources and space.
- Lack of time and opportunity to practise.
- Availability of mentors and educators.
- Difficulty in organising additional access.

Category: Lack of resources and space

Clinical simulation laboratories are usually perceived as a space that is containing resources for teaching practical clinical skills (Stark *et al.* 2003:299). In this study, it emerged that most of the participants identified the lack of resources and physical space in the simulation laboratory. One of the participants (FG-B) said that due to insufficient equipment and large student numbers, two learners per group would have the opportunity to practice a skill and the other eight would only observe the procedure. That she found to be unsatisfactory and said, *"We would like… I would say the government can give us more tools, like dolls because there are few dolls. We don't have time to practise all of us at the same time. Now you have to do groups, maybe ten in a group and then only two will wash the doll… then the time is over, you see, if we can get more equipment".* Wellard *et al.* (2007:7) report in their study that there is an insufficient amount of equipment in their simulation laboratories to support student learning, and many indicate having out-dated equipment as well. Some participants agreed that there was a shortage of basic equipment; participant (FG-B) reinforced this point of view, *"yes we need more dolls, more equipment overall, because there is few scales, there is few baths, there is few of everything…"*

Another participant (FG-A) suggested that if there were an extra smaller replica of the simulation laboratory, then those learners who needed additional practice sessions could use such a facility on their own or in a smaller group, *"If there was a smaller sim lab then as friends we could go and practice on our own, the big lab is always occupied… maybe like a back-up lab".* Limoges (2010:62) finds in her study that learners identify a key benefit of simulation laboratory as the ability to compare their skills to other learners. There is an increasing interest in peer learning in higher education (Havnes in Strand 2009:21). Another participant (FG-F) said that the shortage of laboratory equipment was due to lost or theft *"There is always a shortage of equipment when we go to sim lab because things get lost or stolen. Security needs to be tightened…"* The shortage was confirmed by another participant (FG-F) who said that two of them might have the opportunity to practice, *"Yes we do practice, maybe two at a time".* This participant suggested that more equipment was needed in order to allow each learner the opportunity to practice the skill in the simulation laboratory, *"I wish they can, get more dolls and divide us into groups of five, so that everyone can get a chance".* She expressed her feelings and suggested possible ways of improving the teaching and learning in the simulation laboratory, *"It is boring and it is old, I am sorry to say that, but the resources need to be updated and audio-visuals should be more colourful with PowerPoint presentations…"* Many learners are accustomed to rapid sensory stimulation as a result of digital technology. As a result, they expect to be given hands-on, rapidly paced challenges and modern tools to facilitate their learning (Rothgeb 2008:493).

Many of the (FG-F) participants agreed with their peers that there was a need for more clinical facilitators both in the simulation laboratory and in the clinical facilities, *"We need more mentors… in the sim lab and in the clinical area…"* Childs and Sepples in Ballie *et al.* (2008:303) note that adequate supervision during simulation requires small groups with appropriate staff allocation.

Participants (FG-G) reflected on the lack of physical space to accommodate the number of learners in the simulation laboratory lecture room, *"We are a big group, we need more space, but there are times when we have to sit on the floor for forty minutes… sit upright and concentrate… this is not easy".* This point of view was corroborated by a peer member who said that the group size was large and they were unable to fit comfortably into the simulation laboratory, therefore, viewing the demonstrations was not always easy, *"The group is large, the space is small and we cannot see what is being demonstrated".* Childs *et al.* (2006:157) explain that weaker learners in a large group could become less interactive in group

participation. Strand *et al.* (2009:19) conclude that learners emphasise the fact that a well-equipped and tidy simulation laboratory has a positive influence on their learning. The authors continue to state that lack of time and crowded skills laboratories are the only factors that learners criticise. Reese *et al.* (2010:34) state that the degree of fidelity and complexity of the simulation must also be thoughtfully developed, based on available equipment and learner factors. In summary, participants in this study found that the resources in the simulation laboratory was insufficient and the physical space did not accommodate the learner student groups comfortably; that had a negative impact on teaching and learning for them.

Category: Lack of time and opportunity to practise

Competition to place student nurses at clinical placement sites increases. With mergers of health care institutions the competition can lead to limited availability of sites for students. Therefore, creative educational strategies, such as clinical simulations, are necessary to prepare students to maximise their learning in the clinical sites, as well as to function as safely as possible while providing nursing care to their assigned clients (Jeffries *et al.* 2009:614). In this study, it emerged that insufficient time and opportunity to practice newly acquired skills were problematic. A participant (FG-D) affirmed this observation, *"The time is always an issue. We are constantly in class for the whole day so there is actually no free time. They tell us we must come on a Thursday at one o'clock, which we cannot do as we are in class"*. Kardong-Edgren *et al.* (2008:11) report that repetition allows learners to practice and retain foundational skills while building more advanced skills, such as problem solving and ethics. Finding opportunities to practice newly acquired skills in the services seemed to be challenging for this particular participant (FG-H), therefore, he requested to have more time in the simulation laboratory, *"Sometimes, you don't have the time to practise in the services, therefore, we need more time in sim lab"*. Morgan (2006:159) states that allowing learners sufficient time to practice nursing skills in the simulation laboratory will assist learners in their preparation for clinical practice placement.

Participants also felt inadequately prepared for clinical placement due to insufficient timetabled sessions in the simulation laboratory. A participant (FG-F) could understand that there were not enough clinical facilitators, however, she said that more simulation laboratory time should be included in the timetable for each semester, *"Okay, if there are no extra mentors. Then we need to have more sim lab sessions, the previous block we had two sim lab visits and for this block, there are no sim lab sessions"*.

Learners share the point of view that more time should be dedicated to simulated practice, and simulated practice needs to increase learners' understanding of anatomy and physiology that apply to midwifery (Haigh 2007:99 - 101).

A participant (FG-D) concurred that the clinical facilitator was unaware of the students' timetabled activities, therefore, the facilitator was uncertain about the nursing skills that the learners had been exposed to already, *"My mentor asked me, why I do not do the medication now, why are you not… and I was like… do you know I only had two weeks of class!"* Spending one day practising one particular skill should be considered only as a starting point for developing adequate competence (Strand *et al.* 2009:21). In summary, participants expressed their need for more planned supervised teaching and learning time in the simulation laboratory to master the clinical nursing skills. The articulation about the use of simulation laboratories and their effectiveness should lead to improved learning experiences, both in the simulation laboratory and the clinical placement area (Maginnis *et al.* 2010:5).

Category: Availability of mentors and educators

As defined by Morgan (2006:156), those nurse educators who teach theory in the classroom provide nurse learners with the required knowledge base, however, skills training in a simulation laboratory can either be provided by nurse educators to integrate theory and practice, or it could be provided by qualified nurse practitioners. Lambert *et al.* (2005:665) in their study inform that, apart from anecdotal evidence, an extensive review of the literature produces very little empirical evidence in relation to the role of the clinical facilitator. The authors continue to state that the diverse range of roles with synonymous titles adopted in nursing education creates misunderstanding of the nature or differences of these roles. In this study, the educators were the qualified nurse educators who deliver theory in the lecture theatres while the clinical facilitator was a qualified nurse practitioner with or without nurse education qualification who taught practical skills in the simulation laboratory and facilitated the learner at clinical placement sites.

In this category, it emerged that the availability of clinical facilitators and / or lecturers for student nurses was problematic. The lack of availability of clinical mentors impeded the learning and teaching processes of the student nurses. A participant (FG-E) said that the teaching in simulation laboratory was insufficient and they were told by their clinical facilitators that there would be more training of those procedures at the clinical placement

site, however, that did not happen, *"Then they leave it until you go to the services and you go and practice there… But then they are not there to show you the right procedure"*. Schussler and Imsen in Strand *et al.* (2009:20) maintain that a lack of feedback is one of the reasons that lead to frustration among learners.

Another participant (FG-D) said that in their second year of training they would see the clinical facilitator for assessments only, " *In second year, the clinical facilitators come when they must do an assessment and not all of them have time… they only come out when it is an important procedure*". The learning process in clinical settings is important for facilitating learners' achievement of the level of nursing practice competence that is required for rapidly changing health care environment (Hosoda 2006:2).

A participant (FG-B) said that the clinical facilitator was not always available in the mornings, *"The mentor is not always there in the morning…"* Another participant (FG-A) shared the opinion that the clinical facilitator visited them once per month in the clinical area, and suggested that more frequent visits from the clinical facilitator would be appreciated to assist them with achieving clinical procedure competency, *"…in hospital you maybe, see the clinical mentors once a month, so I would like for them to come two to three times a week… there is no one to check if you are competent… practical books are still empty…"* This sentiment was affirmed by another participant of that group, *"…We are alone in the hospitals, they must come, they must stay here at least two or three days per week"*. Strand *et al.* (2009:20) report that learners want more time for guidance, because the acquisition of practical skills calls for a solid integration of theory and practice.

A few participants agreed with the suggestion that the clinical facilitators should accompany them in the clinical areas when they were doing the practical procedures on patients; a participant (FG-A) said, "*I would like to suggest that out in the services our mentors should be with us to practice the procedures on patients"*. Morgan (2006:159) states that it is important that learners are taught the correct procedures during practice placement to ensure that learning occurs and learning outcomes are met.

A participant (FG-F) suggested that there was a need for more clinical facilitators, *"But I mean… there should be more mentors…"* Wellard *et al.* (2010:43) conclude in their study that it remains unclear whether laboratory learning experiences assist learners in the translation of theoretical knowledge into practice. Another participant (FG-F) confirmed that in her four

weeks at a midwifery unit, there was no visits from a clinical facilitator and the unit staff neglected their learning needs, , *"In the four weeks we were at the MOU* [midwifery and obstetrical units]*, we never even saw a single mentor, and the clinical staff just neglected us"*. Haigh (2007:98) reports in her study that not enough time is spent on clinical skills and relating these to theory especially to labour ward skills. In that group, another participant expressed her acceptance of the fact that there were too few clinical facilitators, however, she said it would be helpful if the clinical facilitators were willing during their few visits to demonstrate the skills that were needed in that clinical area, *"But if our mentor… I know she cannot always be there because she must go to other places, but maybe once or twice, to be there to show us"*. A fellow participant (FG-F) expressed her dismay at being on site with no visits of the clinical facilitator, *"I was looking forward to see my clinical educator, whoever she might have been, but I sure get that negative feeling about the clinical facilitators, I didn't see her and I was there for a month. Where is the support? That support... really do change the whole picture of doing things"*. While reflecting on previous years of study, the sentiment was affirmed by another participant (FG-H) that there was no particular person on site to guide them with performing nursing procedures correctly, *"There is nobody really to guide us… to do it properly"*. Another participant (FG-F) viewed the shortage of clinical mentors to be one of the challenges they faced and added that there were a few clinical facilitators who were very supportive of the teaching and learning needs of the students, *"All mentors are not bad, because some mentors they offer their time, they help us a lot"*. A number of challenges that clinical education facilitators faced in carrying out their functions effectively, is profuse role perceptions, excess workload, and concerns about clinical visibility (Lambert *et al.* 2005:670). In summary, the participants of this study would like to have the clinical facilitation that would enhance the process of achieving their competency in those clinical areas of placement. Several of the novice students would like the repetition of basic nursing skills demonstrations at the patient's bedside. In the midwifery clinical areas, the learners would appreciate clinical facilitation of the midwifery nursing skills. The participants were mindful of the limited number of clinical facilitators available to them. The student to clinical facilitator ratio needs to be research further.

Category: Difficulty in organising additional access

The decreased availability of experience in clinical settings leads to a growing interest in skills laboratories as part of student's practical preparation (Wellard *et al. 2009*:39). Participants in several focus groups voiced their frustrations about organising additional

access to simulation laboratory teaching and learning opportunities. A participant (FG-C) stated that access to the simulation laboratory was limited, since all the learners at college needed to use the same facility, *"It is not easy because we are not the only group that are using the sim lab because the whole college is using the sim lab and everyone has their time when they can and when they are not supposed to use it"*. The School of Nursing was compelled to review and reorganise clinical teaching and learning due to the large student numbers and shrinking access to clinical learning in the service setting (Jeggels *et al.* 2010:52).

Another participant (FG-F) said that if they needed extra facilitation in the clinical area, they would have to contact there clinical facilitator while she had no access to a phone number for her clinical facilitator, **"***I don't think they support us during the clinical placement, they* [clinical facilitators] *make us practise… and it is your responsibility to phone them to come and do this with you. Some of us don't know their phone numbers"*. A fellow participant (FG-F) voiced her concern that she saw her clinical facilitator on the last day of clinical placement and that was her assessment date as well. She felt ill prepared for the procedure and requested more practice time but was informed that it was not possible, *"I did not see my mentor until the last day that I was working… she could only do one assessment with me… I didn't practice it. So, I asked her if I cannot go back, to like now, can I go and make an appointment. She told me, no, they are busy. So, I will just practice on my own"*. Lambert *et al.* (2005:669) find in their study that the clinical facilitators' activities centre around orchestrating factors in the clinical environment in order to facilitate it's functioning as an effective learning environment for the learners. A (FG-G) participant reflected on the previous year of study, and added that he had little time due to lectures and clinical placement to attend the simulation lab for additional sessions, since access times clashed with other learner activities, *"In third year, you don't really have the time because you have class from the morning till the afternoon. It is too late to go to sim lab."* Another participant (FG-H) voiced her experience about organising additional simulation laboratory teaching and learning access by saying that the clinical facilitators were gone by 12 midday, *"And sometimes sim lab staff are gone by twelve o'clock"*. Her response was followed by one of her group members' sharing of the challenge about accessing time in the simulation laboratory, since she could not get to the simulation laboratory in the morning before lectures started, to book an appointment, *"Don't have time in the morning to make an appointment for extra practice sessions with sim lab."* On concluding the discussion about organising additional teaching

and learning time in the simulation laboratory, this participant (FG-G), voiced the suggestion that a designated clinical facilitator should be available to deal with the additional learning needs of students and this person should not be tied up with classes, *"It would be good if at all times there is a designated clinical facilitator at sim lab that we can go to with our queries. The person should not be busy with class; it should be somebody that is available for us... especially at exam time."* Jeggels *et al.* (2010:58) report in their study that a perception exists that learners do not manage their time effectively between the various academic activities and that close to clinical assessments they tend to spend more time in the skills laboratory. In an Irish study, Lambert *et al.* (2005:666) clarify that joint appointments (appointments between higher education and health care institutions) are viewed as effective link roles, with the remit of building bridges between service providers and education authorities. The authors continue by stating that there are difficulties with these functions due to the multifaceted nature and having two managers with different expectations. In summary, the participants of this study voiced the challenges they had encountered while endeavouring to find suitable clinical facilitation in the simulation laboratory and at the clinical placement areas.

3.6   CONCLUSION

The student nurse of this study found that in their first year of the R425 programme leading to registration for the Diploma of General Nursing, Midwifery, Psychiatry, and Community Health Sciences; the simulation laboratory learning and teaching to be effective. However, with the growing number of learners, there was an insufficient supply of equipment and disposable supplies.

From the second year to their final year of study, most of the learner students requested more realistic simulation laboratory teaching with the focus on integrating nursing theory and nursing practice, particularly in the midwifery module of their programme.

The use of scenarios was requested by all of the study participants with the aim of enabling them to see how nurses ought to communicate effectively with patients and how to perform nursing skills in the clinical setting.

There was also a request for the clinical facilitators to reinforce the concepts and terminology of the subjects; such as anatomy, physiology, and pathophysiology as used in the lecture

theatres to enhance the understanding and usage of these terms and concepts, since many of the student learners were communicating in the English as a second or third language.

There was also an appeal for more modern and relevant audio-visual teaching aids, as well as digital and automated equipment commensurate to the ones used at the clinical sites to be introduced to the student learner in the simulation laboratory prior to clinical placement.

CHAPTER FOUR:

GUIDELINES, RECOMMENDATIONS, AND LIMITATIONS OF THE STUDY

4.1   INTRODUCTION

The findings of this study and the literature review are presented in the previous chapters.

The objective of this study was to explore and describe the viewpoints of student nurses about learning and teaching in the simulation laboratory at a School of Nursing in the Western Cape.

This chapter focuses on describing guidelines that clinical facilitators could use for supporting student nurses with learning and teaching in the simulation laboratory at a School of Nursing in the Western Cape.

Guidelines are developed to guide clinical practice even when available evidence is either limited or of unremarkable quality (Polit & Beck 2012:31). Guidelines are developed based on a solid understanding of the problem, careful data collection and analysis, and the support of appropriate literature (Streubert & Carpenter 2011:315)

It was evident that many actions were lacking that need to be implemented in order to fulfil these guidelines and to address the teaching and learning needs of student nurses in the simulation laboratory.

4.2   GUIDELINES

Based on the views of student nurses' learning and teaching in the simulation laboratory of the R425 programme for a Diploma in General, Midwifery, Psychiatry, and Community Nursing Sciences; guidelines that clinical facilitators could implement to support student nurses in the simulation laboratory at a College of Nursing in the Western Cape were described.

4.2.1   The aim of the guidelines for clinical facilitators

Written guidelines for clinical facilitators are needed to support the learning and teaching of student nurses in the simulation laboratory and in the clinical facilities in order to

accommodate the student nurses' different learning needs and learning styles and for clinical facilitators to use different teaching styles and different teaching aids.

4.2.2   Guideline One: Change the pace of self-directed learning of student nurses

Rationale

The rationale of this guideline is to assist clinical supervisors in developing an effective simulated learning and teaching environment for effective cognitive, psychomotor, and affective skills preparation of student nurses prior to clinical placement. A simulated environment provides the space, time, and learning opportunities in a non-pressured learning setting (Haigh 2007:101). Simulation is a teaching strategy that is used to facilitate the establishment of connections among concepts that engage student nurses in the learning process by assisting the student nurses to become an effective member of the nursing team in the clinical setting (Jeffries in Kaakinen *et al.* 2009:1)

Student nurses should be taught effective simulated nursing skills in the simulation laboratory that are linked to nursing theory by ensuring integration of theory and practice; this needs to occur prior to clinical placement with the aim of preparing the student nurses for the clinical placement setting.

The South African Nursing Council (SANC), Act of 2005, Government Notice R425, 3(a), stipulates that the curriculum shall consist of certain subjects and the approach shall be the integration of the various fields of study, particularly in their clinical application.

According to Baillie *et al.* (2009:303), learners who are exposed to simulation teaching at a pace to meet their learning needs, prior to clinical placement are appreciative of knowing the expectations in relation to current clinical placement.

Actions that could assist with preparing the student nurses prior to clinical placement are described below.

The clinical facilitators should change his / her pace of teaching to meet the pace of self-directed learning of student nurses by the following actions:

- It should increase the pace of self-directed learning incrementally in the second year of their course, teaching nursing skills that they would require with their first clinical

placement of that semester in order to allow the student nurses to adjust to the change in pace.

- By working with the second year student nurses, there should be an organised plan of scheduled nursing skills and activities for these student nurses that start from a base of what they know and by working towards expanding their knowledge base and this could increase in pace as the semester progresses and ought to be addressed concurrently with the theoretical knowledge as taught in the lecture theatres.

- Additional support should be provided by the clinical facilitators for student nurses to adjust to the change in pace of self-directed learning.

- Self-directed learning should be made explicit to the student nurses by the academic college staff member and the clinical facilitator. The potential exists to develop current clinical skills sessions to include group deliberative reflection on the decision making process. This would involve clarification and expression of tacit understandings from clinical experience that are leading to expansive learning of the comprehensive learning set (Haigh 2006:101).

- They should plan the simulated classes in collaboration with the lecturing staff members and the clinical facilities, in order to synchronise the teaching programme of student nurses in accordance with the curriculum as stipulated in the South African Nursing Council (SANC) Act 50 of 2005.

- Ensure that the student nurses have access to the required textbooks and notes at the beginning of each semester to enable them to do pre-reading of scheduled simulation classes.

- Student nurses need to be adequately prepared with the required nursing skills for their level of training prior to clinical placement. At the first clinical placement of the semester, student nurses would like to be familiar with the nursing skills that they are due to utilise in the wards. The clinical facilitators' role is developed to succour, guide, and teach student nurses in the clinical areas (Lambert *et al.* 2005:667).

- Participate in the provision of repetition during simulated classes. This should be scheduled routinely to accommodate student nurses that may require additional classes.

- Create a learning environment that is conducive to learning and teaching, as well as encourage constructive criticism and critical thinking of all role players. Ways must be found to promote the development of trust, respect, and caring among group

members, and sufficient class time needs to be allocated for activities that build supportive relationships (Boud *et al.* 1988:131).

- Inform clinical facilities personnel of the nursing skills capabilities of student nurses at various phases of their training by using the necessary policies of the nursing college and the South African Nursing Council.

4.2.3   Guideline Two: Minimise the potential challenges for student nurses

Rationale

The aim of this guideline is to create the opportunity for clinical facilitators to diminish learning challenges that student nurses are experiencing in teaching and learning in the simulation laboratory. The rationale of this guideline is to assist the clinical facilitators with developing a learning and teaching environment in the simulation laboratory that minimises challenges for the student nurse. The facilitator seeks to model respect, caring, self-disclosure, and openness to feedback in his or her own interactions with learners (Boud *et al.* 1988:131).

Student nurses in the R425 Programme, leading to registration with a Diploma in General, Midwifery, Psychiatry, and Community Nursing Sciences, must undergo skills training in a simulation laboratory to integrate nursing theory and nursing practical skills that are required for preparing the student nurses for clinical placement and ultimately preparing them for post-graduation to function as a competent professional nurse. For this reason, guidelines that are based on the findings of this research study need to be described for possible implementation. Clinical simulation laboratory nursing personnel should customise clinical skills training programmes to meet the contextual demands that the student nurses encounter in the clinical setting (Jeggels *et al.* 2010:58).

The South African Nursing Council (SANC), Act 50 of 2005, Chapter 1.3 (d) states that the objectives of the council are to establish, improve, and control conditions, standards, and quality of nursing education and training in the ambit of this Act and any other applicable laws.

Actions could assist with minimising challenges that student nurses may encounter in learning and teaching in the simulation laboratory at the nursing college.

Clinical facilitators should pay attention to teaching and learning opportunities by:

- encouraging student nurses to assume responsibility for their learning activities and to use their prescribed textbooks and notes to prepare themselves for simulation classes. Reading or viewing assignments to be done in preparation for the simulation are also communicated to the student (Jeffries et al 2009:615);

- guiding student nurses to utilise available library and internet resources to check relevant nursing information, both on campus and when available at clinical facilities;

- minimising anxiety and tensions in the confines of the simulation laboratory, to enhance both the learning and teaching processes for all concerned;

- limiting the nursing student group number to 10 (ten) per teaching group to one clinical facilitator, to achieve skill competencies of all student nurses; and

- ensuring that each student nurse is afforded the opportunity to practice the skill during each learning and teaching session. Childs *et al*. (2006:157-158) find in their study that several valuable lessons are learnt during the planning of simulation laboratory teaching and to keep group sizes small, in future planning more groups need to be added in preference to increasing group size. In larger groups, weaker students are able to step back and take a less active role than their peers.

Clinical facilitators should pay attention to the following in the clinical practice setting by:

- demonstrating to student nurses how to apply nursing theory to clinical nursing practice in the simulation laboratory and in the clinical placement setting;

- utilising clinical placement time optimally by encouraging the student nurse to apply the learning and teaching from the lecture theatres and simulation laboratory during the delivery of nursing care to the patients; and

- encouraging student nurses to be a part of the health professional team by actively participating in the holistic care of the patients.

Clinical facilitators should pay attention to communication aspects by:

- encouraging student nurses to utilise the interpersonal skills taught during their first year of study to negotiate a better relationship with clinical facilitators and clinical facilities personnel;

- using discussions and modern audio-visual aids prior to demonstrating a particular skill, as well as having clearly stated objectives for all teaching activities in the simulation laboratory;

- being open to student nurses who are questioning the nursing skills that are taught and how these skills are applied in nursing practice;

- assisting student nurses and personnel to question, to think critically, to reflect upon and to learn from experiences, and to keep abreast of changes and advancements in a rapidly progressive health care profession (Lambert *et al.* 2005:671);

- introducing effective communication skills to all skills base procedures to; and

- enhancing the transfer of nursing skills to the clinical facilities and ultimately in the provision of quality patient care.

4.2.4 Guideline Three: Student nurses should have a good grasp of the practice demands

Rationale

Clinical facilitators should assist the student nurses to understand the expectations of the learning and teaching programme at the different phases of the R425 programme by giving the student nurses the opportunity to prepare for expanding their scope of practice. The rationale of this guideline expects from the student nurses to identify the goals and objectives of the different phases of their learning and teaching programme while they are progressing during their 4 years of study.

Actions that could assist the clinical facilitators, the clinical facilities and nursing college with dealing more efficiently with practice demands as viewed by the nursing students.

A. Study material

- The clinical facilitators should have a hard copy of the planned schedule of skills training for each level of training in the R425 programme, which is synchronised

with the theory being taught, and this plan should be made available to the student nurses at the beginning of each semester.

- The clinical facilitator should explain to the student nurses the content of the scheduled skills training programme at the beginning of each semester.

- The clinical facilitator should ensure that the student nurses have a copy of their current teaching programme with their identified learning objectives and goals at the beginning of each semester.

- The clinical facilitators, in collaboration with the lecturing staff members at the college, need to inform the student nurses at the beginning of each semester about the learning and teaching programme that will take place both in the lecture theatres and simulation laboratory.

B.   Orientation

- Prior to clinical placement, the clinical facilitator should inform the student nurses of the objectives and goals of that clinical placement and how best they can meet these learning objectives.

- The clinical facilitator should be explicit about the expanding scope of practice that the student nurses are to encounter at various phases of their training at the clinical facilities.

- The clinical facilitators need to inform the student nurses about the expansion of their scope of practice during their progress in R425 programme.

- The nursing college and the clinical facilitators need to communicate the learning objectives and gaols of each phase of the R425 programme to the clinical facilities with the view of enabling them to point out learning opportunities for the student nurses.

C.   Collaboration

- The clinical facilitators should work in collaboration with the lecturing personnel and clinical facilities to plan the simulation laboratory learning and teaching programme to integrate nursing theory and nursing practice, as well as maintaining nursing skill standards.

- The nursing college should furnish the simulation laboratory with automated and digital equipment, since it is used in the clinical facilities and such automated

equipment must be utilised in the learning and teaching of nursing clinical skills by the clinical facilitators in the simulation laboratory. Patient safety and the reduction of errors are a primary focus in health care and nursing practice. Simulation laboratories provide a safe place for student nurses to demonstrate and practise these skills (Rothgeb 2008:494).

- The nursing college and clinical facilitators must provide simulation of clinical situations that may be of low-frequency, high impact events that student nurses may not readily experience at the clinical facilities. However, the student nurses must be exposed to such events, for example cardiopulmonary resuscitation (CPR), where the simulation laboratory provides a safe environment for the student nurses to be exposed to the event without any harm to a patient. The low-frequency, high impact events must be repeated yearly and incrementally by introducing the complexities, such as adult and neonatal CPR, with the view of preparing the student nurses to be ready for the clinical practice by the time of graduation. According to Kolb *et al.* (2000:2), the experiential learning theory defines learning as the process of creating knowledge by means of the transformation of experience. Knowledge results from the combination of grasping and transforming experience.

D.   Teaching

- Consistency of teaching specific skills by all clinical facilitators should adhere to the needs of student nurses.

- The clinical facilitators must introduce more interactive teaching methods; such as realistic scenarios, and role play with the accompanying nursing skills during the teaching process. This would be invaluable to the student nurses. Having the opportunity to integrate didactic learning and clinical experience assists the faculty of emphasising foundational skills; such as hand-washing, and communication with the patient and family (Kardong-Edgren *et al.* 2008:11).

- The nursing college and the clinical facilitators need to communicate changes that may occur over time in each phase of the R425 programme to the clinical facilities to ensure that the clinical facilities are able to assist and guide student nurses according to their scope of practice. Morgan (2006:159) states that it is essential that students are adequately prepared at the required level of their training programme with the

purpose of enabling them to link theory and practice during clinical placements to ensure quality patient care.

- The clinical facilitators should design the teaching of nursing skills in various formats, such as role play, and the more complex skills should be set in realistic scenarios. When students are part of a realistic scenario while acting out roles rather than simply rehearsing skills, the students are afforded the opportunity to think aloud. This allows the decision making process to be clarified and challenged. It also engages the student nurses and makes learning fun while mistakes can be rectified by making it part of the learning experience (Haigh 2006:100; Nehring *et al.* 2004:245).

4.2.5 Guideline Four: The personal attitudes of clinical facilitators

Rationale

This guideline enables clinical facilitators to be appreciative of their positive personal attitudes that would contribute to enhancing learning and teaching in the simulation laboratory and at clinical facilities. The rationale of this guideline is to inform clinical facilitators that their attitudes do contribute to the outcomes of learning and teaching of the student nurses. The starting point for any good teacher must be enthusiasm for the subject that is taught. This is complemented by and eagerness to transmit the enthusiasm to other people, which may result in a positive attitude of learners (Ramani *et al.* 2008:362).

Clinical facilitators could adapt their actions to improve interaction with the learning and teaching of student nurses in the simulation laboratory and at the clinical facilities.

A.   Staff development

- The clinical facilitators should encourage student nurses to be punctual for simulation classes and actively include them in the teaching and learning process.
- The nursing college needs to provide continuing workshops for clinical facilitators to enhance their teaching abilities and to increase their knowledge in the use of digital and computer technology that is in keeping with current advances of the 21st century.
- The nursing college should provide suitable forums to encourage clinical facilitators to share their teaching knowledge and skills with one another with the view of creating a positive climate for learning. The emphasis on class participation, on

richness of learning from group activities, and due to the stresses that frequently arise when learners first experience a learner-centred approach; climate setting is a crucial activity. Ways must be found to promote the development of trust, respect, and caring among group members and sufficient class time should be allocated for activities that build supportive relationships (Boud *et al.* 1988:131).

- The nursing college should ensure that all clinical facilitators are able to teach simulated classes in a similar manner to ensure consistency and to maintain standardisation of teaching nursing skills. Maintain and improve professional knowledge and competence that are expected in professional practice and ensure that practice is based on current best practice guidelines (SANC R2598 revision of scope of practice for nurses).

- The nursing college must provide forums for the lecturing staff complement and the clinical facilitators to synchronise the timetables of the theory and simulation laboratory classes in order to enhance the integration of the two classes. This may assist the student nurses with understanding the theory in relation to nursing practice in the simulation laboratory and ultimately at the clinical facilities.

B.   Learning environment

- The clinical facilitators should inform student nurses about the importance of reading through the theory that is applicable to the simulation practice session with the view of encouraging interactive learning and teaching in the simulation classes.

- The clinical facilitator should understand the need to be approachable and enthusiastic to teach in the simulation laboratory.

- The clinical facilitator should understand the different learning styles of student nurses.

- The clinical facilitator should create a pleasant teaching environment that is conducive to learning. Student nurses learn through perceptual senses; such as touch, smell, and emotion that are non-verbal. However, they are embedded in student nurses' memories because of the practical training (Strand *et al.* 2009:21).

- The clinical facilitator should utilise entertaining teaching activities, since it promotes learning.

- The clinical facilitator should encourage student nurses to question what is being taught. Reflection and open and honest dialogue enhance learning.

- The clinical facilitator should be willing to repeat simulated teaching and may review teaching methods to ensure that the student nurses grasp what is being taught.

- The clinical facilitator needs to be cognisant of the different ages, stages, and phases that the current student nurses are from, and should accommodate these differences.

- The clinical facilitator should enthusiastically meet his / her teaching and clinical facilitation obligations to the student nurses both in the simulation laboratory and at the clinical facilities.

- The nursing college, clinical facilitators, and clinical facilities need to work collaboratively on the nursing skills taught to the student nurses to ensure that they are relevant to the current health needs of patients and congruent to SANC requirements. These three separate, but inter-related teaching environments need to be viewed holistically and the transfer of knowledge among these three areas needs more research in terms of the development of pedagogical strategies (Wellard & Heggen 2009:43).

- The nursing college and clinical facilitators need to ensure that student nurses have their textbooks and lecture notes at the beginning of each semester.

- The nursing college needs to ensure that the lecturing personnel have access to the same edition of the textbooks that are available to the student nurses.

4.2.6 Guideline Five: A conducive learning and teaching atmosphere

Rationale

Clinical facilitators should communicate with the practice facilities staff complement that positive attitudes in the clinical area may well enhance student nurses' ability to learn how to integrate nursing theory and nursing practice in a clinical environment that is learner-friendly. This guideline aims at ensuring the delivery of safe patient care from nursing students while they are being guided by professional nurses in the clinical facilities. In the revision document of the code of practice of the nurse and midwife, SANC, R2598, 3.14, it is stated that the professional nurse and midwife should assist colleagues in their own sphere of responsibility to develop their professional competence and to contribute safely according to their own roles.

There are certain actions that clinical facilitators, the nursing college lecturing staff complement, and the professional nurses at clinical facilities can take to improve the learning and teaching that occur in the clinical facilities.

A. Relationships

- The clinical facilitators need to be present and participate in the orientation programme of the student nurses at the clinical facilities.

- The nursing college needs to take the leading role in enhancing relationships between clinical facilities, clinical facilitators, and the student nurses to ensure that the learning and teaching of student nurses are effective and proficient in an environment that is non-threatening and learner-friendly. Ultimately, student nurses need to gain competencies in quality nursing care skills. The quality of the clinical learning environment is an essential factor in determining the quality of the nursing students' clinical experience (Hosoda 2006:1).

- The nursing college needs to ensure that clinical facilitators are able to be present in the clinical facilities to guide and supervise student nurses in the application of theory to practice in the real situation. Clinical accompaniment refers to a structured process when a nursing education institution facilitates assistance and support to the learners by the nurse educators at the clinical facility to ensure the achievement of the programme outcomes (SANC Act No. 33, of 2005).

- The clinical facilitators must be enthusiastic and eager to teach and guide student nurses. They are also the nurse professional role models for student nurses at the patients' bedside or at the community health care facility.

- The clinical facilitators and the professional clinical facility nurses must encourage other nursing personnel at the clinical facilities to embrace the student nurses as significant members of the health care team and encourage the student nurses to participate in appropriate learning opportunities in a caring learner-friendly environment. Clinical learning opportunities refer to the range of learning experiences that is available in a health care setting or other experiential sites for learners to gain the required clinical skills (SANC Act No. 33 of 2005).

B. Code of conduct

- The clinical facilitators should set the example and ensure that student nurses are dressed in the prescribed nurses' uniform as stipulated in the college year book. Childs *et al.* (2006:157) observe that the students who are in uniform appear more professional in their approach to learning.

- The clinical facilitators should motivate the student nurses to report punctually for their shifts as scheduled.

- By role modelling, the clinical facilitator should enhance student nurses' behaviour to be respectful to all staff members at the clinical facilities. They should behave in a dignified manner at all times in the clinical facilities toward staff members, patients, and the community.

- The clinical facilitators should guide the student nurses who experience any untoward behaviour at the clinical facilities, to follow the prescribed route of lodging their concern with the ward / unit manager. This would, in turn, be reported to the clinical facilitator.

- The clinical facilitators should explain to the student nurses to understand the reason for informing the ward / unit manager when they are absent at the start of that shift.

C. Obtaining learning outcomes

- The clinical facilitators should emphasise to student nurses their learning goals and objectives for each area of their clinical placement as set out in their practical books. The opportunities to develop practical skills are achieved by learning according to a set of agreed outcomes (Morgan 2006:157).

- The clinical facilitators should be very visible in the clinical facilities to guide and assist both student nurses and permanent staff members with understanding the learning objectives and goals as set out in the student nurses' practical books. Clinical supervision refers to the assistance and support that are extended to the learner by the professional nurse and staff nurse at a clinical facility with the aim of developing a competent, independent practitioner (SANC Act No. 33 of 2005).

- The clinical facilitators in collaboration with the professional nurses at the clinical facilities must strive towards ensuring that the student nurses attain levels of proficiency in their nursing skills for each of their clinical placements as stipulated in their practical student books.

- The clinical facilitators in collaboration with professional nurses at the clinical facilities should monitor that the student nurses are not utilised to fulfil the shortfall in staffing needs of the ward / unit.

- The clinical facilitators and the clinical professional nurses should ensure that the student nurses are familiar with the clinical facilities and able to be functional with the required nursing skills in the clinical area at their level of training.

- The clinical facilitators and the professional nurses of the clinical facilities must encourage good interaction among all nursing and ward personnel, as well as other health care professionals in that ward / unit to embody growth of the student nurses into their professional role. Creating a good atmosphere and relationships in the clinical settings is regarded as essential, therefore, qualified nurses should be required to strive to making students feel a part of the team and should provide support to students during the learning process (Hosoda 2006:2).

4.2.7   Guideline Six: The language difficulties that student nurses experience

Rationale

The goal of this guideline is to improve student nurses' usage of English during the academic block period and at the clinical facilities. The medium of instruction and teaching at a College of Nursing in the Western Cape is English. The rationale for this goal is to assist student nurses who require additional assistance with the English language by hearing the spoken word from clinical facilitators and lecturers. The use of terminology and concepts as taught in the lecture theatres should be repeated in the simulation laboratory as often as possible to enable the student nurses to improve their usage of the language of instruction.

Actions need to be instituted by clinical facilitators to improve the usage of English terminology and concepts as taught in the lecture theatres and simulation laboratory in order for student nurses to become familiar with the pronunciation and usage of the terminology and concepts in clinical practice.

The clinical facilitators need to:

- identify the student nurses who need additional tuition in the English language and refer them for English language classes;
- know about English tuition classes offered at the nursing college;

- encourage student nurses who need additional English tuition to attend scheduled classes with the English language instructors at the college;

- encourage student nurses to use the library facilities where they may have access to suitable literature to read with the purpose of enhancing their use of the English language;

- encourage student nurses to use the internet access on campus or off campus, for online self-study English language courses;

- ensure that the terminology and concepts as used in anatomy, physiology, pathophysiology, and pharmacology in the classroom are also used in the simulation laboratory when nursing skills are taught. This would enhance the pronunciation and understanding of the words and concepts. In the simulation laboratory, learning can be reinforced and extended by repetition, revisiting, and linking learnt concepts to new nursing skills and in particular using the anatomy, physiology, pathophysiology, and pharmacology when teaching the skills (Haigh 2006:101; Nehring *et al.* 2004:245; Strand 2009:19; Rice *et al.* 2009:301; Alinier 2006:359);

- monitor that the clinical facilities staff complement adheres to using the prescribed official working language, namely English that is understood by all health care professionals and student nurses in the clinical setting. Language, in a social context, provides an important foundation for thinking and awareness (Strand 2009:20); and

- encourage clinical facilities nurse managers to motivate all nursing personnel in the clinical area to attend cultural diversity workshops. This may improve interpersonal relationships among student nurses.

4.3 RECOMMENDATIONS FOR NURSING PRACTICE, NURSING EDUCATION, AND NURSING RESEARCH

Recommendations could be very detailed and practical to achieve optimal learning motivation (Bess *et al.* 2009:168).

4.3.1 Recommendations for the nursing education

- The nursing college must ensure that each student nurse have a copy of their scheduled lectures and the scheduled simulation sessions at beginning of each semester.

- The nursing college must ensure that there is discussion with the student nurses about their schedule lectures and simulation programme, as well as how it applies to expanding their scope of practice as they progress during the four years of study.

- The nursing college must include the professional nurses that are at the point of delivering nursing care to understand what the student nurses are being taught and what there scope of practice would be with the aim of minimising tensions when the student nurses are at the clinical facilities.

- The nursing college must ensure that student nurses have access to the list and copies of the prescribed textbooks at the beginning of each semester.

- The nursing college must create a learning and teaching climate that is conducive to interactive learning and teaching among all student nurses, lecturing personnel, and clinical facilitators.

- The nursing college must ensure that lecturing personnel and clinical facilitators are able to attend workshops, conferences, and interactive groups that deal with learning and teaching in the current technological environment.

- The nursing college should ensure that all lecturing personnel and clinical facilitators are provided with a forum to discuss current learning and teaching problems and ways of working positively through this process to improve the role of individuals who are involved in teaching the student nurses.

- At the end of each semester, the nursing college should have an evaluation process that includes the student nurses, clinical facilitator, and lecturing personnel. This would assist with quality assurance of the learning and teaching processes.

- The nursing college must ensure that student counselling is available for those student nurses who may require this service after hours (19:00) and over weekends. The service should be available particularly for the student nurses who encounter death and dying and other traumatic events for the first time at the clinical facilities.

- The nursing college should schedule regular frequent visits of all lecturing personnel to the clinical facilities to enhance relationships between the college staff

complement and clinical facilities personnel, and to ultimately diminish tensions between the student nurses and clinical facilities personnel.

- The nursing college should have good communication processes in place to enable the clinical facilities to keep the respective college staff members informed about their concerns related to the student nurses.

4.3.2 Recommendations for nursing practice

- The clinical facilities staff complements must have a copy of the learning objectives and goals of all student nurses who are placed at the clinical facility.
- The clinical facilities professional nurses must ensure that they understand the learning objectives and goals of the student nurses.
- The clinical facilities professional nurses must have access to communicating with the nursing college and clinical facilitators that are responsible for the student nurses placed at the clinical facility.
- The clinical facilities personnel must work towards creating an environment of learning and teaching of the student nurses so that the student meets their learning objectives plus participate in the delivery of quality nursing care of the patients.
- The clinical facilities manager must ensure that all staff working at that facility understands that the student nurses are there to experience the art and science of nursing.
- The clinical facilities professional nurses should assist with the professional role-modelling of the nurses in the health care team and in the public domain.

4.3.3 Recommendations for research

We cannot predict the future, but we can speculate about it, since the future never represents a clean break with the past. Indeed, many moments overlap. It is up to the reader to choose among the voices in the contest of moments and to choose the future (Denzin & Lincoln 2000:1057). It is recommended that a qualitative study is conducted about the experiences of clinical facilitators in relation to teaching in the simulation laboratory.

4.4 LIMITATIONS OF THE RESEARCH STUDY

Due to the qualitative, descriptive, and completely contextual nature of this research, it was limited in respect of some factors. Many of the first year and a few of the second, third, and

fourth year participant were satisfied with the learning and teaching in the simulation laboratory. However, there were a few first year and many second, third and, fourth year participants who voiced their need for more time and opportunities to practice nursing skills, scenarios and role play in the simulation laboratory and in the clinical placement areas. The results do not represent the views of all student nurses at that nursing college, since the participants were chosen by means of a purposive sampling, therefore, the results cannot be generalised. However, the results of this research study are important for future research studies.

So, we are now the ultimate bricoleurs, trying to cobble together a story that we are beginning to suspect will never enjoy the unity, the smoothness, the wholeness that the old story had. While we are assembling different pieces of the story, our bricolage begins to take not one, but many shapes (Denzin & Lincoln 2000:1060).

4.5   CONCLUSION

The intentions of this study was to describe the student nurses' views of learning and teaching in the simulation laboratory and suggestions for clinical facilitators about actions they could take to improve learning and teaching for the student nurses at a particular nursing college in the Western Cape. Data were collected by using focus group interviews, field notes, and audio-recorded data were obtained from several focus groups of student nurses from the foundational to the final year of study in the R425 programme that were leading to the Diploma in General, Midwifery, Psychiatry, and Community Nursing Health Science. Data analysis was conducted and the results were compiled. Guidelines for clinical facilitators and recommendations for student nurses, the nursing college, and clinical facilities were described for possible implementation. However, during the literature review it was noted that there was a growing need to embrace simulation laboratory training that paves the way for enhancing the learning and teaching of nursing skills due to diminishing clinical placement opportunities and increasing student nurse numbers.

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UNIVERSITY *of the*

WESTERN CAPE

3.1   ANNEXURE A :   INFORMATION SHEET

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

E-mail: desabrah@yahoo.com

INFORMATION SHEET

Project Title: Guidelines for clinical facilitators to support student nurses in a simulation laboratory at a College of Nursing in the Western Cape

What is this study about?

I am Desiree J. Abrahams-Marra, registered for a Master's Degree in Nursing at the University of the Western Cape with Prof K. Jooste as my supervisor. I am inviting you to participate in this research project because you are a student nurse at the College of Nursing in the R425 programme. The purpose of this research project is to obtain information about your view of learning and teaching in the simulation laboratory in order to assist with developing guidelines for use by clinical facilitators.

You will be asked to complete a consent form before participating in the project.

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

Focus group interviews will be conducted at a College of Nursing in the Western Cape, in a suitable room that ensures privacy and comfort for participants. Each focus group will consist of 10 (ten) participants who will be student nurses in the same year of study.

The focus group interviews will each last around 60 minutes.

The questions that would be asked are "How do you as a student nurse view learning and teaching in the simulation laboratory?" and "What actions do student nurses suggest to clinical facilitators in order to support students in the simulation laboratory?"

Written consent for the interviews to be voice recorded will also be needed. Voice recordings of the interviews will be stored under lock and key for five years after the results of the project have been published before it will be destroyed. Only the supervisor, an independent coder, and the researcher will have access to these recordings.

The researcher will take written field notes during the interviews. However, the participants' names will not be recorded in these notes.

Would my participation in this study be kept confidential?

The research team will do everything in their power to keep your personal information confidential. Participants in the focus group interviews will be encouraged to keep shared information confidential. To help protect your confidentiality, pseudonyms (fictitious names) will be used in field notes instead of your real name. It would prevent any other person from associating specific data with you. You should undertake to keep all discussions in the group confidential and not to divulge the content of the focus group interview to anyone outside of this group.

The publication of the results of the project will not mention any names of participants.

What are the risks of this research?

There are no known risks associated with participating in this research project.

What are the benefits of this research?

The results may assist the researcher to learn more about the viewpoints of student nurses about learning in the simulation laboratory. Suggestions will be made for clinical facilitators to support student nurses in the simulation laboratory at a College of Nursing in the Western Cape.

Information acquired during this research project will be shared with all participants prior to public dissemination. Results of the study will be published in an accredited journal and a peer review journal.

Other people might benefit from this study by obtaining an informed understanding of learning and teaching in a simulation laboratory at nursing colleges for student nurses and the clinical facilitators. This study could be repeated in a different, however similar contextual setting.

Am I obliged to take part in this research project and can I stop participating at any time?

Your participation in this research project is completely free and voluntary. You may choose not to take part at all. If you decide to participate in this research, you may withdraw at any time during the study. If you decide to withdraw from the study, you will not be penalised in any way, neither will you forfeit any benefits to which you otherwise qualify.

How do I get my questions answered?

This research is being conducted by Desiree J. Abrahams-Marra, registered at the College of Nursing, at the University of the Western Cape. If you have any questions about the research study, please contact:

Desiree J. Abrahams–Marra

13 Loumar Court

Ford Street

Bellville

7530

Cell Phone: 083 373 3769

Email: desabrah@yahoo.com

Should you have any questions with regard to this study and your rights as a research participant or if you wish to report any problems you experience related to the study, please contact:

Head of Department: Prof Yinka Adejumo 021 9593024

Email :   oadejumo@uwc.ac.za

Prof Hester Klopper

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17

Bellville 7535

Head of Department

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17

Bellville

7535

Tel No: 021 9592631

Email: hklopper@uwc.ac.za

This research project has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

3.3   ANNEXURE B: WCCN ETHICS APPROVAL

Western Cape Government
Health

DIRECTORATE: WESTERN CAPE COLLEGE OF NURSING

Terebock@pgwc.gov.za

Enquiries: Ms. T M Bock

Date: 2012/05/10

Mrs. Abrahams-Marra

13 Loumar Court

Ford Street

Bellville

7530

Dear Mrs Abrahams-Marra

RE: Request to conduct a research investigation at WCCN

The research ethics committee have perused your research proposal and have granted you the necessary permission to conduct the research here at the WCCN under the following conditions:

1) The focus group interviews are to be conducted when the students are off duty, as to not interfere with the academic programme of the students.

2) Ensuring anonymity of the students must be further explored as the researcher intends using fictitious names, the researcher must ensure that there are no students at WCCN with the fictitious name as there is only one College of Nursing in the Western Cape which will make identification of students very easy, thus breaching a guarantee of anonymity.

The research ethics committee of WCCN wishes you success in your study, and requests feedback with regards to the findings of this intended study.
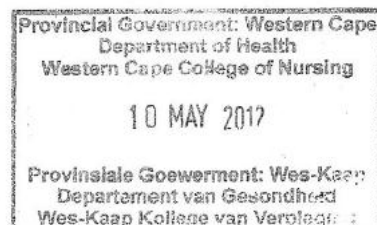
Ms. TM Bock

Head of Campus Metro East Campus: Western Cape College of Nursing

Acting Chair WCCN: Research Ethics committee

Pone: 021 648 1202: 021 638 6899 (fax)

Klipfontein Road, Surwell, Athlone 7764

Provincial Government: Western Cape
Department of Health
Western Cape College of Nursing

10 MAY 2012

Provinsiale Goewerment: Wes-Kaap
Departement van Gesondheid
Wes-Kaap Kollege van Verpleging

3.4   ANNEXURE C: WRITTEN INFORMED CONSENT

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

E-mail: desabrah@yahoo.com

WRITTEN INFORMED CONSENT

Letter of request to participate in the study

Title of Research Project: Guidelines for clinical facilitators to support student nurses in a simulation laboratory at a College of Nursing in the Western Cape.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study are answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. **I undertake to keep all discussions during the focus group interview confidential and will not divulge the content of the focus group interview to anyone outside of this group.**

Participant's name   _____

Participant's signature   _____

I further agree that the interview be voice recorded.

Participant's signature   _____

I further agree that the researcher takes field notes.

Participant's signature   _____

Witness   _____

Date   _____

Should you have any questions in connection with this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Prof Karien Jooste

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021)959-2274

Cell: 0828972228

Fax: (021)959-2271

Email: kjooste@uwc.ac.za

ANNEXURE D: **LETTER OF REQUEST FROM EDUCATIONAL INSTITUTION TO CONDUCT THE RESEARCH**

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592679

E-mail: kjooste@uwc.ac.za

January 2012

College Director

Mr D. I. Govan

Western Cape College of Nursing

Private Bag

Surwell

Athlone

7762

Dear Mr Govan

Consent to Conduct Research Investigation

I am a post-graduate student at the University of the Western Cape, and am studying to fulfil the requirements for a Master's Degree in Nursing. My research topic is: Guidelines for clinical facilitators to support student nurses in a simulation laboratory at a College of Nursing in the Western Cape.

I am a clinical nurse facilitator at the Psychiatric Nursing Science (R425) Programme, and I am interested in the views of nursing students about teaching and learning in the simulation laboratory. The results of the study may well assist with enhancing the teaching policies and processes.

In order to conduct this study, with your permission, small groups of students would be selected by means of purposive sampling and informed consent obtained from them to participate during focus group interviews. Groups of students would be selected from the Extended Curriculum Programme, 1st, 2nd, 3rd, and 4th year and the focus group interviews will be conducted for around 60 minutes. Having access to the college student enrolment numbers would be of great importance to completing the study.

I hereby request your permission to conduct my research investigation at the Western Cape College of Nursing in the Western Cape. Attached is a copy of the student consent form. Students will participate voluntarily and may withdraw, without fear or favour, from the study at any time. All information will be handled confidentially and will be transcribed personally. The students will remain anonymous and pseudonyms will be used to protect participants' identities and the name of the institution. Participants will be requested to keep all discussions in the focus group confidential and not to divulge the content of the focus group interview to anyone outside of that group.

Information acquired during this research project will be shared with all participants prior to public dissemination. Results of the study will be published in an accredited journal and a peer review journal.

Yours sincerely

_____

Desiree J. Abrahams–Marra

Student No: 3105155

_____

Prof Karien Jooste

Supervisor