UNIVERSITY OF THE WESTERN CAPE

Faculty of Community and Health Sciences

The relationship between leadership styles of clinical facilitators and maturity levels of learner nurses in the clinical learning environment of Western Cape hospitals

by

Edwin Lejaha

Student number: 3216946

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Supervisor: Professor Karien Jooste

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DECLARATION

I, Edwin Lejaha, declare that "The relationship between leadership styles of clinical facilitators and maturity levels of learner nurses in the clinical learning environment of Western Cape hospitals" is my own work. I have fully acknowledged all references quoted in this text.

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Edwin Lejaha

DEDICATION

This work is dedicated to all nursing students, unit managers, and clinical facilitators in the nursing profession.

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LIST OF ABBREVIATIONS

CCFO	Critical cross-field outcome
CL	Cooperative learning
CLE	Clinical learning environment
CLT	Central Limit Theorem
CSL	Clinical skills laboratory
IS	Intellectual stimulation
LN	Learner nurse
PBL	Problem based learning
PGD	Postgraduate diploma
PL	Peer learning
PN	Professional nurse
RL	Reflective learning
SANC	South African Nursing Council
SAQA	South African Qualifications Authority
SD	Standard deviation
SDL	Self-directed learning
SGD	Small group discussions
SPSS	Statistical Package for the Social Sciences
UWC	University of the Western Cape
UWCNS	University of the Western Cape Nursing School

DEFINITION OF TERMS

Registered professional nurse (PN) is a person registered as a general or a midwifery nurse under the Nurse Act, 2005 (Act No. 33 of 2005) and who maintains his / her annual subscription (McQuoid-Mason & Dada, 2009, p. 8-9) and (SANC, 2005, p. 30).

Learner nurse (LN) is a person who is undertaking education and training in nursing and who has registered as a learner nurse (Searle, Human & Mogotlane, 2009, p. 163). This term is used interchangeably with nursing student in this study.

Clinical facilitator / clinical supervisor is a registered professional nurse who is employed at an education service provider to supervise a group of learner nurses (Walker, Dwyer, Moxham, Broadbent & Sander, 2011, p. 2).

Course is a planned educational programme for learner nurses that enable them to achieve a specific goal, namely registration or obtaining a qualification(s) (Gravett & Geyser, 2004, p. 142). In this study, the words **programme** and **course** are used interchangeably.

A **leader** is a person who is able to influence a group of people towards achievement of goals (Iro, 2007, p. 18-19) and (Batista, Furtado & Silva, 2011, p. 4).

Leadership, according to Kunzle, Kolbe and Grote (2010, p. 8), is a process of influencing followers towards achieving organisational goals.

Leadership style refers to the behavioural pattern of clinical facilitators as a situational leader towards learner nurses, when they are attempting to influence the activities of the learner nurse (Papastavrou, Lambrinou, Tsangari, Saarikoski & Leino-Kilpi, 2010, p. 178).

Maturity is the degree of ability and willingness that a learner shows to take responsibility for the specific tasks in the clinical learning activities (Houghton & Yoho, p. 2005, p. 66).

The clinical learning environment (CLE): According to Papastavrou *et al.* (2010, p. 176), a clinical learning environment is a complex social unit that influences learner nurse learning outcomes in a clinical setting.

ABSTRACT

Clinical facilitators act as leaders who influence the learning of learner nurses. As leaders, they are involved in the provision of guidance and accompaniment of learners in the clinical learning environment. Learning environments are surroundings, forces, and external stimuli that influence learners, either positively or negatively. Therefore, it is very important that learners are managed in such a way that clinical practice increases professional competency, including independence and self-directedness. One way of achieving this goal is to adjust a leadership style of a clinical supervisor according to the maturity level of a learner in the clinical learning environment. The leadership styles and maturity levels as outlined by the Hersey-Blanchard Theory informed this study.

At hospitals in the Western Cape, learner nurses are accompanied by clinical facilitators who act as leaders in the clinical practice according to their learner nurse maturity level. The relationship between leadership styles of clinical facilitators and the maturity levels of learner nurses in the clinical learning environment at Western Cape Hospitals is unknown.

The purpose of the study was to explore and describe the relationship between the leadership styles of clinical facilitators and the maturity level of learner nurses in the clinical learning environment of Western Cape hospitals. In this study; a quantitative, descriptive, explorative, and comparative design was followed. The accessible population was all the clinical facilitators (N = 30) allocated to 2nd, 3rd and 4th year learner nurses (N = 641) at Western Cape hospitals. *Stratified sampling* was used and the sample size was calculated by applying the proportional allocation of sample sizes. A similar questionnaire for clinical facilitators and nursing students was developed from a literature review and based on a 4-point scale. It took around 30 minutes to complete the questionnaire. Most of the components (sections) of both instruments obtained a Cronbach's alpha (α) above the acceptable standard value of .7. Data was analysed by using the Statistical Package for the Social Sciences (SPSS) Version 21 software program. A descriptive and inferential data analysis was conducted and the Pearson's correlation calculated. Reliability and validity of the research process was ensured and ethical principles adhered to. Out of four components, two indicated a weak positive relationship between the leadership style of a facilitator and the maturity level of a learner nurse. Most learner nurses indicated that they were mature (able and willing) while the clinical facilitators indicated that they focused more on the selling and participation styles of leadership. The general results indicated that there was a weak positive relationship ($r = 0.15$) between the leadership style of the clinical facilitators and the maturity level of learner nurses.

Key words: relationship, leadership styles, clinical facilitator, maturity, learners, perceptions, clinical environment, and hospital.

CHAPTER 1
OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

A number of literature studies have been conducted about the phenomena that influence the educational activities of learner nurses in the clinical learning environment (Warne, Johansson, Papastavrou, Tichelaar, Tomietto, Van den Bossche, Moreno & Saarikoski, 2010, p. 809-810), related to the ward unit atmosphere, the complexities of care, and the relationships between a learner nurse and educators (Papastavrou *et al.*, 2010, p. 177). This study explored the unknown relationship between the leadership styles of clinical facilitators and the maturity level of learner nurses in the clinical learning environment. Papastavrou *et al.* (2010, p. 176) define the clinical learning environment as a complex social entity. According to Perli and Brugnolli (2009, p. 886), a learning environment is determined by adequate surroundings in the clinical area, open communication, clinical facilitator, and learner nurses to ensure continuity in the clinical education and learning.

Learner nurses registered at a university in the Western Cape are guided in clinical practice by clinical facilitators. As a leader, the clinical facilitator may influence learning outcomes in the clinical setting. Leadership is an influential relationship between the leader and the follower with the intent to achieve their shared goals (Muller, Bezuidenhout & Jooste, 2006, p. 393). In this study, the clinical facilitator was viewed as a situational leader in the clinical learning environment who was directing and influencing the student learning environment. A clinical environment is not easy to control, unlike an academic environment, because there are a lot of stimuli that makes it difficult for learner nurses to focus on an essential learning activity (Ip & Chan, 2005, p. 665-666).

Consensus is reached in the literature about the clinical learning environment that can influence the learner nurses positively or negatively because of its complexity that requires clinical facilitation (Smedley & Morey, 2010, p. 76). According to Naidoo (2010, p. 1), a learner nurse experiences a number of levels of ability / expertise before gaining and developing clinical competencies in the clinical environment, hence the learner nurse needs strong support and guidance from the clinical facilitator while mastering skills. Meyer, Naudé and Van Niekerk (2004, p. 84) recommend that the learner nurses must be accompanied to a greater extent at first than during later allocation to the clinical environment. The reason is motivated by learner nurses' limited ability and maturity level in relation to the tasks / competencies. Facilitators and other nursing personnel should provide a positive supporting learning climate for learner nurses. Clinical practice is one way of increasing learner nurses' professional competencies, including independence and

self-directedness (Papp, Markkanen & Bonsdorff, 2003, p. 262). David, Barbara, George and Malcom (2007, p. 864) conclude that the clinical learning environment must be made responsive to professional development and learning should be rooted in caring for patients. Meyer *et al*. (2004, p. 70) mention that clinical facilitators are involved as leaders in the provision of guidance and accompaniment of learners in the clinical setting. According to Jasper (2011, p. 1049) and Jooste (2009, p. 25), the importance of the *leadership* process lies in the ability of the leader to influence followers in a particular direction with the purpose of achieving a mission and tasks, as well as directing the organisation in a way that unifies it.

According to Jasper (2011, p. 1048-1049), a clinical facilitator adjusts her / his style when directing, supporting, empowering, and developing learner nurses' competencies. Clinical facilitators as situational leaders should modify their leadership styles based on the behaviour (direction), emotional support (relationship behaviour), and maturity (readiness, desire, and willingness) level of the task in the clinical learning environment. It is congruent to what Foster (2007, n.p.) states that responding to learner nurses' needs is the surest way of achieving effectiveness and accomplishing goals. The clinical facilitators as situational leaders vary their leadership styles to meet the needs of learners who are led, to diagnose readiness, and to adjust with the aim of acknowledging individual learner nurses' situations.

In South Africa, undergraduate nursing education with the purpose of becoming registered nurses (RN) consists of a four-year course at degree level and also a four-year fulltime diploma course respectively at accredited universities and colleges. Nursing programmes at universities and colleges are recognised by the South African Nursing Council (SANC) for registration (Muller, 2009, p.30) and are also registered and accredited at the South African Qualification Authority (SAQA). The SANC approves training schools and facilities for clinical practice (Searle *et al.*, 2009, p. 159). Learner nurses, who are registered for a nursing programme at universities in the Western Cape, are guided in the clinical learning practice by clinical facilitators.

1.2 BACKGROUND TO THE THEORETICAL DEPARTURE

1.2.1 The clinical learning environment

Clinical learning allows learner nurses to use psychomotor, cognitive, and affective skills that enable them to develop competencies in the application of knowledge, skills, and attitudes to clinical situations (Chan, 2002, p. 517-518). The clinical facilitator as a leader supervises and influences learner nurses in the clinical learning area. However, sometimes a clinical facilitator expects learner nurses to perform to a certain level even though they are learning (Elliott, 2002, p. 34). The purpose of clinical facilitator is accompaniment of

learner nurses and facilitation of an effective clinical learning environment that brings about transformation in a learner's behaviour (Meyer & Van Niekerk, 2008, p. 170-171).

According to Papp *et al.* (2003, p. 263), a clinical learning environment consists of surroundings, forces, and external stimuli that influence the individual learners. The clinical learning environment is defined as "the interactive network of forces within the clinical setting that influences the students' clinical learning outcomes" (Chan, 2002, p. 518). A learning environment can be the clinical environment. The clinical environment refers to everything that surrounds the learner nurse: The equipment, the personnel, the patients, and the facilitators. The clinical environment is not easily controlled, unlike an academic environment because there are a lot of stimuli that makes it difficult for learner nurses to focus on an essential learning activity (Papp *et al.*, 2003, p. 263). To this end, a clinical facilitator must guide, lead, and influence learner nurses in the clinical learning environment because he / she is responsible for the learning of learner nurses in clinical practice and facilitation of an effective learning environment.

An effective clinical facilitator as a leader in the clinical learning environment for learners is flexible and adjusts his / her styles to meet situations and the needs of learner nurses. The situational leadership model of Hersey-Blanchard (1970-1980) states that learning is specific to a particular situation. According to Jasper (2011, p. 1048-1049), the model states that – instead of using just one style when supporting, coaching, empowering, and developing learners' competencies – clinical facilitators as situational leaders should change their leadership styles based on the tasks behaviour (direction), emotional support (relationship behaviour), and maturity (readiness and willingness) level in relation to the task in the clinical learning environment. This study focused on the leadership styles of a clinical facilitator and the maturity (able and willing) level of a learner nurse in the clinical learning environment.

1.2.2 Leadership styles

According to Cherie and Gebrekidan (2005, p. 86), leadership behaviour presents patterns called leadership styles such as: *Authoritarian / autocratic, democratic / participative,* and *laissez-faire / permissive*. These styles can be regarded as a continuum from a highly controlling and directive type of leadership to a very inactive style. Leadership behaviour is also displayed by *telling*, *selling*, *participating*, and *delegating* (Jasper, 2011, p. 1048-1049). According to Iro (2007, p. 22), the authoritarian leader dominates the whole situation and commands to get the work done.

In a more democratic style, the followers are motivated because they are allowed to take part in decision making and communication is bidirectional (Iro, 2007, p. 22). The authoritarian leader maintains control over the followers. This control may be dictatorial with a disregard for the needs and feelings of the

followers. An authoritarian leader gives orders and expects followers to obey. The leader singlehandedly makes all the decisions without the participation of followers. According to Cherie and Gebrekidan (2005, p. 87), it limits the degree of trust and openness between the leader and followers. A directive style is appropriate when the leader wants the job to be completed successfully (Jooste, 2009, p. 49).

A democratic leader encourages participation of the followers in decision making. The leader values individuality in the group. Such a leader creates a more participative and less controlling environment than an authoritarian leader (Cherie & Gebrekidan, 2005, p. 88). The democratic leader stimulates and guides the followers towards achievement of goals. Rather than telling, the democratic leader asks stimulating questions and suggests options to guide the followers to reach goals (Jooste, 2009, p. 50). The democratic style demands a strong faith in the ability of the group to solve problems and to accomplish goals. The laissez-faire style implies that no leadership exists at all; members act independently of one another and frustration levels rise. The goals are unclear and in most cases this type of leadership is unproductive and ineffective, since it is permissive (Cherie & Gebrekidan, 2005, p. 91). According to Iro (2007, p. 22), in this type of leadership style there is no control. This leadership style is beneficial when the followers are mature and require little involvement from the leader. Iro (2007) mentions *charismatic* as another style of leadership. A charismatic leader is described as very manipulative since he / she is cajoling people to do what he / she wants them to do. Some political leaders apply this style of leadership. In addition, Jooste (2009, p. 52) refers to *participative* as a leadership style where the leader weighs the responses of followers to a proposal and makes the final decisions for actions. The style is a compromise between the authoritarian and democratic styles. The Hersey-Blanchard's situational leadership model is mostly applied in management (Jasper, 2011, p. 1047-1057). According to Jooste (2009, p. 71-72), one should first understand the situation and the importance of the outcomes before the situational model is being implemented. This leadership approach is based on the assumption that the situation determines the type of leadership style that is going to be used.

1.2.3 Maturity of a learner

Knowing when to use a particular leadership style is largely dependent on the maturity of the learner nurse. *Maturity* is the degree of ability and willingness that a learner displays to take responsibility for the specific tasks during clinical learning (Houghton & Yoho, p. 2005, p. 66). The theory of Hersey-Blanchard (1970-1980) refers to the different levels of maturity: that comprise the ability and willingness of the learner nurse to confidently demonstrated knowledge, skills, and commitment in the clinical learning environment. Shapiro, Miller and White (2006, p. 115) explain that ability reflects the continuum of the degree of a learner's knowledge, skills, and experience. Willingness, on the other hand, refers to the learner nurse's

degree of confidence, commitment, and motivation to execute tasks in the clinical learning environment. Kozulin, Gindis, Ageyev and Meller (2003, p. 4) assume that the learner nurse is able to perform tasks, while it is highly possible to perform more complex tasks in a collaborative environment. From a learner's point of view, clinical facilitators should play the role of an educator, assessor, excellent coach, and guide to influence clinical learning and should have genuine concern about learners while having their best interests at heart (Baglin & Rugg, 2010, p. 146).

According to Kleffner (2010, p. 13), greater responsibility for patient care should be associated with the learner nurse's higher knowledge and skills as rated by the clinical facilitator. When a learner nurse demonstrates a high level of maturity, Kleffner (2010) is of the opinion that the facilitator ought to allow more responsibility while still monitoring actions in a non-intimidating manner. Lillibridge (2007, p. 45) emphasises that the leadership style of a clinical facilitator is detrimental to developing higher knowledge and skills by the learner nurse in the clinical learning environment. Whittle (2007, p. 19) establishes that a learner nurse with the qualities of high self-confidence and self-governance wants to be led rather than to be directed, and wants to contribute to decision making. Given these characteristics of a learner nurse, clinical facilitators as situational leaders are advised to support learners to achieve this goal. As the abilities and confidence level of a learner nurse increase, the clinical facilitator needs to lead more by means of support and active involvement (Kleffner, 2010, p. 13). The next step is to allow participation in decision making during their clinical learning while the clinical facilitator still focuses on support and guidance.

According to Thach, Thompson and Morris (2006, p. 304), the use of the situational leadership theory is contained in its usefulness for describing how, for example a clinical facilitator as a situational leader can best collaborate with learner nurses and how learner nurses can best cooperate with clinical facilitator. Both parties are working towards the common goals of attaining a positive learning environment and modelling future professional nurses. According to Yukselturk and Bulut (2009, p. 13), clinical facilitators influence the individual learner nurse to take the initiative, with or without the assistance of other people, in identifying their learning needs and material resources for learning. The learner nurse as an adult learner must be able to make use of learning opportunities when they are arising in the clinical environment (Quinn & Hughes, 2007, p. 41).

1.3 THEORETICAL FRAMEWORK AS POINT OF DEPARTURE AND ASSUMPTIONS OF THE STUDY

Hersey-Blanchard (1970-1980) propose that one style of leadership does not work for all learners and that a clinical facilitator must familiarise himself / herself with each individual learner nurse's skills level, confidence, and willingness to execute tasks. The Hersey-Blanchard theory refers to the leadership styles of

telling, selling, participating, and delegating (www.higheredbcs.wiley.com lgacy college schermerhorn 0471734608 module16 pdf). For the purpose of this study, the following assumptions were made:

- Telling is where the leader behaves according to the maturity level of the learner. The clinical facilitator demonstrates directive behaviour in the clinical learning environment due to a lack of skills and motivation of the learner nurse in nursing practice (unable, unwilling, and insecure).
- The leader could also provide directive behaviour (selling) and a supporting role in the clinical learning environment of a learner nurse. She / he issues fewer directives due to learner nurses showing a willingness to work on the task but do not have the skills to complete it successfully (Jooste, 2009, p. 71).
- The leader creates a positive relationship environment for the learner nurse by encouraging participation and support in the clinical environment because a learner nurse is able, but unwilling, to do what the leader expects from him / her.
- Lastly, the leader behaves according to the maturity level of a learner nurse, she / he delegates duties and enhances participation and support (Jooste, 2009, p. 72), in the learning environment because the learner nurse is able and willing to do tasks.

1.4 RESEARCH PROBLEM

Learner nurses see the clinical learning environment as the most powerful situation in relation to the acquiring of nursing skills and knowledge (Ip & Chan, 2005, p. 666). The researcher worked in clinical practice and observed several complaints from clinical facilitators and learner nurses. Clinical facilitators indicated at a number of meetings that learners were not mature enough to independently take responsibility and initiative for completing the clinical component of their training programme. On the other hand, learners complained that the clinical facilitators did not lead them to obtain the learning outcomes that were expected of them in the clinical component of their 4-year programme. They mentioned that they:

- felt insecure in the clinical learning environment due to the absence of support by the clinical facilitators;
- were not allowed to perform routine tasks in the unit, such as carry out an intramuscular injection; and
- did not receive opportunities to participate in decisions making in the clinical learning environment.

Studies have indicated weaknesses in the leadership styles of clinical facilitators by pointing out the lack of providing support to learner nurses (Papastavrou *et al.*, 2010, p. 176). When a learner nurse demonstrates a higher level of maturity while performing tasks and displays a readiness in the clinical environment, a

clinical facilitator as a situational leader could allow the learner more responsibility while still monitoring actions (Kleffner, 2010, p. 13). However, the relationship between leadership styles of clinical facilitators and the maturity levels of learner nurses in a clinical learning environment at Western Cape hospitals was thus unknown.

The research questions of this study were:

- What is the leadership style used by clinical facilitators in the clinical learning environment of learner nurses?
- How mature (able and willing) are the learner nurses to make decisions in the clinical learning environment?
- What is the relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in the clinical learning environment?

1.5 THE PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the relationship between the leadership style of clinical facilitators and the maturity level of learner nurses in the clinical learning environment.

1.6 OBJECTIVES OF THE STUDY

The study sought to:

- determine the leadership style used by clinical facilitators in the clinical learning environment of learner nurses;
- determine the maturity level (ability and willingness) of learner nurses to make decisions in the clinical learning environment; and
- describe the relationship between the leadership style of the clinical facilitator and the maturity level of the learner nurses in the clinical learning environment. envy

1.7 DESIGN

Research design is a plan / blueprint of how the researcher is going to conduct the research process in response to the research problem (Babbie & Mouton, 2011, p. xxvi). The researcher employed a quantitative, exploratory, descriptive, and comparative design. According to Burns and Grové (2009, p. 23) *quantitative design* is an objective, systematic process in which numerical data are used to obtain information about the phenomenon in a particular field of study.

An *exploratory design* refers to results of a study that are not going to be generalised to a large population (Burns & Grové, 2009, p. 359). The results of this study were limited to the 2nd, 3rd and 4th year learner nurses at an educational facility in the Western Cape Province. This type of study provides knowledge about the field of study. A *descriptive design* is a research study that describes the phenomena or the relationship between the variables that are examined (Brink, 2008, p. 201). A *comparative design* compares the responses of groups in a study (Brink, 2008, p. 199). In this study, the researcher wanted to describe the relationship between leadership styles of a clinical facilitator and the maturity level of learner nurses in the clinical learning environment.

1.7.1 Population and sampling

Study population refers to individuals who possess specific characteristics of interest to researcher (De Vos, 2004, p. 198; Babbie & Mouton, 2011, p. 174). An *accessible population* refers to the segment of the population to which a researcher has reasonable access (Burns & Grové, 2005, p. 342). In this study, all clinical facilitators (N = 30) and registered learner nurses at a university in the Western Cape Province (N = 641) placed at academic hospitals constituted the accessible population. *Sampling* is a process of selecting respondents for study participation (Burns & Grové, 2009, p. 35). *Stratified sampling* was used with learner nurses grouped according to possible similar characteristics, by defining strata (Fowler, Jarvis & Chevannes, 2005, p. 11), with the purpose of ensuring some degree of accuracy (Burns & Grové, 2005, p.349). For the clinical facilitators, the researcher sought to include all year levels of clinical facilitators.

According to De Vos (2004, p. 199), a sample is the subset of measurements drawn from a population in which a researcher is interested. The formula of Bartlett, Kotrlik and Higgins (2001, p. 43-44) was used to determine the total sample size of the three (3) strata (year levels of study) (Chapter 3).

Sampling method

Clinical facilitators

With the allocation of sample size for clinical facilitators, the researcher decided to include the accessible population (n = 30). Twenty-three of the facilitators agreed to participate in the study (n = 23), and were issued with questionnaires.

Proportional stratification is the process of establishing sample sizes for each subgroup of learner nurses, reflecting the sizes of those in the population (Fowler *et al*., 2005, p. 11).Three strata of learner nurses were established, namely the 2nd, 3rd and 4th years levels (Table 1.1). A formula was used to determine the number of learners to be included from each stratum (Gupta, Sud & Parsad, n.d., p. 299)(see Chapter 3).

Table 1.1: Number of randomly selected learners and per strata/level

Year of study	Learner nurses (n)
2nd year	156
3rd year	144
4th year	107
Total	**407**

1.7.2 Data collection

The *survey method* is a method of collecting original data for describing a population that is too large to observe directly (Babbie & Mouton, 2011, p. 232; Burns & Grové, 2009, p. 245). A *survey method* uses questionnaires to collect information from participants and is used for descriptive purposes (Babbie & Mouton, 2011, p. 232). A *questionnaire* is a printed self-report form designed to obtain information from a respondent's written replies (Burns & Grové, 2009, p. 406). An instrument was developed from literature reviewed.

Appointments were made at the university campus for meeting learner nurses and clinical facilitators to discuss the issues pertaining to: (1) voluntary participation, (2) consent and confidentiality, (3) purpose of the research study, (4) importance of completing the questionnaire, (5) date of handing out questionnaires in closed envelopes, and (6) time for collection of questionnaires. The clinical facilitators and the learner nurses allocated to them on the three different year levels completed a similar questionnaire. Each learner was given two questionnaires, (i) his / her own copy of the questionnaire to complete, as well as (ii) a questionnaire to be completed by his / her specific facilitator. Each questionnaire had two sections. The first section required anonymous demographic data and the second section required responses about the framework of the study. A 4-point scale was used to rate the responses of respondents (Quinn & Hughes, 2007, p. 303) (Table 1.2).

Table 1.2: Scale on the instrument

Scale students (Questionnaire A)	Scale facilitators (Questionnaire B)
1 = Unable and unwilling to	1 = Tell the student how to
2 = Willing but do not have the skills to	2 = Guide the student how to
3 = Able but unwilling to	3 = Support the student to
4 = Able and willing to	4 = Am available when the student asked to

The advantage of data collection by means of a questionnaire was that respondents completed information in their own space and at a convenient time (Burns & Grové, 2009, p. 409). It took around 30 minutes to complete the questionnaire. Pretesting of the instrument was undertaken to eliminate problems in wording of questions and a lack of precision of instructions (Brink, 2008, p. 164). The instrument was provided to five respondents representing each of the learner nurse levels and two clinical facilitators. These respondents did not take part in the main study.

1.7.3 Data analysis

Data was analysed with the assistance of a statistician at the university who used the Statistical Package for the Social Sciences (SPSS) Version 21 software program. Data analysis is the process of providing meaning to the gathered data (Burns & Grové, 2009, p. 44). *Descriptive data* analysis was conducted and resulted in an indication of frequencies, mean values, and standard deviations. According to Brink (2008, p. 202), frequency means the number count of responses in a group. A *mean* is the total value divided by the number of values and a *standard deviation* is a statistic that indicates the average deviation of all the values in a set of data from the mean value of that data (Kirkwood & Stern, 2003, p. 33-35). The data was visually presented in the format of charts, tables, and figures.

Inferential statistics was followed. *Pearson's correlation* was used to calculate the strength of the relationship between two variables that indicated the direction of relationships between leadership styles and maturity levels of the learner nurses.

1.8 VALIDITY AND RELIABILITY

Validity refers to accuracy and truthfulness of the scientific findings while *reliability* means consistency and dependability of a research instrument to measure a variable (Brink, 2008, p. 207). Chapter 3 describes validity and reliability in more detail.

1.9 ETHICS

The research project was presented for approval by the University of the Western Cape (UWC) Ethics Committee of the Faculty of Community and Health Sciences and by the Senate Research Committee respectively (12/9/24). Proper research is only possible when there is respect, trust, and assurance between the researcher and the respondents (Manzini, 2004, p. 20). The Ethics Committee of the Faculty of Community and Health Sciences at the UWC approved the study and the department / school of nursing granted permission to access information.

Information needed for respondents to make an informed decision was made known. That included what would happen with the data gathered, maintaining anonymity and confidentiality throughout the study, and when the results would be published. No known risks were anticipated for respondents in the study.

Anonymity: The questionnaires were allocated numbers to ensure that respondents' identity could not be linked to responses (Brink, 2008, p. 198). Questionnaires bore no respondents' names (Burns & Grové, 2009, p. 202).

Autonomy: The respondents were free to withdraw at any time during the study (Burns & Grové, 2009, p. 202). They had the right to decide whether or not to take part in the study without any punishment or prejudice (Brink, 2008, p. 32).

Privacy: It means handling information in a confidential manner. De Vos (2004, p. 67), describes privacy as an individual's right to decide where, when, and to whom attitudes, believes, and behaviour will be revealed. In this study, information was only available to the researcher, the supervisor, and the statistician. Whatever discussion happened between the researcher and the respondents was kept confidential. Respondents completed the questionnaires in their own time at home.

Confidentiality: In the study, the researcher's responsibility was to prevent data gathered during the study to be available to any other person except to the researcher, supervisor, and statistician (Burns & Grové, 2009, p .196). According to Molopo (2007, p. 44), there should be no possibility of linking respondents to any response. Data collected would be kept in a safe place under lock and key for five years after the results had been published.

Right to withdraw from research: The researcher made sure that respondents were informed about their right to decline to take part in the research and to withdraw from the research project at any time (Burns & Grové, 2009, p. 202), with an assurance that it would not adversely affect either their learning experience or jobs.

Informed consent: It means that adequate information about the purpose of the investigation, the procedures that were followed during the investigation, voluntary participation, as well as advantages and disadvantages were provided to the respondents (De Vos, 2004, p. 65). Respondents had given written informed consent before the questionnaires were handed out.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

Literature is defined as the body of written work relevant to the topic of interest, produced by scholars and researchers who specialise in a given field (Brink, Van der Walt & Van Rensburg, 2012, p. 71). Chapter 2 focuses on leadership styles and the maturity levels of individuals within the framework of situational leadership as the topic of interest. A literature search also serves as an explanation why things are done; "that way, not this way" (Sawatzky, Enns, Ashcroft, Davis & Harder, 2009, p. 260). Research works by famous researchers are frequently published, inferences are made, and ongoing developments on topics in the fields of science and technology are documented for the world to know about them. As a result, a literature review always serves as a critical source of information from around the world (Polit & Beck, 2004, p. 757).

2.2 LEADERSHIP

According to Cherie and Gebrekidan (2005, p. 86), leadership behaviour surfaces in distinct patterns called leadership styles. The styles can be seen as a continuum from a highly controlling and directive type of leadership to a very inactive style.

2.2.1 Types of leadership styles

Leadership styles are defined as permanent and consistent patterns of behaviour while individuals are interacting with one another at work, e.g. clinical practice (Abedi, Hedayatizadeh & Rostami, 2011, p. 939). According to Mkhize (2005, p. 16), the behaviour or leadership style of a clinical facilitator brings about the academic success of learner nurses. Effective leadership is one of the most important elements of success in any organisation (Ngcobo & Tikly, 2008, p. 2) and in clinical education; there is no exception (Walker, Cooke, Henderson & Creedy, 2011, p. 743). Effective leaders are recognised as having the skills and knowledge to generate and share an institutional vision and purpose to motivate staff, support collaboration, and pave the way for change to occur (Henderson, 2011. p.1). Clinical facilitators should apply these characteristics to their work in order to gain the respect and trust of the learner nurses and to lead the development of clinical practice. By demonstrating an effective leadership style, one is in a powerful position to influence the successful development of, e.g. learner nurses, by ensuring that professional standards are maintained and enabling the growth of competent practitioners (Frankel, 2008, p

1). In a study by Bondas (2006, p. 332), leaders are admired when they are viewed as driving forces. They are regarded as a source for inspiration and as role models for future nurse leaders.

According to Iro (2007, p. 22), the *authoritarian* leader would likely dominate a whole situation and commands to get the work done. This is in contrast to a more democratic style when the followers are motivated because they are allowed to take part in decision making and communication is bidirectional (Iro, 2007, p. 22). An authoritarian leader maintains control over the followers. This control may be dictatorial with disregard for the needs and feelings of the followers. An authoritarian leader gives orders and expects followers to obey. The leader single-handily makes all the decisions without the participation of followers. According to Cherie and Gebrekidan (2005, p. 87), it limits the degree of trust and openness between a leader and followers. A directive style is appropriate when the leader wants the job to be completed (Jooste, 2009, p .49). *Autocratic leaders* make all the decisions and tell the followers what, how, and when to perform tasks (Lewington & Bristol, 2012, p. 6), the same applies to *bureaucracy*, where a leadership hierarchy and lines of authority are solid, with some people being the bosses and the other ones subordinates who receive commands from the leader (Tomey, 2004, p. 176). The structured organisational leader draws direction from policies, "chain of commands", and procedures to make decisions (Murphy, 2005, p. 131). Learners who are subjected to this type of leadership / supervision are likely to be passive, dependant, and demotivated in their clinical learning because there is no opportunity for developing a relationship with the leader (Booyens, 2005, p. 126). However, Casida and Pinto-Zipp (2008, 7-15) state that bureaucracy with rewards may be essential for maintaining performance. A previous study concludes that students under this leadership style are reluctant to volunteer for tasks when given the chance to (Ahmad & Sajjad, 2011, p. 1768).

A *democratic* leader encourages the followers to participate in decision making. The leader respects individuality in the group. Such a leader creates a more participative and less controlling environment than an authoritarian leader (Cherie & Gebrekidan, 2005, p. 88). The democratic leader stimulates and guides the followers towards achieving goals. Rather than telling, the democratic leader asks stimulating questions and suggests options to guide the followers to reach goals (Jooste, 2009, p. 50). The democratic style demands a strong faith in the ability of the group to solve problems and to accomplish goals. The democratic leader strives to reach consensus with learners, and focuses on developing relationships and motivation (Wendling, 2012, p. 8) with the aim of empowering them. This shared leadership invites inputs and actions in decision making from learner nurses (Ngcobo & Tikly, 2008, p. 12). Collective learning requires participation of learners and a shared practice includes feedback and assistance to support individuals (Zito, 2011, p. 28). Learner nurses under a democracy leadership style may develop feelings of responsibility / ownership to plan and execute their daily tasks in the unit and to become more independent (Casida & Pinto-Zipp, 2008, p. 7-15).

According to Haeseler (2013, p. 45), a democratic leader is client-centred, guidance-orientated and non-prescriptive in his / her leadership style, vision-driven, and creative (Munir & Nielsen, 2009, 1834).

Laissez faire leaders on the other hand believe that followers should be left alone to perform tasks (Clark, 2009, p. 8). However, the avoidance of leadership responsibilities threatens goal achievement, and people may not work in a consistent manner (Armstrong & Rustin, 2011, p. 3). On the contrary, this style of leadership is appropriate for mature learner nurses who are independent, self-driven, and responsible enough to perform learning activities on their own (Taylor, 2010, p. 94). The laissez-faire style implies that leadership functions are delegated without providing direction to the execution of these functions; members act independently of one another and frustration levels could rise owing to the lack of cohesion. The goals are unclear, and in most cases, this type of leadership is viewed as unproductive and ineffective since it is permissive (Cherie & Gebrekidan, 2005, p. 91). According to Iro (2007, p. 22), in this type of leadership style there is no control. This leadership style is beneficial when the followers require little involvement from the leader.

Iro (2007, p. 22) mentions *charismatic* leadership as another style of leadership. A charismatic leader is described as very manipulative, since he / she is persuading people to do what he / she wants them to do. Some political leaders apply this style of leadership. Charismatic leaders have an inspirational quality as 'role models' to students, instil self-confidence, and communicate high expectations (Haeseler, 2013, p. 46). Bennett (2011, p. 6) confirms that motivational factors associated with charismatic leadership focus on the relationship between leaders and followers in the social setting of a clinical environment. Learner nurses working with charismatic clinical facilitators are motivated to exert extra effort because they like their clinical facilitator and express greater satisfaction (Mkhize, 2005, p. 22).

In addition, Jooste (2009, p. 52) and Muller (2009, p. 176) considers *participative* leadership as another style. The participative leader weighs the responses of followers to a proposal and makes the final decisions for actions. The style is a compromise between the authoritarian and democratic styles.

Another leadership style is the *transformational* type of leadership called *intellectual stimulation* (IS) (Bolkan, Goodboy & Graffin, 2011, p. 343). It is a highly engaging leadership style, since the leader encourages followers to think creatively and reflect on their experiences (Howitz, Howitz, Daram, Brandt, Brunicardi & Awad, 2008, p. 50). The leader focuses on followers' needs to accomplish what is expected of them; motivation and followers' participation are characteristics of intellectual stimulation (Bolkan *et al*., 2011, p. 338). Transformational leadership is cited as one of the most effective approach because it emphasises the development of supportive relationships and encourages follower creativity (Callaghan, 2008, p. 207). Transformational leaders are role models who provide a sense of direction and encourage

self-management (Tomey, 2004, p. 176). A study of Pounder (2008, p. 238) shows that transformational leadership positively impacts students learning, cognitive learning, affective learning, and general satisfaction.

The Hersey-Blanchard's situational leadership model is mostly applied in management (Jasper, 2011, p. 1047-1057). According to Jooste (2009, p. 71-72), one should first understand the situation and the importance of the outcomes before the situational model can be properly implemented.

This leadership approach is based on the assumption that the situation determines the type of leadership style that needs to be used. Shamir (2011, p. 308) argues that certain leader behaviour or a leadership style may have positive effects at certain phases but not in other phases, hence a variety of leader behaviour is recommended in order to be most effective. Leadership is also displayed by telling, selling, participating, and delegating behaviour (Jasper, 2011, p. 1048-1049).

2.2.2 Situational leadership

Situational leadership focuses on the relationship between tasks and maturity level. It is a learner-centred style of leadership that relies on leaders' skills to make available support to learners based on their needs (Meyer, 2012, p. 4). Flexible, adaptive leadership is crucially important when there are substantial changes in situations and the relevant leadership behaviour that that is needed as a result of these changes. The Hersey-Blanchard (1970-1980) theory observes the behaviour of the leader and the followers in a variety of situations when performing certain functions (Yukl, 2008, p. 2). They recognise the influence that a leader exerts and the followers' willingness, motivation, and readiness to perform assigned tasks (Lockwood-Rayermann, 2003, p. 33). The premise of this model acknowledges that it is not the best leadership style for all situations; rather a leader's effectiveness is maximised by appropriately matching the leadership style with the maturity level of the followers (Vroom & Jago, 2007, p. 19). When clinical facilitators are being held accountable for the academic performance of the learner nurses in the care, it is critical that they effectively adopt a directive, guiding, supporting, or delegating style of leadership congruent to the maturity level of learner nurses. This study investigated the leadership styles of clinical facilitators and the maturity levels of the learner nurses in the clinical learning environment.

2.2.3 Maturity

Learner nurses are moving from one developmental level to another during their professional career (Haag-Heitman & Schedler, 2004, p.1-4). To determine the most appropriate leadership style, one should assess

the maturity level of the learner nurses. According to the situational leadership theory, one needs to know when to intervene in a situation, and when to step back (Dickson, Walker & Bourgeois, 2006, p. 417-418).

Kozulin *et al.* (2003, p. 4) assume that individuals are able to perform tasks, while it is highly possible to perform more complex tasks in a collaborative environment. From a learner's point of view, clinical facilitators should play the role of an educator, assessor, excellent coach, and guide to influence clinical learning and should have a genuine concern about learners while having their best interests at heart (Baglin & Rugg, 2010, p. 146).

According to Kleffner (2010, p. 13), greater responsibility for patient care should be associated with the learner nurses' more advanced knowledge and skills as rated by the clinical facilitator. When a learner nurse demonstrates a high level of maturity, Kleffner (2010) explains that the facilitator ought to allow more responsibility while still monitoring actions in a non-intimidating manner. Lillibridge (2007, p. 45) emphasises that the leadership style of clinical facilitators is detrimental to developing more advanced knowledge and skills by a learner nurse in the clinical learning environment. Whittle (2007, p. 19) establishes that learner nurses with high self-confidence and self-governance want to be led rather than being directed, and wants to contribute to decision making. Given these characteristics of a learner nurse, it is suggested that clinical facilitators as situational leaders support learners to achieve goals.

As the abilities and confidence level of a learner nurse increase, the clinical facilitator needs to lead more by means of support and active involvement (Kleffner, 2010, p. 13). The next step is to allow participation in decision making during their clinical learning, while the clinical facilitator still offers support and guidance. According to Thach, Thompson and Morris (2006, p. 304), the value of the situational leadership theory lies in its usefulness for describing how, for example a situational leader can best work with individuals and how they, in turn, can best work with the leader. Both parties then work towards the common goals of attaining a positive learning environment and modelling future professional nurses. According to Yukselturk and Bulut (2009, p. 13), clinical facilitators influence an individual learner nurse to take the initiative, with or without the assistance of other people, in identifying their learning needs and material resources needed for learning. The learner nurse as an adult learner should be able to make use of learning opportunities when they occur in the clinical environment (Quinn & Hughes, 2007, p. 41).

- **Maturity and leadership style**

A clinical facilitator as a leader adopt a *directive* leadership style for the learner nurse who is *unable and unwilling to perform a task*, for example a learner nurse who has never observed an intramuscular injection given on the gluteus area would require a telling leadership style from the clinical facilitator. One who

knows, has observed, and may have administered several of these injections would definitely would require a completely different style; perhaps a delegating style when he / she performs the task. A *guiding* leadership style may be needed by a learner nurse who is *willing but do not have the skills* for an assigned task, a *supporting* leadership style may also be required for the learner nurse who is *able but unwilling* to complete it, and a *delegation* leadership style for a learner nurse who indicates some competence in the assigned task (*able and willing maturity)*. This information is supported by Le Roux (2007, p. 46-49), Muller (2009, p. 162-163) and Meyer, Naudé, Shangase and Van Niekerk (2009, p. 201) that knowledgeable individuals represent a certain stage of development and such individuals will perform more skilfully than the ones who are at an earlier stage in their learning process, hence leadership will differ.

Maturity is assessed when conducting tasks in the clinical learning. *Maturity* is defined by Houghton and Yoho (2005, p. 66) as the degree of ability and willingness a learner nurse displays to take responsibility for the task during, e.g. clinical learning. In this study, maturity level was assessed in relation to: (a) the relationship between the clinical facilitator and the student, (b) during participation in the teaching and learning approach, (c) using teaching methods, and (d) during clinical practice.

During earlier stages, learner nurses in the clinical learning setting need close, effective leadership from people with formal authority in their learning environment ; "clinical facilitator, preceptor or mentor" (Haag-Heitman & Schedler, 2004, p.3). This implies a leader-centred leadership (autocratic / telling style) because lower levels of maturity of learners as novices. However, later in their learning process during clinical practice, they may require a learner-centred leadership (laissez-faire / delegating style and / or participating style) (Huber, 2010, p. 16-17). This could be a learner who has been exposed to the environment several times or is in his / her last year of training as a learner nurse.

The clinical facilitator is expected to support, offer encouragement, and intervene when the learner nurse seeks assistance or when a facilitator decides there is a need for leadership. The ability and commitment of a learner nurse to function properly is dependent on having good clinical leadership, and to work with proficient leaders who foster proper learning, skills development, and who integrate theory into practice (Henderson, Twentyman, Eaton, Creedy, Stapleton & LIoyd, 2009, p. 178).

Evidence in literature confirms that a leadership style can be a factor that determines whether a learner nurse succeeds or fails (Clark, 2009, p. 4), and that leadership influences followers to function independently (Andrews, Richard, Robinson, Celano & Hallaron, 2012, p. 1104). This implies that a leadership style must fit the appropriate maturity level of followers (learners) during task performance.

As applied to this study, it was assumed that the behaviour of a clinical facilitator changed from 'hands-on instruction' to a 'hands-off' approach as a learner nurse's knowledge increases according to his / her maturity level. *Maturity level* refers to how responsible the learner nurse is to practice clinical tasks (Witt & Kerssen-Greip, 2011, p. 78). Maturity level comprises two components (Leadership, 2010, p.129-130). *Competence* refers to the ability of a learner nurse to perform an expected task well (Pepin, Dubios, Gigard, Tardif & Ha, 2011, p. 269). On the other hand, *commitment* refers to task readiness and psychological readiness to learn how to perform tasks (Gagne & Deci, 2005, p. 331). Awareness of the competency and commitment of the learner nurse leads to using the most effective leadership style that is congruent to the developmental level of a learner nurse with regard to understanding their responsibilities and roles (Henderson, Alexander, Haywood, Stapleton, Cooke, Patterson, Dalton & Creedy, 2010, p. 150).

As leaders, the clinical facilitators are expected to continually create new ideas, as well as change leader behaviour for effectiveness and productivity in the nursing education milieu. They are required to use the appropriate leadership style for motivating learner nurses to accomplish the educational objectives set for the specific course.

2.3 TEACHING AND LEARNING IN THE CLINICAL LEARNING ENVIRONMENT

2.3.1 Factors that influence clinical learning

In clinical learning, supervision of learner nurses needs careful planning in order to provide appropriate learning opportunities to advance their competencies and to develop their personal, professional skills, as well as their professional satisfaction (Bond & Holland, 2010, p. 15).

Undergraduate nursing education relies on several factors that influence clinical learning of learner nurses. These factors relate to a positive clinical learning environment**,** motivation to conduct clinical learning, a continual relationship between the clinical facilitator and the learner nurse, empathy and support of learners, communication between the two parties, evaluation of clinical learning, setting goals for teaching and learning in clinical practice, timely and appropriate feedback to learners, as well as enabling learner nurses to learn in a safe and supportive environment.

The value of a positive clinical learning environment benefits learner nurses, since they successfully gain knowledge in the clinical setting. Henderson, Cooke, Creedy and Walker (2012, p. 299; Begum & Slavin, 2011, p. 332) mention that learner nurses encounter real as opposed to academic nursing care opportunities; learn procedures and master basic nursing skills, gain confidence and understanding, as well become independent (Henderson *et al.*, 2009, p. 177).

Clinical learning should provide the learner nurses with frequent opportunities to observe role models, to practise independently; to reflect upon what is observed, heard, and done (Chan & Ip, 2007, p. 678); and to enable them to deal with unexpected circumstances (Lopez-Preez, Ambroma, Gregory, Stocks & Oceja, 2013, p. 1), for example nursing a terminally ill patient. However, as fundamental as it is to the nursing learners' learning, many learners experience challenges during their clinical practicum (Edgecombe, Jennings & Bowden, 2013, p. 138).

After a clinical facilitator has conducted a demonstration, learner nurses are given an opportunity to practise what has been shown to them in order for them to become proficient in the technique. According to a study by Calpin-Davies (2003, p. 4), a conducive clinical environment allows competent learners to conduct activities independently and the ones who still need guidance are assisted by a clinical facilitator. For instance, a first year learner nurse who is able to prepare an intramuscular injection can do that independently, but with the administration of that injection the clinical facilitator has to be present for support and guidance. Learner nurses are allowed to reflect upon the practice or experience with their colleagues and develop portfolios that include their experience obtained from their clinical practice. These learning activities assist them to bridge the gap between theory and practice.

According to Uusiautti (2013, p. 2), happy learners are assisting one another and exercise more self-control than distressed students. Self-government and -acceptance of learners, role clarity, quality of supervision and opportunities for learning are all variables that distinguish a conducive clinical learning environment from an unfavourable setting (Uusiautti, 2013, p. 2). According to Sawatsky *et al.* (2009, p. 261), a positive atmosphere supports learners happiness and results in peer support to achieve goals.

To establish a positive learning environment, an effective clinical facilitator displays the following qualities:

(a) Is clear and precise about what needs to be achieved

A clinical facilitator informs the learner nurse about what they need to learn during their placement, and what to achieve in clinical teaching and learning (Trees, Kerssen-Griep & Hess, 2009, p. 399).

(b) Builds logically and gradually from simpler concepts and tasks to more complex ones

She / he starts with elementary cases and progresses to more complicated ones while considering the developmental level of his / her learner nurse.

(c) Provides encouragement and positive constructive feedback

She / he reinforces the correct procedures and suggests specific ways to improve. It is confirmed by Smith and King (2004, p. 203-205) that feedback from clinical facilitators to learner nurses occupies the central role in teaching and learning. Feedback draws attention to task level, motivation, and learning results to improve the performance of the learner nurse.

(d) Treats learner nurses as individuals, with individual learning approaches

She / he provides opportunities for learner nurses to learn according to the way they learn best, for example discussion groups (Bolkan & Goodboy, 2011, p. 11).

(e) Creates an environment of honesty and openness

The clinical facilitator admits when she / he does not know something, while assuring the learner nurse that she / he will find the answer and get back to him / her. A clinical facilitator is not the source of all knowledge. Simmons (2008, p. 69) warns that trust does not get established overnight; it gets build with time and needs to be maintained.

(f) Encourages discussions amongst the learners

Discussions enable learner nurses to learn from one another's experiences and areas of expertise. By learning collaboratively, team members solve their learning problems collectively and benefit from constructive criticism (Elbousty & Bratt, 2010, p. 7).

(g) Responds to feedback from learners

The clinical facilitator is not frightened to obtain the opinion of learners when he / she maintains a good relationship with their learner nurses.

(h) Considers the safety of the learning environment

If a learner nurse trusts a clinical facilitator, the environment is perceived as non-judgemental and assures a secure environment for learning (Knowles, Holton & Swanson, 2011, p. 14). Fear of the clinical facilitator can be counterproductive (Trees *et al.*, 2009, p. 398) and an indiscernible clinical facilitator in clinical practice could produce a feeling of insecurity when learners need assistance (Staun, Bergstrom & Wadensten, 2010, p. 634).

2.3.1.1 Continual relationship between the clinical facilitator and the learner nurse

A relationship should be established that extends over time (Zito, 2011, p. 35). The process of facilitation occurs in the established relationship between the clinical facilitator and learner nurse (Bergjan & Hertel, 2012, p. 2). Qualities required for this to happen are requirements for safety and accepting learners as members of the health team. The continual nature of facilitation allows a relationship to grow and develop with the purpose of accepting learner nurses' differences, considering their welfare, and enabling them to become valued members of the clinical team of practice (Den Hartog & Den Hoogh, 2009, p. 203).

Caring relationships are characterised by the clinical facilitator being approachable, available, encouraging acknowledging mutual respect, providing support and encouragement in the clinical learning environment, and listening attentively to learners (Pross, 2010, p. 558). The role of the clinical facilitator is to be present and available at all the times, to follow learners' development, to guide them with workbook and assignment completion, and to engage with students each day with the aim of building a continual relationship (Staun *et al*., 2010, p. 634).

Lack of a learner-facilitator relationship is perceived as an obstructive factor to clinical learning (Lofmark, Thorkildsen, Raholm & Natvig, 2012, p. 165). In fact, a good relationship enhances psychological well-being, learner nurses become motivated, and it makes it easier for them to set goals for obtaining clinical learning in the ward (Deci, La Guardia, Moller, Scheiner & Ryan, 2006, p. 314).

2.3.1.2 Empathy and support

Empathy and caring support, according to Lekalakala-Mokgele and Du Rand (2005, p. 7), are very important in helping relationships. Clinical facilitators should habitually show empathy (Lopez-Preez *et al*. 2013, p. 1) because caring is a core value of nursing education (Li-Min Wu, Chi-Chu Chin & Chung-Hey Chen, 2009, p. 973). According to Bolkan and Goodboy (2011, p. 13), a caring and empathetic leader is willing to assist learner nurses on a personal level, since clinical learning can be stressful.

Humane approaches (Rogers 1902-1987) are conducive for achieving learning in situations that are under the control of the learner and where they are understood and valued (Van Vuren, 2012, p. 6). Nursing students who lack self-confidence need to be nurtured and empowered with tools that assist them with their learning. At university level, nursing education should prepare learners with the knowledge to be safe, professionally capable, and work ready (Meehan-Andrews, 2009, p. 25). An experienced clinical facilitator with a friendly attitude is needed to guide novices (Fabre, 2009, p. 148).

2.3.1.3 Bidirectional communication

Communication is a fundamental element of nursing practice (Meyer, Naudé, Shangase & Van Niekerk, 2011, p. 102-103). According to Hawker (2006, p. 130), the word *communication* means the act of conveying and sharing information or the science and practice of transmitting information. This definition acknowledges the link between *teaching* and *communication*, since educators are constantly sharing knowledge, or transmitting information. For teaching and learning to be successful, both the clinical facilitator and the learner nurse should communicate with one another (Elbousty & Bratt, 2010, p. 6). A mutual or written supervisory contract in terms of clinical accompaniment with regular feedback is needed (King, Schrodt & Weisel, 2009, p. 236-237). According to Gillespie and McFetridge (2006, p. 642), a learner nurse and clinical facilitator should have discussions about portfolio development. This bilateral communication process includes regular feedback between the learner nurses and their facilitators. In a supervisory contract, learning strategies and evaluation methods addressing the development of learners' competencies should be articulated (Kadagad, 2013, p. 81-82). The agreement between supervisors and nursing students should in particular identify relationship building factors and scheduling of frequent appointments that are critical for accomplishing the objectives of both parties (Guide for senior supervisors at SFU, 2005, p. 1).

2.3.1.4 Evaluation and monitoring of clinical learning

Evaluation occurs after there has been enough facilitation to expect a certain degree of competence according to the learning outcomes (Lofmark *et al.*, 2012, p. 166). It is performed against set standards of professional roles and codes of practice that provide the basis for deciding whether a learner nurse is competent (Muller, 2004, p. 135). However, Witt and Kerssen-Greip (2011, p. 77-78) focus on the credibility of the clinical facilitators who conduct the evaluation during clinical learning. Credibility is the degree to which a clinical facilitator objectively evaluates learner nurses.

The learner nurse should be objectively evaluated at regular intervals by clinical facilitators for augmenting positive progress and providing constructive criticism (Blees & Rittberger, 2009, p. 4). Immediately after evaluation, accurate and immediate positive feedback should be provided, strengths and weaknesses should be discussed with the learner nurses, and areas for improvement should be defined (Uusiautti, 2013, p. 7). Potential mistakes could be accepted as a natural part of any learning experience by the learner nurse (Haag-Heitman, 2006, p. xlviii), therefore, reasonable time should be allowed for the learner nurse to prepare for evaluation (Ballon & Waller-Vintar, 2008, p. 27).

Evaluation sends a strong message to a learner nurse about what constitutes proper knowledge in a particular learning environment. The process includes assessing the quality of a learner nurse's performance (Weurlander, Soderberg, Scheja, Hult & Wernerson, 2012, p. 747). Having said that, ineffective evaluation of a learner nurse could result when:

- Communication to learner nurses about their personal progress is absent (Henderson *et al.*, 2010, p. 150). Inadequate feedback deprives the learner nurse of the chance to know about his / her progress and the opportunity to improve (Dungy & Whitaker, 2010, p. 225).
- The clinical facilitator does not do evaluation as a part of the learning experience of the learner nurses (Davis & Ponnamperum, 2005, p. 279).
- Learner nurses are not evaluated according to set methods and do not know what end results should be achieved. Any assessments that adjudicate students' progress should be appropriate for the specific set of course objectives, as well as for the learner nurses of a facilitator (Darling-Hammond, 2012, p. iv).
- Set objectives are not useful because they are unclear in describing the expected learning behaviour of the learner nurse in the ward.

2.3.1.5 Setting objectives / goals for clinical practice

A clinical facilitator has the authority and duty to establish aims and learning objectives for the learner nurse (Oluwatoyin, 2006, p. 31), to communicate with them, and to explain the expectations for learner nurses (Ullrich & Haffer, 2009, p. 7) with the purpose of guiding and supporting them. Objectives provide guidelines for the classification of the level of learning that is required and establish the learning needs of individual learners (Gravett & Geyser, 2004, p. 144); hence learning objectives serve to focus the learner nurse's clinical learning endeavours.

2.3.1.6 Timely and appropriate feedback

Continual constructive feedback facilitates the development of self-assessment (reflection) during the learning process (Nicol & Macfarlane-Dick, 2006, p. 205). Both verbal and written feedback should be provided to learner nurses in respect of aspects that indicate whether their clinical practice meets legal, ethical, and / or professional standards (Mckenna, Innes, French, Streitberg & Gilmour, 2011, p. 235). Timely and appropriate actions should be taken in situations where there is evidence of poor clinical practice by the learner nurses (King, Schrodt & Weisel, 2009, p. 237). According to Fabre (2009, p. 123), providing feedback to a learner nurse develops professional responsibility and should allow the learner nurse to

understand the positive and negative elements of their behaviour with the purpose of affording them an opportunity to change their actions (Ullrich & Haffer, 2009, p. 7-8).

In summary, factors that influence clinical learning play a critical role in the teaching and learning of learner nurses. They serve as the roadmap for realising a desired goal. It is important that these factors are being taken into consideration in order for the clinical learning environment to become less stressful and more supportive of self-directed and participative learning of the novice nursing student with the purpose of increasing professional responsibility.

2.4 TEACHING APPROACHES

Traditional learning and teaching focus on what the educator does rather than on what the learner does (Shuell, 1986, p. 412). This results in memorisation rather than comprehension. However, recent research into student learning indicates that the learning activities of students are of the greatest importance (Kovak & Montgomery, 2010, p. 35).

According to Elizabeth, Christine and Ewa (2008, p. 526), *teaching* is a consistent process between a clinical facilitator and a learner nurse during which different teaching methods that progress from an educator- to a learner-centred approach. *Clinical facilitation* is making clinical learning easier for the novice, since the clinical practicum is quite a complex process (Midgley, 2006, p. 339). According to findings by Evans and Stevenson (2010, p. 239-241), a clinical facilitator enhances the capability of the learner nurse by building a positive learning environment and using a variety of teaching methods that are consistent with current evidence that is based on learning principles that do not expect the facilitator to know it all (Kadagad, 2013, p. 80). According to Adelman-Mullally, Mulder, McCarter-Spalding, Hagler, Gaberson, Hanner, Oermann, Speakman, Yoder-Wise and Young (2013, p. 30), clinical facilitators have power and expertise in clinical practice to influence the opinion and behaviour of a learner nurse because they have been practising before, therefore, learner nurses look up to them for knowledge, guidance, and role modelling.

A teaching approach tailored to enhance learner nurse's knowledge and develop skills encompasses roles and authentic clinical activities that are relevant in the real world (Harrington & Harrington, 2008, p. 70). Such an approach develops self-directedness in learners (Uys & Meyer, 2005, p. 16). Similarly, McKimm and Jollie (2007, n.p.) emphasise the importance of a learner-centred approach in clinical settings. This requires expertise and practical skills during practice in clinical settings. A facilitative educator:

- makes continual use of learners' ideas during instructional interactions by involving them and implements some of the learners' ideas during clinical facilitation. This process values the learners' contribution (Van Ooijen, 2003, p. 5).
- discusses learning needs according to clinical practice and engages learner nurses in debates about patient care in order to facilitate learning (Adelman-Mullally *et al.*, 2012, p. 32).
- motivates learners by reinforcing good behaviour whenever they do well in clinical learning (Sadeghi & Pihie, 2012, p. 188).
- responds to feelings of learners and attempts to create a sociable atmosphere for them to learn (Lerret & Frenn, 2011, p. 379).

Researches, educators, and facilitators have developed learner-centred andragogy that emphasises active teaching approaches to engage students in their learning. Some of these teaching approaches are problem-based learning (PBL), cooperative learning (CL) and reflective learning (RL).

2.4.1 Problem-based learning

PBL is a learner-centred method of teaching aimed at enhancing learning through the active participation of learners (Crawford, 2011, p. 124). It results in taking responsibility for one's own learning. Problem-based facilitation prepares learner nurses for real world problems they are going to face during their profession (Lee, Lee, Liu, Bonk & Magjuka, 2009, p. 179). The benefit of this educational method is that it allows the application of theoretical knowledge in a real clinical setting (Shields, Bruder, Taylor & Tom, 2012, p. 4). PBL stimulates the recollection of prior knowledge and assists learner nurses with formulating new meanings after seeking information in relation to a particular problem / skill (Moore, 2009, p. 151).

In PBL, learner nurses are presented with a problem situation that paints a real life situation from which they identify learning needs and objectives. As part of clinical facilitation, it also enables learner nurses to reflect on the experiences gained during clinical learning (Brown, Mattera, Millar, Palm & Rode, 2008, n.p.). The clinical facilitator chooses an appropriate case or scenario, e.g. a sick patient to demonstrate skills acquired and content knowledge in the clinical learning. Learners work cooperatively to determine approaches to the particular nursing situation. Through PBL, learner nurses develop the key skills of effective and efficient self-directed learning, communication, and problem solving (Yuan, Williams, Yin, Liu, Fang & Pang, 2011, p. 577-578). This approach allows learner nurses the freedom and responsibility to search for information that they collaboratively discuss under the supervision of their clinical facilitator (Thurley & Dennick, 2008, p. 623-624).

2.4.2 Cooperative learning

CL encourages collaboration, leadership skills building, and serves as a source of motivation to peers (Watts & Gordon, 2012, n.p.). Learners enjoy sharing clinical experiences, for instance a learner who is competent in particular procedures can volunteer to demonstrate those procedures to peers (Henderson, Twentyman, Heel & LIoyd, 2006, p. 565). The *reciprocal teaching* characteristic of CL involves learner-to-learner interaction that promotes successful learning by collaborating with team members who are willing to share knowledge and skills (Hassan, Yusof, Mohammad, Abu & Tasir, 2012, p. 739). Nursing students become peer-educators by providing continual support to one another and assume responsibility for the learning of fellow students, as well as for his / her own learning (Edgecombe & Bowden, 2009, p. 92). According to Goldsmith, Stewart and Fergusion (2006, p. 123), peer-learning is a valuable strategy for teaching and learning.

2.4.3 Reflective learning

Reflection is recommended as a learning method to overcome the problem of a disconnect between theory and practice and to develop practice-based nursing, since healthcare is continually changing and requires a professional nurse who is confident, self-directed, flexible, communicative, and innovative (Delany & Molloy, 2009, p. 5). Delany and Molloy (2009, p. 6) describe RL as useful in nursing when learner nurses are given assignments with the aim of developing portfolios. The rationale of a portfolio is that it assesses learner performance and curriculum outcomes which are related to attitudes and professionalism (Al-Wardy, 2010, p. 207-208). Similarly, Chinn and Kramer (2008, p. 102) claim that reflective knowledge is fundamental to the nursing profession, since it determines the deficiencies in the proficiency of a learner nurse.

According to Jacobs, Vakalisa and Gawe (2004, p. 10), adults learn by updating and replacing skills, knowledge, and learning strategies during experience and reflection. Incorrect educational approaches in clinical facilitation of adult learners may result when:

- The principles of adult education may not be followed on a continuous basis. For instance, the clinical facilitator may not be willing to afford a learner nurse the chance to perform tasks independently (Sawatsky *et al.,* 2009, p. 261).
- Learners may not always have the opportunity to expand their skills and competencies in the absence of reflective practice (Bulman & Schutz, 2005, p. 27).
- Some facilitators are not familiar with the concept of creating a relationship of trust with learners during the clinical learning process (Chuan & Barnette, 2012, p.193).

- Some clinical facilitators only follow traditional methods of education (Edgecombe & Bowden, 2009, p. 92). For instance, they use the *ward round* that does not require much preparation and planning as a problem solving session. The restricted use of teaching methods, such as decision making sessions in the presentation of a learner development programme, leads to a lack of learner participation. One should not lose sight of the fact that learners at higher learning institutions are independent adults (Evans & Stevenson, 2010, p. 241). They are expected to actively interact with clinical facilitators during their own clinical learning (Bengtsson & Ohlsson, 2010, p. 150).
- Generally, clinical facilitators do not allow time for coaching on a daily basis (Tsang, 2011, p. 12).

2.5 TEACHING METHODS

Teaching methods involve the principles and methods used for instruction. Some of these teaching methods comprise small group discussions (SGDs), self-directed learning (SDL) and peer learning (PL).

2.5.1 Small group discussions

Individual learners or learners in small groups have to discuss a case-based problem while being guided by a clinical facilitator. Following the discussion of a case-based problem, learners reflect in groups on tasks to better understand the problem and to experience how problems are being solved in the clinical setting (Dent & Harden, 2007, p. 57), for example learners are presented with a case that represents a real scenario which focuses on the treatment of a patient with that particular health problem. The role of a clinical facilitator in this regard is to maintain focus, to guide the process, and to provide constructive feedback to each learner or to the whole group (Badeau, 2010, p. 244). In SGD, learners should conduct prior reading, constructively contribute to the learning experience during the session, and effectively reflect on the issues raised (Essers, Van Weel-Baumgarten & Bolhuis, 2012, p. 660). The group approach is learner-centred and assists the learner nurse to develop interpersonal and communication skills, the ability to work in a team, and personal growth (Thurley & Dennick, 2008, p. 623-624).

2.5.2 Self-directed learning

SDL is a component of an andragogical theory that is based on an adult's motivation to learn, the ability to self-monitor his / her learning process, planning and implementation of strategies that meet learning goals in clinical skills development, and effective interpersonal communications skills that will enable him / her seek assistance in meeting their learning goals (Knowles *et al.,* 2011, p. 37). Andragogical philosophy assumes that as adults mature, the desire to learn moves from a dependency on external motivation towards a self-driven human activity, taking responsibility for one's own learning. Motivation is internal, rather than

external (Knowles, 1984). They plan their clinical learning around daily activities in the ward (Thurley & Dennick, 2008, p. 625). SDL allows learning to grow beyond knowledge acquisition and increases active participation of a learner nurse and enhances the critical thinking skills that are necessary for clinical practice (Tseng, Chou, Wang, Ko, Jian & Weng, 2011, p. 42). According to Cheng, Kuo, Lin and Lee-Hsieh (2010, p. 1152), SDL is the process during which a learner nurse takes initiative with or without the assistance of other people in establishing their learning needs, formulating learning needs, identifying human and material resources for learning, choosing and implementing appropriate learning strategies, and evaluating outcomes. It is a teaching and learning approach that provides the learner nurse with autonomy and empowers the learner to make the most of the learning opportunities he / she is exposed to (Lerret & Frenn, 2011, p. 379).

2.5.3 Peer learning (PL)

The role of a learner nurse in PL (learner-to-learner) is a formalisation of an unofficial process during which learners assist one another with learning (William, Mckenna, French & Dousek, 2012, p. 1). In clinical learning, senior learners can provide junior learners with emotional support, demonstrate clinical skills / procedures, promote learner participation, and reassure one another in difficult situations (Sidelinger, Bolen, Frisby & McMullen, 2012, p. 291). According to Hrastinski and Stenbom (2013, p. 67), peer teaching is a popular technique; learners observe one another and exchange support, companionship, feedback, and assistance.

In conclusion from the literature about teaching approaches, success is eminent when a clinical facilitator employs teaching approaches that involve active participation of learners. At university level, teaching approaches should emphasise learner-centeredness, as well as reflective and evaluative skills to engage learners in their clinical learning. It goes without saying that attitudes of learners, as observed in their desire to learn and motivation, have an influence on the success of clinical learning practice. Clinical facilitators should bear in mind that when the learners do not actively learn to identify and solve problems, the superficial approach to learning will result in the lack confidence of the learner nurses.

The teaching and learning process should include teamwork, trust, and respect to enable each learner nurse to make a useful contribution to the learning tasks during clinical practice.

2.6 COMPLEXITY OF THE CLINICAL LEARNING ENVIRONMENT

Learning is the process that changes the state of knowledge of an individual (Knowles *et al.*, 2011, p. 15). Learners in a clinical setting interact, learn, and get support from colleagues and unit managers as their role models involved in daily decisions, processes, and management of the unit (Cassimijee & Bhengu, 2006, p.

51). *Theoretical knowledge* means reading about something, for example a learner nurse study how to carry wound dressing in classroom; that is theoretical knowledge. Later, the learner goes to clinical placement and does the wound dressing with a patient, which is *practical knowledge* (Myrick & Yonge, 2005, p. 37). *Practical knowledge* assists learner nurses with acquiring the nursing techniques relevant to their professional roles (Peter, 2008, p. iii). *Practical-theoretical knowledge,* therefore, is important in nursing education and each should complement the other (Peter, 2008, p. 2).

The identification of factors that characterise a conducive clinical learning environment could lead to strategies that promote the factors most predictive of desirable learning outcomes and improve the ones that may have a negative impact on learners' outcomes. The clinical learning environment consists of everything that surrounds the learner nurse; namely personnel, patients, facilitators, and equipment (Dadgaran, Parvizy & Peyrovi, 2012, p. 1713). Learning in this environment can occur only when one is able to understand theoretical materials through practising procedures and skills that have been demonstrated (Gregory & Chapman, 2007, p. 1).

In the clinical learning environment, learner nurses develop attitudes, interpersonal communication skills, and clinical problem-solving abilities. However, Chan, So and Fong (2009, p. 307) are of the opinion that learners may face challenges or threats due to the complexity of the clinical learning environment; such as high technology medical equipment, maintaining good relationships with nursing staff, and managing sudden changes in patient conditions. Clinical facilitators, educational institutions, and hospitals are responsible for providing a caring support and nurturing environment for professional development of learner nurses (Begum & Slavin, 2011, p. 332) in order for learners to later apply caring behaviour in their professional lives.

2.6.1 Challenges in clinical teaching and learning environment

Certain challenges exist in clinical practice. Learner nurses may experience a period of adjustment, stress, and growth when entering nursing practice (Mannix, Faga, Beale & Jackson, 2006, p. 7). According to Nash, Lemcke and Sacre (2009, p. 49), learner nurses learn about language / terminologies used in clinical practice, as well as the rules and practices of the healthcare environment and culture. Along the way, the learner nurse is likely to experience feelings of inadequacy and discomfort.

Chan *et al.* (2009, p. 307) emphasise the problems that affect the learners' clinical learning environment, such as stress. Andrews, Brodie, Andrews, Hillan, Thomas, Wong and Rixon (2006, p. 863) maintain that anxiety due to initial clinical experience and the theory-practice gap present a challenge to learner nurses. The responsibility lies with the clinical facilitator to guide learners by empowering them with the necessary

skills. Many unit managers and nurses focus on the needs of the patient without recognising the benefit of including the learner nurse in the identification and provision of care as an opportunity to support the learning progress (Henderson *et al.*, 2009, p. 178).

According to Keogh and Lynn (2007, n.p.), male learner nurses face gender-based barriers during their nursing education programmes. The gender barriers deprive learners of clinical learning experiences that are vital and core components of the nursing profession (Hosoda, 2006, p. 480-481). In another study, Keogh and Gleenson (2006, n.p.) find that male nurses are nervous about using physical touch. They use coping strategies in response to their fears of being accused of touching patients inappropriately. The clinical learning experience provides a real-life situation and develops the learner nurse's cognitive, psychomotor, and affective skills; these skills are vital for the development of knowledge, problem-solving skills, and values in the nursing profession (Kapucus & Bulut, 2011, p. 1149). Badeau (2010, p. 246) cautions that reinforcement of wrong information to a learner nurse may occur in the clinical learning environment when the facilitator is not readily available at all the times. Despite all these challenges, Scully (2011, p. 93) views clinical learning as as the process of developing clinical competencies of a learner nurse, along with knowledge, attitudes, values, principles, and behaviour that are appropriate to professional nursing practice.

The role of a clinical facilitator also poses some challenges in relation to enabling the development of reflective learning by assisting to identify learner nurse needs, guiding group processes, supporting critical thinking, and assessing the achievement of learning objectives / goals (Lindahl, Dagborn & Nilsson, 2009, p. 6). Del Prato, Bankert, Grust and Joseph (2011, p.11) add that a clinical facilitator should address feelings of helplessness that manifests in the group resistance, since some learners experience a lack of confidence with decision making and difficulties with an unfamiliar clinical setting.

2.7 PRINCIPLES OF ADULT EDUCATION

In the current competitive educational environment that is presently characterised by change more than ever before, facilitators in higher education settings should possess a number of individual qualities in order to influence and engage with adult learners (Yassine & Kumar, 2013, p. 119).

The effort of an educator to engage with students in the clinical environment is an important element in ensuring that learning outcomes and objectives are achieved. With the rapidly changing setting of higher education, educators should continually seek new and effective teaching strategies to engage, lead, and motivate the students with whom they interact (Bennett, 2011, p. 1). In the current educational milieu, several new methods focus on the education of adult learners.

Adult education includes a collection of theories and methodologies for describing the conditions that may augment the process of learning (Trivette, Dunst, Hamby & O'Herin, 2009, p. 1). Theoretical and methodological assumptions include an emphasis on active participation, learner-centeredness and self-directedness, responsibility to own life and the learning process, the ability to identify problems, and to evaluate learning activities (Burke, Barker & Marshall, 2012, p. 52). Since nursing students are adult learners, nursing education should follow the principles of adult learning (Bengtsson & Ohlsson, 2010, p.150). According to Knowles *et al.* (2011, p. 1), adults learn differently from children. Phillips (2011, p. 102) states that adult learners prefer dialogue with an educator in order for meaningful learning to occur, since their life experience annuls their novice learner status. Adult learners are motivated to learn when such learning will assist them deal with a particular problem / task in their work and learn effectively when the context applies to real life situations (Burke *et al.*, 2012, p. 52). According to Dunlap, Dudak and Konty (2012, p. 19-20), effective facilitation is evident when principles of adult education are implemented by a facilitator. The following educational principles for adults are recommended.

2.7.1 Create a relationship based on trust

Research studies indicate that positive facilitator-learner relationships are most essential for successful learning (Trede & Smith, 2011, p. 615) and that mutually beneficial relationships in clinical practice are characterised by a clinical facilitator being approachable, available, respectful, trusting, and providing support to the learners.

2.7.2 Reveal the expectations of both clinical facilitator and the learner nurses

The roles and responsibilities for clinical facilitators, as well as for learner nurses should be revealed for successful clinical learning to take place (Zurakowsk, Taylor & Bradway, 2006, p. 356-357). The roles of learner nurses, clinical facilitators, and the faculty should be synchronised to positively influence learning outcomes. However, it is important to mention that the setting places limitations on time, space, and access to patients. The nursing student is expected to be an active adult learner; the faculty is expected to assess the nursing student's needs, arrange a preceptorship learning environment consistent with programme goals, and to evaluate the nursing student's work; and the preceptor is expected to provide day-to-day clinical education while meeting clinical practice expectations. Meeting the expectations is not always easy for any of the parties.

2.7.3 Obtain the right environment for learning

Oluwatoyin (2006, p. 4) indicates that a clinical facilitator has the authority to either create or destroy a learning environment. A positive environment ensures freedom of expression and promotes a critical thinking process (Del Prato *et al.*, 2011, p. 110).

2.7.4 Focus on meaningful problem-orientated learning

Research shows that adults attain knowledge when they are aware of the applicability of what is being learnt (Anderson, 2011, p. 15), for example when a case-based method is used to demonstrate clinical competencies. Adults learn by solving problems once they are able to associate the solutions with their reality (Bengtsson & Ohlsson, 2009, p. 150). When they cannot link what they learn in class to issues they have to deal with during clinical learning, the learning process will be notably ineffective.

2.7.5 Assist the learner nurse who experiences problems

It may be the first time that learner nurses are in a clinical learning environment. Visibility and availability of a clinical facilitator in the clinical area serves as a strengthening agent for an adult learner to receive timely assistance to his / her problems. Research establishes that nursing students fail to learn owing to psychosocial problems that interfere with their ability to attend to and fully engage with instructional activities (Buckley, 2009, p. 195). An empathetic understanding of the problems that a learner nurse experiences during clinical experience is critical. A novice learner nurse in a unit should be accompanied to a greater extent. This is emphasised in Evans and Stevenson (2010, p. 244) that the first placements represent a critical time of conversion and most learner nurses seem to want and expect significant support and structured input during this period. Therefore, there is a need for greater institutional support and supervision from a clinical facilitator. In a study about nursing students' experiences of clinical practice, Sharif and Masoumi (2005, p. 1-2) find that learner nurses who lack professional nursing skills and knowledge to take care of patients experience anxiety, sometimes fear the unknown, and might make mistakes during the learning process. In such a situation, learner nurses should be able to get immediate assistance from the facilitator (Zuzelo, 2010, p. 2-3).

2.7.6 Acknowledge the individuality of learner nurses in teaching and learning

Clinical facilitators should beware that adult learning is unique to each individual; adults learn at their own pace and in their own way (Bulman & Schutz, 2005, p. 27). Hence, patience and understanding of an adult learner is critical for supportive clinical facilitation.

There are varieties of teaching methods from which the clinical facilitator can select (Dickson *et al.,* 2006, p. 417); these methods include demonstrations, discussions, and case-based studies. According to Bigdeli, Boushehri and Biabangardy (2012, p. 1983), it is beneficial for clinical facilitators to use different teaching methods because learner nurses learn differently during clinical practice.

2.7.7 Present a staff development programme

Clinical facilitators must be given chance to attend in-service training interventions, further their education that enables them to maintain skills, knowledge, and competencies required to deliver good clinical facilitation of learners (Clifford & Clark, 2004, p. 8). It is the right and responsibility of the professional practitioner to maintain competencies and continue learning in order to deliver quality training to a learner nurse. Casterle, Willemse and Verschueren (2008, p. 754) maintain that clinical facilitators are leaders who empower learners and assist them with professional growth.

2.7.8 Active involvement is an opportunity for learning

The clinical facilitator is responsible for preparing the learner nurses to function independently; this can successfully be achieved by getting an adult learner nurse actively involved in clinical practice (Gravett & Geyser, 2004, p. 51). The learning that happens in a real clinical learning environment is carrying greater weight than learning that is acquired in a classroom environment, since the learner nurses are more actively involved (Quinn & Hughes, 2009, p. 341).

2.7.9 Continual accompaniment in nursing practice

Accompaniment is a process during which learner nurses are monitored and guided by a clinical facilitator with the aim of developing them into professional and independent nurses (Uys & Meyer, 2005, p. 12). According to Mntambo (2009, p. 74), the clinical facilitator needs to be available with the purpose of clarifying aspects in relation to the gap between theory and practice. Uninspiring and indiscernible clinical facilitators produce a lack of self-confidence, foolishness, and feelings of abandonment; according to study findings about Finnish and Swedish nursing students (Jonsen, Melender & Hilli, 2012, p. 4).

2.7.10 Establish open communication channels

Open communication between the clinical facilitator and a learner nurse should exist. When this is the case, the clinical facilitator and a learner nurse are able to share thoughts, feelings, and experiences without fear of any negative consequences. This opinion is validated in Murata (2010, p. 578) that teaching and learning are a bidirectional exchange of learner nurses' ideas, experiences, and content in a meaningful way

facilitated by an educator. This principle makes it easy for a learner nurse to ask a question when something is unclear. A clinical facilitator should communicate clinical progress of learner nurses. According to Hamid and Mahmood (2010, p. 224), providing feedback to learner nurses develop them academically while simultaneously developing the tutors' expertise. Without communicating feedback, learner nurses may have a skewed idea about their progress, especially when the focus solely remains on allocating marks.

2.7.11 Respect for learners as decision makers

Adult learners desire to be decision makers; however, they are rarely given the opportunity of being decision makers during either classroom learning or clinical practice (Po-ying, 2007, p. 225). Once they are given the opportunity to set goals, understand their needs, experiment with different ways of learning, and select suitable strategies according to their own areas of strength, they actually are capable of deciding what would improve the quality of their learning.

Clearly, becoming familiar with adult learning principles forms part of effective educator / facilitator leadership; the principles involve an understanding of effective adult learning strategies. With an adult learner programme, clinical facilitators move to a less structured learning approach, more responsibility, and less direct facilitation at an appropriate pace that is commensurate with the maturity level of each learner nurse.

2.8 CONCLUSION

In this chapter, the researcher provides an account of the literature review about the leadership styles of clinical facilitators and the maturity levels of learner nurses in the clinical learning environment. The literature review guides the related issues of leadership, teaching and learning in a clinical learning environment, teaching approaches, the complexity of the clinical learning environment, and adult learning principles.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research methodology. According to Lobiondo-Wood and Haber (2006, p. 567), research methodology is the controlled investigation and extent of collecting and analysing data. This includes an explanation of the research design, the population and sampling of the respondents, and the instrument for collecting data. The role of the researcher is defined. This study focused on the relationship between the leadership style of the clinical facilitators and the maturity level of learner nurses in the clinical learning environment.

3.2 PARADIGM AND RESEARCH APPROACH

A *paradigm* is the fundamental assumptions and intellectual structure upon which research and development in a field of inquiry is based (Polit & Beck, 2004, p. 13). In this study, the researcher departed from the philosophical premise of positivism. Firstly, a positivist paradigm is deep-rooted in defining an accessible population of interest and secondly, it allows a researcher to generalise the findings obtained from studying a sample of the population by using statistical techniques to determine the likelihood that sample findings are likely to apply to that accessible population. According to Terre Blanche, Durrheim and Painter (2011, p. 140), a researcher who employs a quantitative research approach surmises that the best way of measuring research variables is through assigning figures according to a set of rules to describe the gravity of an attribute that each variable possesses. A descriptive, non-experimental approach was employed in this study to explore and describe the relationship between the leadership styles of the clinical facilitator and the maturity level of the learner nurses in a clinical learning setting.

3.3 RESEARCH QUESTIONS

The following research questions directed the study:

- What is the leadership style used by the clinical facilitators in the clinical learning environment of learner nurses?
- How mature (able and willing) are the learner nurses to make decisions in the clinical learning environment?
- What is the relationship between the leadership style of the clinical facilitator and the maturity level of the learner nurses in the clinical learning environment?

3.4 RESEARCH DESIGN

A *research design* is a blueprint, or outline for research processes with the purpose of exercising maximum control over factors that could interfere with the validity of the results (Babbie & Mouton, 2011, p. xxvi). A research design seeks to investigate a research problem; it guides the planning and implementation of a study. This study applied an *exploratory*, *descriptive*, and *comparative* design to interrogate the relationship between the leadership style of clinical facilitators and the maturity level of learner nurses. A quantitative approach measures objective evidence (De Vos, Strydom, Fouché & Delport, 2005, p. 102). Quantitative research measures data of any dimensions (De Vos *et al.*, 2005, p. 132). It uses numbers that rely on objective means of collection of data with the result that a researcher and human influences are separated from each other (Polit & Beck, 2004, p. 15-16).

The results of a study address the hypothesis in the context of the relationships among the theoretical concepts that are derived from research questions. *Hypothesis* is an educated prediction about the manner in which the variables are likely to be interrelated (Terre Blanche *et al.*, 2011, p. 209). It originates from the theoretical framework of a study. The study departed from a *null-hypothesis* that stated: "There is no relationship between the leadership style of facilitators and the maturity level of learner nurses in the clinical learning".

An *exploratory* design takes a closer look at whether a phenomenon exists (Costello, 2013, p. 2). Whatever it discovers provides an insight into a newly investigated phenomena or into areas of interest about which little is known (Bezuidenhout, 2011, p. 50). An exploratory design provides a better understanding of a sample that has been examined (Daniel, 2010, p. 52). In this study, the researcher wanted to establish whether the leadership style of clinical facilitators and the maturity level of learner nurses were related.

A *descriptive* design describes the phenomena and provides an accurate account of characteristics of a particular individual, event, or group in real life situations, as well as the relationship among the variables (Brink, 2008, p. 201). This study aimed at describing the relationship between the leadership style of clinical facilitators and the maturity level of learner nurses in clinical practice. A *comparative* design describes variables, as well as the differences among groups (Brink *et al.*, 2012, p. 114). In this study; the comparative design sought to identify the differences between variables in relation to the 2nd, 3rd, and 4th year levels clinical facilitators and their learner nurses.

3.5 POPULATION AND SAMPLING

3.5.1 Population

Population refers to individuals who have specific characteristics in common that are of interest to a researcher (De Vos, Strydom, Fouché & Delport 2009, p. 193). Individuals who participate in research should meet the sample criteria for inclusion in the research study (Burns & Grové, 2007, p. 549). An *accessible population* refers to all members of a population who match the selected criteria and who are accessible as respondents of the study (Polit & Beck, 2008, p. 338). The accessible population included in this study was female and male learner nurses in their 2nd year, 3rd year and 4th year of study (N = 614) and their clinical facilitators (N = 30) at a university in the Western Cape Province (Table 3.1).

The learner nurses were pursuing a four year baccalaureate degree in nursing that leads to registration as a nurse (general, psychiatric and community) and midwife, according to Regulation 245 of the SANC, 1985.

3.5.1.1 Setting

Clinical learning at the university consisted of the clinical skills laboratory (CSL) that enabled the learner nurses to practice procedures before real application and hospital placement for real practical experience. Godson, Wilson and Goodman (2007, p. 942) consider CSL as a good way of learning, since it happens in a safety environment and builds confidence.

Learner nurses were placed at different hospitals and the clinical facilitator rotated amongst these hospital wards for daily following ups on clinical practica. For clinical practica, 2nd year level learner nurses were placed twice a week for the duration of the year, 3rd year level learner nurses were placed three times a week, and 4th year learner nurses placed four times a week, during the year.

The clinical facilitators involved in the education and training of learner nurses were males and females with different educational qualifications. Each clinical facilitator in the study setting guided 8 – 35 learner nurses in clinical practice.

Table 3.1: Accessible population

Year of study	Accessible population Learner nurses	Accessible population Clinical supervisors
2nd year	245	18
3rd year	227	7
4th year	169	5
Total	**641**	**30**

3.5.2 Sampling and sample

3.5.2.1 Sample size

The formula of Bartlett, Kotrlik and Higgins (2001, p. 43-44) was used to determine the total sample size of each of the three strata, i.e. year levels of learner nurses for the study.

$$n \geq \frac{N \times Z^2_{\alpha/2} \times p \times q}{(N-1) \times d^2 + Z^2_{\alpha/2} \times p \times q}$$

The small letter *n* is the required sample size, *N* is the population of the study, and *d* is the level of precision set at 3%. The distribution over population is normally denoted by Z-test, level of significance, α = 5%, *Zα/2* = 1.96, margin error *d* = 0.03, probability that learner nurses answering correctly to the instrument *p* = 50%, and the probability of not answering *q* = 50%.

Calculations using the abovementioned formula yielded the sample size required.

3.5.2.2 Sampling method

Twenty-three clinical facilitators agreed to participate in the study.

Proportional stratification is the process of establishing sample sizes for each subgroup independently to represent the same proportion between population and sample of each stratum (Fowler *et al.*, 2005, p. 11). The learner nurses were grouped according to year level of study, called *strata.* Random sampling was

performed independently for each stratum by creating a frame list; printouts of class lists were obtained of learner nurses registered for the four year programme at the university at every year level, and samples were systematically selected from a random table by using a sampling interval number of two. In this manner, representativeness of the sample was created and sampling errors were reduced (Green & Thorogood, 2009, p. 118). According to Gupta, Sud and Parsad (n.d., p. 299), when strata vary considerably, it is advantageous to sample each group independently because it assures that members of larger strata have the same probability of being included in the sample than the ones in smaller strata. The following formula was used to determine the number of learners to be included from each stratum (Gupta, Sud & Parsad, n.d., p. 299):

$$n_i = (N_i \div N)n,$$

where n_i was the sample size for stratum i, N_i was the population size for stratum i, N was total population size, and n was total sample size. Here, n was the total sample size of all the strata.

The strata were mutually exclusive, which meant that every learner nurse who was systematically selected from the population was assigned to not more than one stratum, i.e. either 2nd, 3rd, or 4th year level. The final sample size is illustrated in Table 3.2.

Table 3.2: Number of selected learner nurses and volunteer clinical facilitators

Year of study	Learner nurses (n = 420)		Clinical facilitators (n = 23)		
	Sample	Returned questionnaires	Sample (learner nurse questionnaires distributed to 23 clinical facilitators)	Returned questionnaires (from 23 clinical facilitators)	
				Number of learner nurse questionnaires n = 420	No of facilitators (n = 23)
2nd year	161	156	161	156	14
3rd year	147	144	147	144	6
4th year	112	107	112	107	3
Total	**420**	**407**	**420**	**407**	**23**

Of the 30 clinical facilitators, 23 indicated their willingness to participate in the study (Table 3.2).

According to Bauer (2009, p. 103), "statistics provides tools for comparing randomly drawn samples including at least thirty (30) cases and that these probability based comparisons are made possible by the special characteristics of normally distributed data".

However, each facilitator who had taken part completed a questionnaire for each of the students they supervised (Table3.2). The number of instruments distributed to learner nurses were (n = 420) and a similar amount to the 23 clinical facilitators (n = 420). These larger stratified samples minimised the non-response factor. Clinical facilitators committed to completing the questionnaires of the learner nurses within a month. Student numbers were entered on the questionnaires. Only the matching questionnaires (same student number on facilitator and student questionnaire) were included in the final sample.

3.5.3 Eligibility criteria

An *eligibility criterion* refers to a researcher explicitly stating the precise specific characteristics respondents should have for either inclusion in or exclusion from a study (Polit & Beck, 2012, p. 274; Johannes, Kim Le, Zhou & Johnston, 2010, p. 1231).

Criteria for inclusion and exclusion for this study were;

(a) Inclusion criteria

Learner nurse

- Male and female learner nurses at 2nd, 3rd, and 4th year level of study at the university.
- Learner nurses had to be registered with the university before data collection started.
- Only learner nurses who were placed in clinical practice at the time of data collection could respond.

Clinical facilitator

- All clinical facilitators (male and females) who accompanied learner nurses on daily basis.

(b) Exclusion criteria

Learner nurse

- Learner nurses who were not currently registered at the university.

Clinical facilitator

- Clinical facilitators who were not accompanying the learner nurses on a daily basis.

The sample was drawn after permission had been granted by the school of nursing to proceed with data collection for the study.

Four hundred and seven (97% of 420) instruments from learner nurses were analysed, since 13 instruments were either not returned by a learner nurse or a clinical facilitator. With a response rate of 77%, twenty-three (n = 23) of the 30 clinical facilitators participated in completing their 407 learner nurse questionnaires.

3.6 METHOD

In this study, a survey was conducted. A *survey* is a group of methods that applies to quantitative analysis (Grové, Burns & Gray, 2013, p. 224). The benefits of surveys are that they can accurately document outcomes and define associations among variables in a sample, and with survey data a researcher is able to draw reasonable conclusions of the existing situation in an effort to reduce bias (Glasow, 2005, p. 1). With a survey, a researcher is able to obtain information from a sample of the population that can usually be generalised to the population (Scott & Mazhindu, 2011, p. 28).

3.7 RESEARCH INSTRUMENT (QUESTIONNAIRE)

In this study, a self-administered structured instrument was used as a research instrument (Bezuidenhout, 2011, p. 52). *Self-administered* means that a researcher provides an instrument to respondents to complete on their own and in their own time, with the aim of returning it to the researcher (Head, Stansfeld, Ebmeier, Geddes, Allan, Lewis & Kivimaki, 2013, p. 2-3). A self-administered instrument was considered cost-effective to administer and convenient, since respondents completed their questionnaires individually and without supervision.

Literature also indicates that self-administered questionnaires are valid data collection instruments for younger and middle aged respondents (Head *et al.*, 2013, p. 2). The term "structured*"* refers to fixed items that are a series of questions or scales with pre-coded response options from which respondents can choose

(Grové *et al.*, 2013, p. 425-426). The instrument used for this study was developed from a literature review (Chapter 2). Borg and Al-Busaidi (2011, p. 284) confirm that to develop a questionnaire / instrument, a researcher has to conduct an intensive literature search. Despite limited time and resources and after ensuring validity and reliability, the use of a questionnaire as an instrument benefits a research project, since it enables a researcher to confidently collect data of a high quality (Evans & Rooney, 2014, p. 258-259). A survey instrument makes it possible to conduct a study in a short time period, is practically easy to administer, and the data gathered could be easily analysed (Thompson, 2010, p. 49). Survey questionnaires offer complete anonymity. *Closed-ended questions* were used in the instrument of this study to explore and describe the leadership styles of the clinical facilitators and the maturity level of learner nurses in the clinical learning environment. This type of questions / items provides respondents with an opportunity to select an option that best describes their point of view (Eiselen, Uys, & Potgieter, 2005, p. 6).

3.7.1 Design and content of a questionnaire as a research instrument

Due to the different roles that learner and facilitator respondents play in clinical learning, the researcher made use of two instruments with the same content to compare the relationship between leadership styles of the clinical facilitators and the maturity level of the learner nurses in the clinical learning. A similar instrument was developed for the clinical facilitators (Annexure D) and for the learner nurses (Annexure E). The instruments consisted of two parts; Sections A and B that had to be completed by indicating a response with a cross (X) in the appropriate box.

Section A sought to obtain biographical and demographic information. Learner nurses had to complete five items with reference to gender, age group, home language, year of study, and whether a learner had repeated any academic year. *Section A* of the instrument for the clinical facilitators, had six items that sought to obtain information about gender, age, highest qualification, training workshops attended, home language, and the years of experience in clinical facilitation of learner nurses.

Section B of the learner nurses' instrument assessed the maturity level in decisions making, and for the clinical facilitators it assessed the leadership style applied for the level of maturity of each learner nurse in clinical practice based on the following theoretical constructs:

- Telling leadership style – suitable for learners who are new or inexperienced and need a lot of assistance, direction, and support to complete an assigned task. Structure and guidance to the learner nurse come from the facilitator who directs him / her in respect of what, how, when, and where to do various tasks (maturity refers to unable and unwilling).

- Selling leadership style – where the main function of the facilitator is to provide assistance to learners executing a task who lack the skills for that task. With the facilitator's direction and guidance, learners are coached in the skills of the task. Direction and supervision are the key components of this style of leadership while the facilitator is encouraging and motivating the learner (maturity refers to willing but do not have skills).
- Participatory leadership style – where learners have the capability to perform a task. However, the learner may be reluctant to start or complete the task. In this leadership style, both the learners and the facilitator as a leader contribute to the decision-making process and implement the decisions collaboratively. The facilitator emphasises relationships and individuals' feelings. The leader provides moral support and encouragement and acts as a resource person and assistant (maturity refers to able but unwilling).
- Delegation orientated leadership style – requires the facilitator as a leader to delegate tasks, since the learner nurse is capable and willing to assume accountability for directing his / her own behaviour. The leader trusts the learner to perform his / her learning role and observes from a distance. The learner nurse is motivated and self-driven and the facilitator remains available whenever the situation calls for assistance (maturity refers to able and willing).

Based on the theoretical constructs of the study, the ordinal 4-point scale of the instruments read as follows:

The learner nurse:

1. unable and unwilling to;
2. willing but do not have skills to;
3. able but unwilling to; and
4. able and willing to.

The clinical facilitator:

1. tells the nursing student how to;
2. guides the student in the process of how to;
3. supports the nursing student to; and
4. is available when the nursing student asks.

Below are examples of how instruments were completed by each group respectively:

Table 3.3: Scale of instrument – learner nurse

The relationship of the nursing student with the clinical facilitator					
		Maturity level			
	I, as the nursing student is	Unable and unwilling to	Willing but do not have skills to	Able but unwilling to	Able and willing to
		1	2	3	4
1	Establish a continual relationship with the clinical facilitator for teaching and learning in clinical practice.	X			

Table 3.4: Scale of instrument – clinical facilitator

The relationship of the clinical facilitator with the nursing student					
		Leadership style			
	I, as the clinical facilitator	Tells the nursing student how to	Guides the nursing student through the process of how to	Supports the nursing student to	Is available when the nursing student asks
		1	2	3	4
1	Establish a continual relationship with the nursing student for teaching and learning in clinical practice.	X			

The 4-point scale of the instruments enabled the researcher to compare the responses of the learner nurses and clinical facilitators. The items in Section B of the instruments addressed:

- the relationship of the clinical facilitator and the nursing student (Items 1 to 8);
- teaching and learning activities (Items 9 to 21);
- teaching techniques / principles (Items 22 to 29); and
- clinical practice (Items 30 to 32).

There were a total number of 32 items in Section B that both the learner nurses and the clinical facilitators had to respond to.

3.8 DATA COLLECTION

3.8.1 Permission and preparation of the field

Access to the learner nurses and clinical facilitators was gained after the research proposal had been approved by the Senate Higher Degree and Ethics Committee of a university in the Western Cape Province (Ethical clearance number 12/9/24). The sample was drawn after receiving a permission letter from the Director of the School of Nursing to continue with the study. The 2nd, 3rd and 4th year learner nurses were identified in the first month after registering for their new academic year at the beginning of 2013.

Preparation of the field meant that the researcher had to carefully plan the collection of data in the setting with the purpose of ensuring a high response rate (Hertel, Singer & Van Cott, 2009, p. 305-306). It involved establishing an affiliation with year level coordinators and lecturers where the data collection was going to take place to ensure the cooperation of the respondents. The researcher had to answer questions; such as:

- Where the data would be gathered?
- How would it be possible for all the respondents to get the instrument in the same way?
- Was confidentiality ensured?
- Whom should respondents contact when respondents need a question clarified?

Meetings were arranged with the year level coordinators and lecturers to meet learner nurses and clinical facilitators to explain the study, its purpose, and rights of the respondents. The voluntary nature of participation in the study was explained to all respondents in an information sheet. Therefore, respondents could decide whether to take part or not. Respondents were informed that it would take 30 minutes to complete an instrument.

3.8.2 Pretesting of the instrument

Instrument pretesting is an evaluation process that seeks to establish whether there are any ambiguities in the construction of an instrument for a study (Dawson, 2010, p. 100). According to Bezuidenhout (2011, p. 55), the essence of the process is to comment on the structure and reveal whether respondents will understand the instructions and whether any confusing questions are asked that may affect the response rate from respondents (Polit & Beck, 2012, p. 296). The researcher opportunely chose five learner nurses from each year level and two clinical facilitators; one of the clinical facilitators was from 2nd year level while

the other one was from 4th year level to complete and comment on the constructed instrument. The reason for including 2nd and 4th year clinical facilitators in the pretesting was that they were able to assess appropriate language terms for the learner nurses' year level, since the university had a diverse learner nurse population in terms of language proficiency. Their recommendations had been of an editorial nature and the final instrument was adjusted accordingly. Consequently, respondents who had taken part in the pretesting of the instrument were excluded from the main study.

3.8.3 Gathering of data

The identification of respondents and the defined systematic gathering of information relevant to the research purpose, objectives, and questions of the study are termed data gathering (Dawson, 2010, p. 98). The researcher had gathered data during the 2nd term of 2013 by means of a similarly structured, self-administered and hand delivered instrument. Instruments were coded beforehand to match clinical supervisors and learner nurses.

The researcher was allocated time by the lecturers involved during their lectures on a specific day to explain the research study and to issue instruments to learner nurses. Some learner nurses completed the instrument at the time; an opportunity was provided to the other ones to complete the instrument at home and to return them the following day in enclosed sealed envelope. De Vos *et al.* (2009. p. 168) recommend that instruments should be collected within 48 hours in order to save time.

However, clinical facilitators were allowed a period of one month to complete the instrument, since they had to complete one for each responding learner nurse. Each clinical facilitator was provided with the number of instruments and envelopes equivalent to the learner nurses they facilitated. Returning the instruments in sealed envelopes was arranged and agreed upon with each clinical facilitator. The period of collection had to be extended for some clinical facilitators owing to the larger number of learner nurses under supervision.

3.9 DATA ANALYSIS

Data analysis is the systematic organisation and synthesis of research data and, in quantitative studies, the testing of hypotheses using that data (Polit & Beck, 2012, p. 725). It is a way of working with lots of figures by putting them into rows and columns to make them workable for the statistician / researcher (Grové *et al.*, 2013, p. 45). Data analysis relies on the research questions, purpose, and conceptual framework of the study (Speziale & Carpenter, 2003, p. 218). With the assistance of a statistician at a university in the Western Cape, the instrument items were analysed using the SPSS Version 21 software program. *Descriptive*

statistics are statistical procedures used to describe or summarise numerical observations and to make sense of a set of scores (Boslaugh, 2013, p. 83). In this study, data was reported as frequencies (f), mean values ($\bar{x}$) percentages (%), and standard deviations (SD) (Brink *et al.*, 2012, p. 172).

Frequency distribution is a description of variables providing a count of the number of cases that fall into each of the categories of a variable (Daniel, 2010, p. 22). It is used to get a rough idea of results. The *mean* value is a measure of central value for a continuous variable given for a sample of observations, by the sum of the observations divided by the number of observations (Bauer, 2009, p. 88). In this study, mean values provided the mathematical basis for comparing two distributions; one for learner nurses and another one for clinical facilitators. A *standard deviation* (SD) is a statistical measure of accuracy for a series of repetitive measurements (Bauer, 2009, p. 91). SD expresses the dispersion (percentile) of values within a set of observations (Everitt, 2003, p. 205). The lower the value of SD, the higher the precision, since data is more densely concentrated around mean. The higher value of SD indicates that the data points are spread out over a large range of values and said to have a low level of precision.

Inferential statistics are a method that permits to confirm or reject a hypothesis (Field, 2009, p. 49). It is used to draw conclusions about the reliability and generalizability of the findings and allows the researcher to infer from data by analysing the relationship between two variables (Sha, 2007, p. 81). In this study, the inference focused on whether there was a relationship between the leadership style of the clinical facilitators and the maturity level of learner nurses.

The approach of the Central Limit Theorem (CLT) was used to motivate the use of the Pearson coefficient. According to this approach, if the population is non-normal, then the sampling distribution of $\bar{x}$ is approximately normal only for values of *n*. A small sample is sufficiently large to use the normal distribution as an approximation for the sampling distribution of $\bar{x}$. Therefore, the set of all sample means of size *n* will be normally distributed (Department of Statistics and Population Studies. Study guide: Introductory Statistics. Faculty of Natural Science. University of the Western Cape, 2012).

The Pearson Product Moment Correlation was used to show the linear relationship between the two sets of data. The letters "r" was used when referring to a sample. The correlation coefficient measured the strength between two correlated variables. Depending on the sign of the coefficient correlation, the correlation might be either positive or negative. The coefficient correlation is between -1 and 1. With regard to statistical significance, the p-value that needs to be less than 5%. With regard to the interpretation of the correlation coefficient (r) and the null-hypothesis, there is:

- no relationship between two variables if r = 0;

- a weak and positive relationship between two variables if r is positive and between 0.1 to 0.49;
- a moderate and positive relationship between two variables if r is positive and between 0.5 to 0.69;
- a strong and positive relationship between two variables if r is positive and between 0.7 to 0.79;
- a very strong and positive relationship between two variables if r is positive and between 0.8 and 0. 9; and
- a perfect and positive relationship between two variables if r is positive and equal to 1.

When the p-value is less than 0.05, then the interpretation is made that there is a statistically significant moderate and positive correlation between variable X and variable Y.

3.10 VALIDITY AND RELIABILITY

According to Grové *et al.* (2013, p. 45), the notion of measurement in research and standards demonstrated by a researcher of a study create confidence in the reliability and validity of the findings (Chapter 1). *Validity* according to Davis and Ponnamperuma (2005, p. 281) is the extent to which the instrument assesses and measures what it intends to measure. In the context of this study, validity was the extent to which the developed instrument assessed the leadership style of the clinical facilitator and the maturity level of the learner nurse in the clinical learning environment (Schuwirth, 2004, p. 17). In the instrument, the researcher took care to state relevant items to the respondents in a clear and an unambiguous manner. The instrument was developed from the literature review with the guidance of the supervisor and a statistician. It was evaluated whether the instrument measured what it was supposed to measure on a 4-point scale: The relationship between the leadership styles of clinical facilitators and the maturity level of the learner nurses in the clinical learning environment.

Face and content validity was also evaluated by five experts (lecturers) in nursing science. Face validity refers to the appearance of an instrument to adequately obtain the desired information. Content validity is the extent to which a questionnaire covers all the information that was required to be measured. The questionnaire included items that measured the constructs of leadership styles and maturity level in clinical practice.

Reliability was ensured by pretesting the instrument with five respondents from learner nurses and two clinical facilitators that were not part of the main study. It assisted the researcher to reformulate some items as efficiently as possible (Jasper, 2011, p. 1051). The reliability of this questionnaire was increased by the inclusion of items that strongly correlated with the variables being measured. The questionnaire was easy to use, which reduced the chances of the respondents becoming tired or frustrated while completing the questionnaire. It enhanced consistency of answers by all respondents and a higher rate of participation

(Goddard & Melville, 2001, p. 47). Most of the components obtained a Cronbach's alpha (α) value above the acceptable standard value of .7 (Table 3.5). Inter-rater reliability was maintained by the use of similar questionnaires distributed to clinical facilitators and the learner nurses (Burns & Grové, 2005, p. 375). In this study, there was limited scope for random error by the researcher due to the questionnaire being self-administered; its completion did not require any direct researcher involvement.

Reliability means consistency / stability in data collection (Boursicot & Roberts, 2005, p. 18). In other words, the degree to which items measured the same underlying construct. Table 3.5 presents the areas of focus in the instruments with high obtained Cronbach's alpha values.

Table 3.5: Cronbach's alpha on components of the research instrument

Sections of the instrument	Learner nurse Cronbach's alpha (α)	Clinical facilitator Cronbach's alpha (α)
The relationship of the learner nurse and the clinical facilitator (8 items).	.808	.876
Teaching and learning approach of a learner nurse (13 items).	.868	.926
Teaching methods of a learner nurse (8 items).	.820	.845
Learner nurse clinical practice (3 items).	.613	.824

Most of the components obtained a Cronbach's alpha (α) above the acceptable standard value of .7.

A slightly lesser Cronbach's alpha of .613 was obtained for the component of a learner nurse in clinical practice (Table 3.4). According to Pallant (2011, p. 100) to adjust the error, the researcher had to check for incorrectly scored items and might consider removing items with low item-total correlations. The mean inter-item correlation for 3 items in the last component of the instrument was .377 with values ranging from .363 to .392, which was acceptable because the optimal range for the inter-item correction could be .2 to .4 (Pallant, 2011, p. 97). Items were thus not removed, since they were related.

3.11 CONCLUSION

This chapter describes the research methodology, purpose, objectives, as well as reliability and validity of the study. The role of the researcher is explained. The obtained and analysed data is presented in Chapter 4.

CHAPTER 4
PRESENTATION OF RESULTS

4.1 INTRODUCTION

The purpose of the study was to explore and describe the relationship between the leadership style of the clinical facilitator and the maturity level of the learner nurses in a clinical learning environment. This chapter seeks to answer the following questions:

- What is the leadership style used by the clinical facilitators in the clinical learning environment of learner nurses?
- How mature (able and willing) is the learner nurse to make decisions in the clinical learning environment?
- What is the relationship between the leadership style of the clinical facilitator and the maturity level of the learner nurses in the clinical learning environment?

The results are presented as:

- Section A: Biographical and demographical information of the respondents.
- Section B: Leadership style of the clinical facilitators and maturity level of the learner nurses, with reference to the:
    - relationship between the facilitator and the learner;
    - teaching and learning activities of the learner nurse;
    - teaching techniques / principles for learner nurse; and
    - learner nurse's clinical practices.

4.2 SECTION A: BIOGRAPHICAL AND DEMOGRAPHIC INFORMATION

4.2.1 Gender of respondents

The learner nurses represented more female learner nurses (n = 331, 81.3%) than male learner nurses (n = 76, 18.7%) (Table 4.1). It is known that nursing is a female-dominated profession (Ozdemir & Akansel, 2008, p. 153).

Table 4.1: Gender of learner nurses

Gender	n	%
Male	76	18.7
Female	331	81.3
Total	407	100.0

Table 4.2 shows a similar trend as amongst learner nurses. The majority of clinical supervisors (n = 19, 82.6%) was female.

Table 4.2: Gender of clinical facilitators

Gender	n	%
Male	4	17.4
Female	19	82.6
Total	**23**	**100.0**

These results affirms the notion claimed by Kessels and Steinmayr (2013, p. 233-235) that a lack of male role models could be perpetuating the gender gap in favour of female nurses in general. The other possible reason could be that males who enter nursing are questioned about their masculinity or sexuality; sociologists describe the sex role socialisation as "instrumental" for men and "expressive" for women (Ozdemir, Akansel & Tunk, 2008, p. 154).

Table 4.3 depicts the gender distribution of learner nurses according to the three academic year levels. A female majority was found at all year levels. However, the female majority was more pronounced among the 3rd year learner nurses (n = 125, 86.8%).

Stott (2007, p. 25) emphasises that nursing is a traditionally and predominantly female profession, and Ozdemir, Akansel and Tunk (2008, p. 154) say the profession has failed to attract male recruits. However, the fact that more than a 10 per cent of the learner nurses on the different year levels were represented by males was an encouraging sign.

Table 4.3: Gender of learner nurses and year of study

Year of study	Gender					
	Female		Male		Total	
	n	%	n	%	n	%
4th year	82	76.6	25	23.4	107	100.0
3rd year	125	86.8	19	13.2	144	100.0
2nd year	124	79.5	32	20.5	156	100.0

Eswi and Sayed (2011, p. 94) confirm that the number of males entering the nursing profession has increased globally although they remain a minority group in the nursing profession (Meadus & Towmey, 2011, p. 269).

In terms of Table 4.4, female clinical facilitators were the majority in all year levels. At 2nd year level, female facilitators were 11 (47.8 %) compared to 3 (13.0%) males. Furthermore, at 3rd year level, female clinical facilitators were 5 (21.8%) while males in the same level were represented 1(4.4%). No male clinical facilitators were represented at 4th year level.

Table 4.4: Clinical facilitator gender by year level

Gender	Clinical facilitator year level						Total	
	2nd Year		3rd Year		4th Year			
	n	%	N	%	n	%	n	%
Male	3	13.0	1	4.4	0	0.0	4	17.4
Female	11	47.8	5	21.8	3	13.0	19	82.6
Total	**14**	**60.8**	**6**	**26.2**	**3**	**13.0**	**23**	**100.0**

4.2.2 Age of respondents

Table 4.5 indicates that nearly half of the learner nurses were ≥ 23 years of age (n = 178, 43.7%). The admission policy of the university at which the study was conducted, states that at this age learners are mature to learn (www.uwc.ac.za Documents admission policy UWC 2010.pdf). However, 229 (56.3%) of the 407 (100.0%) learners were younger than 23 years of age.

Table 4.5: Age of learner nurses

Age of learners											
≤ 19 years		20 years		21 years		22 years		≥ 23 years		Total	
n	%	n	%	n	%	n	%	n	%	n	%
21	5.2	75	18.4	74	18.2	59	14.5	178	43.7	407	100.0

The majority of 19 (82.6%) clinical supervisors were ≥ 29 years of age (Table 4.6). It is assumed that a clinical facilitator has to be somebody with experience and maturity. Maturity is not only observed at one's task level but one's age could also relate to responsibility and commitment (Hougton & Yoho, 2005, p. 66). Only 2 (8.7%) of the clinical facilitators were ≤ 25 years.

Table 4.6: Ages of clinical supervisors

Age	n	%
≤ 25 years	2	8.7
26 years	2	8.7
27 years	0	0.0
28 years	0	0.0
≥ 29 years	19	82.6
Total	**23**	**100.0**

Female learners' domination was found in all age groups (Table 4.7). Male nurses are likely to remain nursing minority for many years to come (Dyck, Oliffe, Phinney & Garrett, 2009, p. 649). The majority of females were 19 years or less (n = 20, 95.2%) while males were more in the age group 23 years and above (n = 45, 25.3%).

Table 4.7: Learner nurses age by gender

Gender	Age									
	≤ 19 years		20 years		21 years		22 years		≥ 23 years	
	n	%	N	%	n	%	n	%	n	%
Male	1	4.8	6	8.0	11	14.9	13	22.0	45	25.3
Female	20	95.2	69	92.0	63	85.1	46	78.0	133	74.7
Total	**21**	**100.0**	**75**	**100.0**	**74**	**100.0**	**59**	**100.0**	**178**	**100.0**

Table 4.8 shows that most supervisors were ≥ 29 years of age. However, the majority of 15 (65.2%) were female supervisors and male supervisors represented 17.4% (4). The result may emphasise the former point that a clinical supervisor should be a mature and responsible person. Two (8.7%) of both groups of respondents indicated that they were respectively < 25 years and 26 years of age. No respondents were represented at the age of 27 years and 28 years of age (n = 0, 0.0%).

Table 4.8: Age of clinical supervisors by gender

Gender	Age of clinical facilitator %										Total	
	< 25 Years		26 Years		27 Years		28 Years		≥ 29 Years			
	n	%	n	%	N	%	n	%	n	%	n	%
Male	0	0.0	0	0.0	0	0.0	0	0.0	4	17.4	4	100.0
Female	2	8.7	2	8.7	0	0.0	0	0.0	15	65.2	19	100.0
Total	**2**	**8.7**	**2**	**8.7**	**0**	**0.0**	**0**	**0.0**	**19**	**82.6**	**23**	**100.0**

4.2.3 Academic year levels

Table 4.9 depicts the three academic year levels of the learner nurses. Second year level represented the most (n = 156, 38.3%) learner nurses followed by the third year level (n = 144, 35.4%), and then the fourth year level learners (n = 107, 26.3%). It seemed that as the programme advanced the percentages of the learner nurses decreased. There were challenges faced by learners; such as poor academic performance, psychological variables (e.g. lack of motivation), and an inability to successfully perform a particular task

(Peterson, 2009. p. 421-413). All these challenges were reported as causes that might lead to learner nurses not to progress sufficiently to complete their training programme.

Table 4.9: Academic year level of study of learner nurses

Year	n	%
2nd year	156	38.3
3rd year	144	35.4
4th year	107	26.3
Total	**407**	**100.0**

Table 4.10 portrays the allocation of clinical facilitators to the year levels. Second year level had the most clinical facilitators (n = 14, 60.9 %), followed by clinical facilitators allocated to the third year level (n = 6, 26%) and last, the fourth year level (n = 3, 13%). The reason to the decrease could be associated with the number of learner towards the end of their nursing programme (Table 4.9).

Table 4.10: Clinical facilitators by year level

Clinical facilitators by year level	n	%
2nd year	14	60.9
3rd year	6	26.1
4th year	3	13.0
Total	**23**	**100.0**

4.2.4 Repeaters during the nursing programme

Table 4.11 indicates that 89 (21.9%) of the 407 (100.0%) respondents had repeated a year during their studies. The highest percentage (n = 318, 78.1%) were non-repeaters, which indicated a successful performance outcomes for the school of nursing. Good performance of the learner nurses could be attributed to good leadership in clinical supervision and collaboration between clinical facilitators and learner nurses (Walker *et al.*, 2011, p. 743; Ngcobo & Tickly, 2008, p. 2). Another contributing reason could be the suitability of the teaching and learning methods that facilitators were applying (Harrington & Harrington, 2008, p. 70; Kadagad, 2013, p. 80). Sadeghi and Pihie (2012, p. 188) indicate that by motivating learners

and responding to their feelings a sociable atmosphere is created that assists them with succeeding in their learning (Lerret & Frenn, 2011, p. 379).

Table 4.11: Repeaters

Repeat year of study	N	%
Yes	89	21.9
No	318	78.1
Total	**407**	**100.0**

4.2.5 Language

Table 4.12 indicates that respondents were mostly isiXhosa (n = 178, 43.7%) and Afrikaans (n = 108, 26.5%) speaking. These statistics are congruent with those of the wider population of the Western Cape Province. Languages other than the official languages of South Africa were represented by 2 (0.5%), since the school of nursing also admitted international nursing students to their programme.

Table 4.12: Home language of learner nurses

Home language – learner nurses																			
English		**Afrikaans**		**isiZulu**		**isiXhosa**		**Sesotho**		**Sepedi**		**Setswana**		**siSwati**		**Others**		**Total**	
n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**N**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
86	21.6	108	26.5	16	3.9	178	43.7	11	2.7	1	0.2	3	0.7	2	0.5	2	0.5	407	100.0

More than a third (n = 9, 39.1%) of the 23 (100.0%) clinical facilitators highlighted that Afrikaans was their home language (Table 4.13). In addition, over a quarter (n = 7, 30.4%) of them indicated English as their home language. On the other hand, the ones who were isiXhosa speaking presented 6 (26.1%), which made isiXhosa the third most spoken home language of facilitators. IsiZulu speaking facilitators (n = 1, 4.4%) were the minority. Table 4.13 signals clearly that isiXhosa and Afrikaans are not the only languages spoken in the Western Cape Province.

Table 4.13: Home language of clinical facilitators

Home language – clinical facilitators									
English		Afrikaans		isiZulu		isiXhosa		Total	
n	%	n	%	n	%	n	%	n	%
7	30.4	9	39.1	1	4.4	6	26.1	23	100.0

4.2.6 Qualification of clinical facilitators

Table 4.14 depicts the highest qualifications that clinical facilitators had obtained. More than a third (n = 9, 39.1%) of the respondents respectively obtained either a Bachelor's degree in nursing or a postgraduate diploma in nursing education (PGD). Masters in nursing qualifications set (n = 3, 13%).

Table 4.14: Highest qualifications of clinical facilitators

Qualifications of clinical facilitator	n	%
3 Year General Nursing	0	0.0
3-4 Year Diploma in Comprehensive Nursing	1	4.3
B Degree in nursing	9	39.1
Post-graduate Diploma in nursing education	9	39.1
Master's degree in nursing	3	13.0
Doctorate degree	0	0.0
Others	1	4.3
Total	**23**	**100.0**

According to Zuzovsky (2003, p. 39), educator qualifications are associated with student achievement. Indeed, Table 4.14 shows that a need exist for facilitators to obtain post graduate qualifications as only 3 (13.0%) respondents obtained a Master's degree as highest qualification.

More female facilitators (n = 6, 26.1%) held a Bachelor's degree than their male counterparts (n = 3, 13%) (Table 4.15). While 9 (39.1%) female facilitators held PGD in nursing education, none of the male facilitators indicated that they held this qualification.

Table 4.15: Highest qualification by gender

Qualifications	Male		Female		Total	
	n	%	n	%	n	%
3-4 Year comprehensive nursing diploma	1	4.4	0	0.0	1	4.4
BCur in nursing	3	13.0	6	26.1	9	39.1
PGD nursing education	0	0.0	9	39.1	9	39.1
Master's degree in nursing	0	0.0	3	13.0	3	13.0
Others	0	0.0	1	4.4	1	4.4
Total	**4**	**17.4**	**19**	**82.6**	**23**	**100.0**

4.2.7 Workshop training attendance on clinical facilitation

The majority of nearly two thirds (n = 14, 60.9%) of clinical facilitators had not attended workshop training on clinical facilitation (Table 4.16). The ones who had attended were 9 (39.1%). It could be interpreted that the majority of facilitators were involved in clinical supervision of nursing students merely on the basis of clinical experience not on an applicable qualification. Nell (2007, p. 4-5) cites that in South Africa, there is no formal qualification for function of a clinical facilitator. Mostly supervisors were selected on the basis of their experience in clinical settings.

Table 4.16: Workshop training attendance

Workshop training attendance	n	%
Yes	9	39.1
No	14	60.9
Total	**23**	**100.0**

4.2.8 Experience of facilitators in supervision of learner nurses

Table 4.17 illustrates the experience of clinical facilitators in clinical supervision of learner nurses. In this item, over a quarter (n = 7, 30.4%) of clinical facilitators indicated that they had experience of less than 12 months while 4 (17.4%) indicated they had three years of experience. Also, 9 (39.1%) of the 23 facilitators responded that they had more than 4 years of experience in clinical supervision of learner nurses. These results showed that nearly three quarters (n = 16, 69.6%) of the facilitators had experience of more than a year, which could also explain the success of the learner nurses. According to Zuzovsky (2003, p. 41) the effect of educator experience on scholar learning have found a positive relationship between educators effectiveness and their years of experience even though the association observed was not always a significant one.

Table 4.17: Experience of clinical facilitators in supervision of learner nurses

Years of experience	n	%
< 12 months	7	30.4
1 year	0	0.0
2 years	3	13.1
3 years	4	17.4
≥ 4 years	9	39.1
Total	**23**	**100.0**

4.3 SECTION B: LEADERSHIP STYLE OF THE CLINICAL FACILITATORS AND MATURITY LEVEL OF THE LEARNER NURSES

This section provides an account of the leadership styles of clinical facilitator and the maturity level of 2nd, 3rd and 4th year learner nurses in clinical learning practice. The discussion follows the following components of the questionnaire:

- relationship of the clinical facilitator and the learner nurse;
- teaching and learning activities of a learner nurse;
- teaching techniques / principles for the learner nurse; and
- clinical practice of a learner nurse.

Each component is presented in a summary table comprising a description of the number of frequencies (f), percentages, mean values ($\bar{x}$), and standard deviations (SD) for each item in the questionnaire. After each of the items, where significant, the correlation coefficient (r) between the leadership style of clinical facilitator and the maturity level of the learner nurses for the item is indicated.

The following is the scale and interpretation of leadership style and maturity level;

Facilitator scale		**Interpretation of leadership style**
1	Telling …	Tell the learner
2	Guiding …	Selling
3	Supporting …	Participating
4	Available …	Delegating
Learner scale		**Interpretation of maturity level**
1	Unable to …	Immature
2	Willing but …	Somewhat mature
3	Able but …	Moderately mature
4	Able and …	Mature

The number of the responses to all the items referred to learner nurses (n = 407) and 23 clinical supervisors who had completed 407 questionnaires for the learner nurses allocated to them. *For purposes of the discussion n= will thus refer to the number of responses on an item, not the number of respondents answering an item* (as 23 supervisors answered 407 questionnaires).

4.3.1 The relationship between the facilitator and the learner nurse

Tables 4.18 and 4.19 indicate the responses of the clinical facilitators and the learner nurses to Items 1 – 8 in relation to the component about the relationship between the facilitator and the learner nurse. Table 4.20 indicates the significance of the relationship between the learner nurses and the clinical facilitators.

Table 4.18: The relationship between the facilitator and the learner nurse

	Responses of clinical facilitator	Leadership styles											
		Tells the nursing student how to:		Guides nursing student to:		Supports nursing student to:		Is available to:		Total		$\bar{x}$	SD
		Telling		Selling		Participating		Delegating					
		1		2		3		4					
	Items	n	%	n	%	n	%	n	%	n	%		
1	Establish a continual relationship with the nursing student for teaching and learning.	68	16.7	44	35.4	87	21.4	108	26.5	407	100.0	2.58	1.054
2	Sign a supervisory contract with the nursing student with regard to his / her clinical accompaniment.	79	194	88		140	34.4	100	24.6	407	100.0	2.64	1.055
3	Set goals to be obtained in teaching and learning in the unit.	59	14.5	116	28.5	129	31.7	103	25.3	407	100.0	2.68	1.008
4	Identify learning needs according to the clinical practice experience required.	34	8.4	128	31.4	134	32.9	111	27.3	407	100.0	2.79	0.938
5	Perform nursing duties in the clinical setting to fulfil individual nursing students' learning needs.	26	6.4	157	38.6	134	32.9	90	22.1	407	100.0	2.71	0.883
6	Communicate with a nursing student about his / her clinical progress in clinical practice.	54	13.3	98	24.1	124	30.5	131	32.2	407	100.0	2.82	1.031
7	Provide empathetic understanding of problems the nursing student experiences during clinical facilitation.	13	3.2	63	15.5	197	48.4	134	32.9	407	100.0	3.11	0.775
8	Interact with the clinically skilled role model who is involved in daily decisions, processes, protocols, and management of the unit.	49	12.0	127	31.2	120	29.5	111	27.3	407	100.0	2.72	0.995

Table 4.19: The relationship between the learner nurse and the facilitator

	Responses of learner nurse	Maturity levels											
		Unable and unwilling to:		Willing but not have the skills to:		Able but unwilling to:		Able and willing to:					
		1		2		3		4		Total		$\bar{x}$	SD
	Items	n	%	n	%	n	%	n	%	n	%		
1	Establish continual relationship with the clinical facilitator for teaching and learning in clinical practice.	8	2.0	43	10.6	44	10.8	312	76.7	407	100.0	3.62	0.752
2	Sign a supervisory contract with the clinical facilitator with regard to my clinical accompaniment.	31	7.6	59	14.5	65	16.0	252	61.9	407	100.0	3.32	0.984
3	Set specific goals to be obtained for my teaching and learning in the unit.	7	1.7	51	12.5	52	12.8	297	73.0	407	100.0	3.57	0.775
4	Identify my learning needs according to the clinical practice experience required.	2	0.5	43	10.6	40	9.8	322	79.1	407	100.0	3.68	0.679
5	Perform nursing duties in the clinical setting to fulfil my individual learning needs.	5	1.2	38	9.3	43	10.6	321	78.9	407	100.0	3.67	0.695
6	Communicate with the clinical facilitator about my progress in clinical practice.	9	2.2	40	9.8	50	12.3	308	75.7	407	100.0	3.61	0.753
7	Receive empathetic understanding of problems I experience during my clinical learning.	19	4.7	58	14.3	64	15.7	266	65.4	407	100.0	3.42	0.900
8	Interact with a clinically skilled role model who is involved in daily decisions, processes, protocols, and management of the unit.	18	4.4	65	16.0	63	15.5	261	64.1	407	100.0	3.39	0.908

Table 4.20: Significance of relationships between leadership styles and maturity levels in relation to the component relationships between learner nurses and clinical facilitators

No.	The relationship between learner nurses and clinical facilitators	Correlation *(r)*	p-value
1	Establish a continual relationship with the nursing student for teaching and learning.	0.07	0.191
2	Sign a supervisory contract with the nursing student with regard to his / her clinical accompaniment.	-0.05	0.364
3	Set goals to be obtained in teaching and learning in the unit.	0.09	0.069
4	Identify learning needs according to the clinical practice experience required.	0.11	0.022
5	Perform nursing duties in the clinical setting to fulfil individual nursing students' learning needs.	0.13	0.010
6	Communicate with the nursing student about his / her progress in clinical practice.	0.00	0.946
7	Provide an empathetic understanding of problems the nursing student experiences during clinical learning.	0.14	0.005
8	Interact with a clinically skilled role model who is involved in daily decisions, processes, protocols, and management of the unit.	0.12	0.016

4.3.1.1 Establish a continual relationship with the nursing student for teaching and learning (Item 1)

A good relationship enhances achievement of set goals and psychological well-being of nursing students (Deci *et al.*, 2006, p. 314) whereas the absence of a learner-facilitator relationship could obstruct clinical learning (Lofmark *et al.*, 2012, p. 165).

The facilitators had a lower mean value and wider distribution of responses ($\bar{x}$ = 2.58; SD = 1.054) than the nursing students ($\bar{x}$ = 3.62; SD = 0.725).

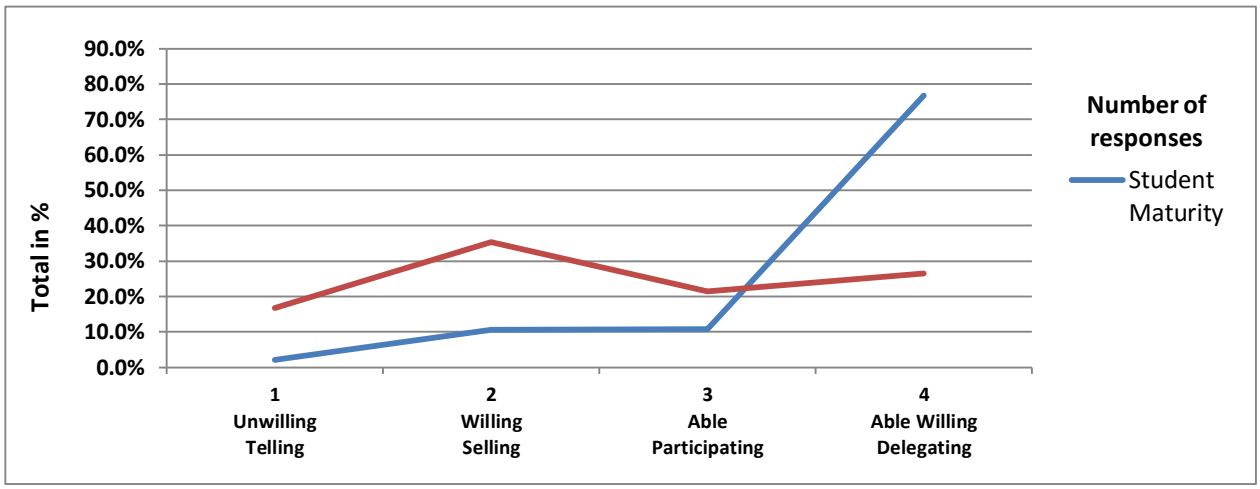

Figure 4.1: Establish a continual relationship with the clinical facilitator for teaching and learning in clinical practice (Item 1)

In Item 1, the highest rate of the responses of the learner nurses indicated that they were *mature* (able and willing) to make decisions to establish a continual relationship with the clinical facilitator for teaching and learning in clinical practice (n = 312, 76.7%). On the other hand, the highest rate of responses by the clinical facilitators indicated that they were using a *selling* style of leadership (guiding) for learner nurses to establish a continual relationship for teaching and learning in clinical practice (n = 144, 35.4%).

Furthermore, 68 (16.7%) of the responses of the clinical facilitators indicated that they *ordered* (telling style) learner nurses to establish a relationship in a clinical learning, while 8 (2.0%) of the learner nurses responses indicated that they were *immature* (unable and unwilling) to form a relationship in clinical learning environment.

Over a third (n = 144, 35.4%) of the 407 (100.0%) responses of the clinical facilitators indicated that they used *selling* (guiding) style of leadership for learner nurses (nursing students) to establish a good relationship for teaching and learning in the clinical learning environment. However, 43 (10.6%) of the 407 (100%) learner nurses responses indicated that they were *somewhat mature* (willing but did not have the skills) to establish this relationship.

Less than a quarter (n = 87, 21.4%) of responses of clinical facilitators indicated that they *participated* (support) with learner nurse to establish a relationship in a clinical learning environment while a tenth (n = 44, 10.8%) of the learner nurses' responses indicated they were *moderately mature* (able but unwilling) to establish a relationship in clinical placement.

A quarter (n = 108, 26.5%) of the responses of the clinical facilitators indicated that they used a *delegating* style of leadership (being available) for learner nurses to establish a continual relationship in the clinical learning environment; yet three quarters (n = 312, 76.7%) of the learner nurses' responses indicated that they were *mature* (able and willing) to establish a continual relationship with clinical facilitators in clinical learning.

The findings indicated no relationship between the leadership style of the facilitator and the maturity level of the learner nurse for establishing a continual relationship with the clinical facilitator for teaching and learning in clinical practice (r = 0.07, p < 0.191, Table 4.20).

4.3.1.2 Sign a supervisory contract with the learner nurse with regard to his / her clinical accompaniment (Item 2)

The mean value of 2.64 (SD = 1.055) of the 407 (100.0%) responses from the facilitators was obtained with a wider distribution of responses than the mean value of 3.32 (SD = 0.984) from learner nurses' responses.

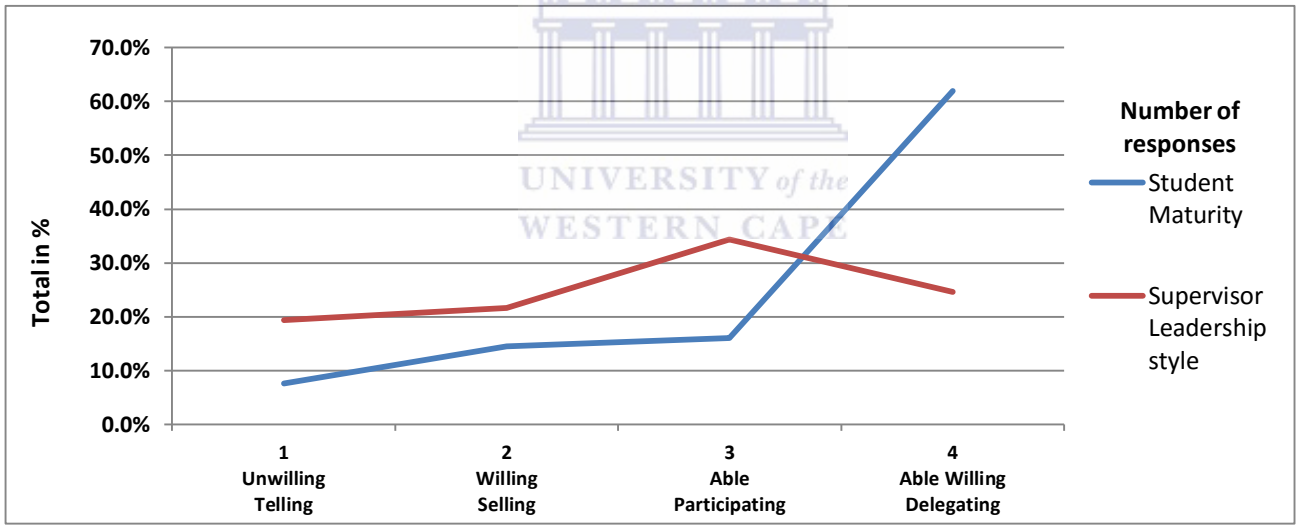

Figure 4.2: Sign a supervisory contract with clinical facilitator with regard to clinical accompaniment (Item 2)

The highest rate of responses of the clinical facilitators indicated that they used a *participating* leadership style (support) for learner nurses to sign a supervisory contract with regard to clinical accompaniment in clinical practice (n = 140, 34.4%). On the other hand, the majority of the learner nurses indicated that they were *mature* (able and willing) to make decisions to sign a contract with regard to their clinical accompaniment (n = 252, 61.9%).

Only 31 (7.6%) of the learner nurses indicated that they were *immature* (unable and unwilling) to sign the agreement with regard to clinical accompaniment, while a response rate of 79 (19.4%) by the clinical facilitators showed that they *directed* (telling style) learner nurses to sign the contract.

Likewise, 59 (14.5%) of the learner nurses' responses stated that they were *somewhat mature* (willing but did not have the skills) to sign the contract. On the other hand, less than a quarter (n = 88, 21.6%) of the responses by the clinical facilitators denoted that they used a *selling* leadership style (guiding) for learner nurses to sign a contract with regard to clinical accompaniment.

In respect of signing a supervisory contract with regard to clinical accompaniment, 140 (34.4%) of the 407 (100.0%) responses by the clinical facilitators indicated that they used a *participating* leadership style (support) for learner nurses while only 65 (16.0%) of the 407 (100%) learner nurses' responses indicated that they were *moderately mature* (able but unwilling) to sign this agreement.

A quarter (n = 100, 24.6%) of the responses by the clinical facilitators indicated that they used a *delegating* style of leadership (being available) for learner nurses to sign the contract with regard to their clinical accompaniment. However, less than two thirds (n = 252, 61.9%) of the learner nurses' responses indicated that they were *mature* (able and willing) to sign the contract.

The ability of a learner nurse to sign a supervisory contract could be linked to maturity and may result in the learner nurse assuming responsibility of his / her clinical learning (Saccomano, 2008, p. 11).

There was no relationship between the leadership style of the facilitator and the maturity level of the learner nurse about signing a supervisory contract with a clinical facilitator with regard to clinical accompaniment in clinical learning. The findings indicated a negative Pearson's correlation (r = -0.05, $p < 0.364$, Table 4.20).

4.3.1.3 Set goals to be obtained in teaching and learning in the unit (Item 3)

The facilitators indicated a wider distribution of responses (SD = 1.008) with a lower mean value ($\bar{x}$ = 2.68) than their learner nurses ($\bar{x}$ = 3.62; SD = 0.775).

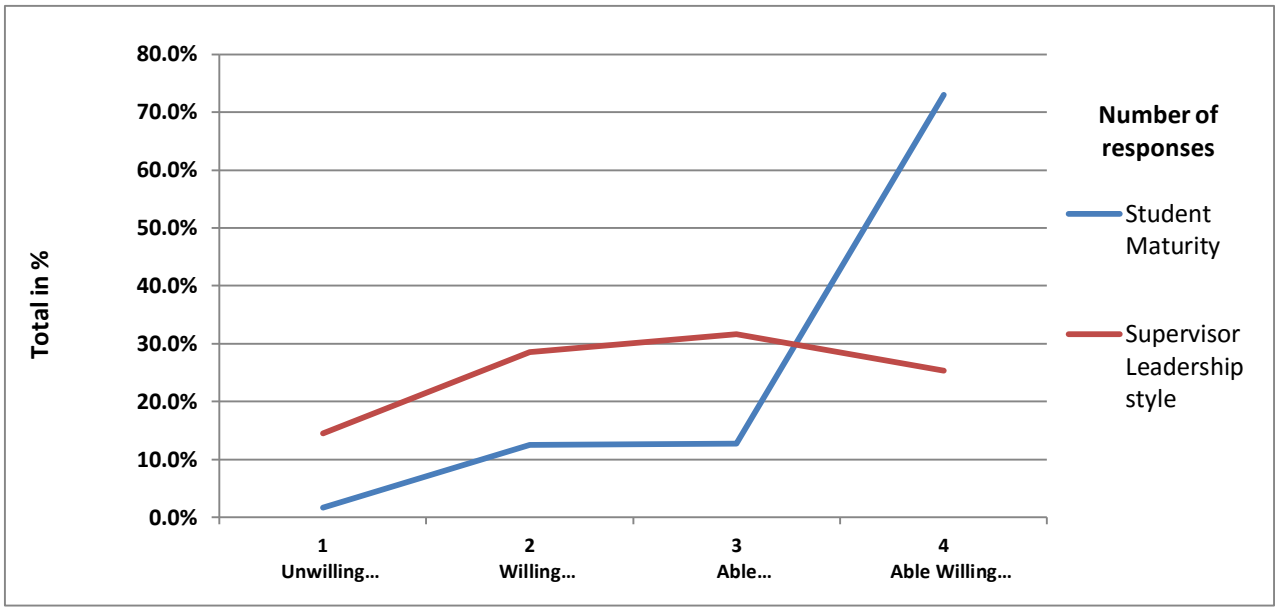

Figure 4.3: Set specific goals to be obtained for my teaching and learning in the unit (Item 3)

The highest rate of responses of the learner nurses indicated that they were *mature* (able and willing) to make decisions to set goals to be obtained in clinical teaching and learning in the unit (n = 297, 73.0%). On the other hand, the highest rate of responses of the clinical facilitators indicated that they *participated* (supported) with learner nurses to setting the goals to be obtained in a clinical teaching and learning environment (n = 129, 31.7%).

The smallest percentage (n = 59, 14.5%) of the responses of clinical facilitators indicated that they informed (*telling style*) learner nurses to set own goals to be obtained in teaching and learning in the unit. On the other hand, 7 (1.7%) of the learner nurses indicated that they were *immature* (unable and unwilling) to set own goals to be obtained for teaching and learning in the unit.

Slightly more than a quarter (n = 116, 28.5%) of the clinical facilitators' responses indicated that they used a *selling* leadership style (guiding) for learner nurses to set goals to be obtained in clinical practice, and only 51 (12.5%) of the learner nurses' responses pointed out that they were *less mature* (willing but did not have the skills) to set goals for teaching and learning in the ward.

On the other hand, only 52 (12.8%) of the 407 (100%) response by the learner nurses indicated that they were *moderately mature* (able but unwilling) to set goals to be obtained in teaching and learning in the unit.

A quarter (n = 103, 25.3%) of the facilitators' responses indicated they were *available* (delegating style) for the learner nurses to set goals for teaching and learning in the ward. There was no relationship between the

leadership style of the facilitator and the maturity level of the learner about setting specific goals to be obtained for teaching and learning in the unit (r = 0.09, p < 0.069, Table 4.20). It could be interpreted that learners were not confident in setting goals / objectives to achieve during clinical practice. Inability to set goals conveys lack of focus to the learner and obstructs the learning process (Gravett & Geyser, 2004, p. 144).

4.3.1.4 Identify learning needs according to the clinical practice experience required (Item 4)

The mean value of 2.79 (SD = 0.938) of the 407 (100.0%) responses by facilitators was lower and represented a broader distribution of responses around the mean value than the mean value of 3.68 (SD = 0.679) of the 407 (100.0%) learner nurses, which indicated a more narrow spread of responses around the mean value.

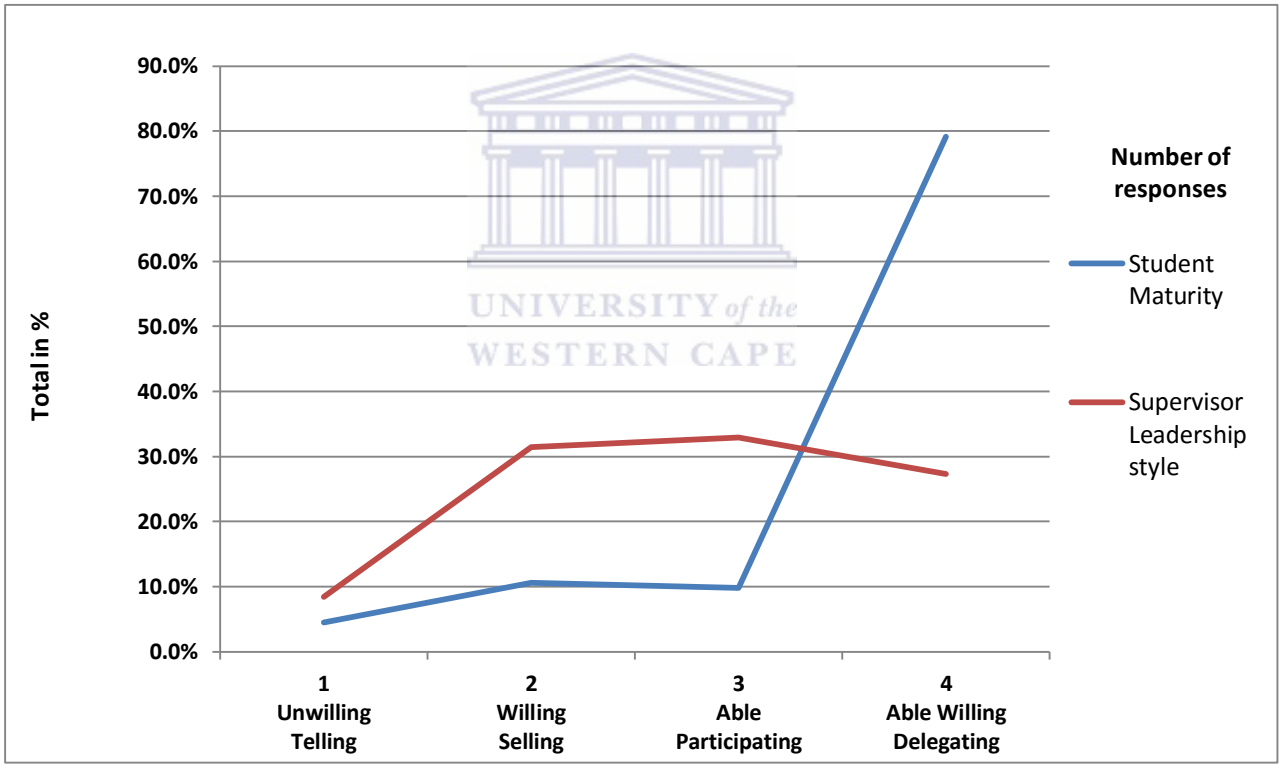

Figure 4.4: Identify learning needs according to clinical practice experience required (Item 4)

A participative leader vigorously involves followers (learner nurses) to identify learning needs (Bolkan *et al.*, 2011, p. 343), with the aim of motivating and empowering them with knowledge and skills (Wendling, 2012, p. 8).

The highest rate of responses by the learner nurses indicated that they were *mature* (able and willing) to make decisions about identifying learning needs according to clinical practice requirements (n = 322, 79.1%). On the other hand, the highest rate of responses by clinical facilitators indicated that they *participated* (supported) with learner nurses to identify their learning needs according to clinical practice (n = 134, 32.9%).

Only a few (n = 34, 8.4%) of the clinical facilitators responses indicated giving orders (*telling style*) to learner nurses about identifying learning needs according to clinical learning, and 2 (0.5%) of the responses by the learner nurses indicated that they were *immature* (unable and unwilling) to identify learning needs according to requirements for clinical practice.

Another 128 (31.4%) responses by the clinical facilitators indicated that they used a *selling* leadership style for learner nurses to identify clinical learning needs according to the practice. Only 43 (10.6%) responses by the learner nurses indicated that they were *somewhat mature* (willing but did not have the skills) to identify learning needs according to the clinical practice requirements.

On the other hand, a tenth (n = 40, 9.8%) of the 407 (100%) responses by learner nurses indicated that they were *moderately mature* (able but unwilling) to identify learning needs as required by the clinical practice.

Over a quarter (n = 111, 27.3%) of responses by the clinical facilitators indicated that they used a *delegating* style of leadership (being available) for learner nurses to identify learning needs according to clinical practice experience required.

The results demonstrated a weak positive relationship between the leadership style of the facilitator and the maturity level of the learner nurse in the item about identifying learning needs according to clinical practice experience required ($r = 0.11$, $p < 0.022$, Table 4.20).

4.3.1.5 Perform nursing duties in a clinical setting to fulfil individual learner nurses' learning needs (Item 5)

Responses of learner nurses demonstrated a narrower distribution of responses around the mean value ($\bar{x}$ = 3.67, SD = 0.695) than the mean value ($\bar{x}$ = 2.71, SD = 0.883) of the facilitators.

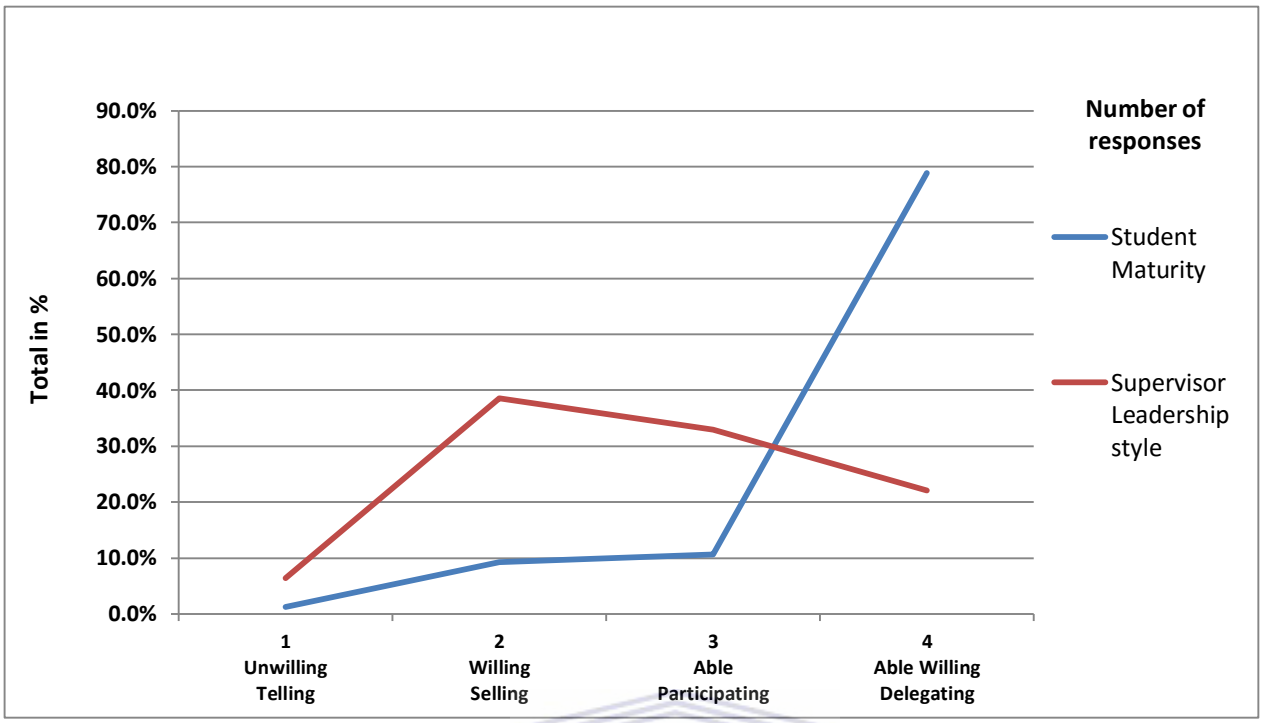

Figure 4.5: Perform nursing duties in a clinical setting to fulfil learning needs (Item 5)

The highest rate of responses by the clinical facilitators indicated that they used a *selling* style of leadership (guiding) for learner nurses to perform nursing duties in order to fulfil learning needs in practice (n = 157, 38.6%). On the other hand, 321 (78.9%) was the highest rate of responses by the learner nurses who indicated that they were *mature* (able and willing) to decide about the performance of nursing duties to fulfil individual learning needs in clinical practice.

Only 26 (6.4%) responses by the clinical facilitators indicated that they gave *orders* (telling style) to learner nurses to perform nursing duties in order to fulfil learning needs in practice, and 5 (1.2%) of the learner nurses' responses indicated that they were *immature* (unable and unwilling) to individually perform nursing duties in a clinical setting.

Only 38 (9.3%) of the 407 (100%) responses by the learner nurses showed that they were *somewhat mature* (willing but did not have the skills) to perform nursing activities that fulfilled individual learning needs.

A third (n = 134, 32.9%) of the facilitators' responses indicated that they supported (*participating* style) individual learners who performed nursing duties to satisfy learning needs in clinical practice. Only 43 (10.6%) of the learner nurses indicated that they were *able but unwilling* (moderately mature) to perform nursing duties to fulfil individual learning needs.

Almost a quarter (n = 90, 22.1%) of the clinical facilitators' responses indicated that they used a *delegating* leadership style (being available) for individual learner nurses who were performing nursing activities / duties to fulfil their learning needs. A learner and a facilitator should function as a team in order to fulfil learning needs (Steen-Vander Veen, 2004, p. 21). Positively, a leadership that socialises and actively involves learner nurses in clinical activities empowers them effectively with skills to develop professionally (Feldman, 2011, p. 288).

A weak positive relationship between the clinical facilitator leadership style and the maturity level of the learner nurses was shown in this item about performing nursing duties in a clinical setting to fulfil individual learning needs ($r = 0.13$, $p < 0.010$, Table 4.20).

4.3.1.6 Communicate with nursing students about their clinical progress (Item 6)

The mean value 2.82 (SD = 1.031) of the 407 (100.0%) responses by the facilitators was lower than the mean value of 3.61 (SD = 0.753) of the 407 (100.0%) learner nurses and presented a *participating style* (support) of leadership while learner nurses' mean value represented a *mature* (able and willing) learner regarding communicating with nursing students about their clinical progress.

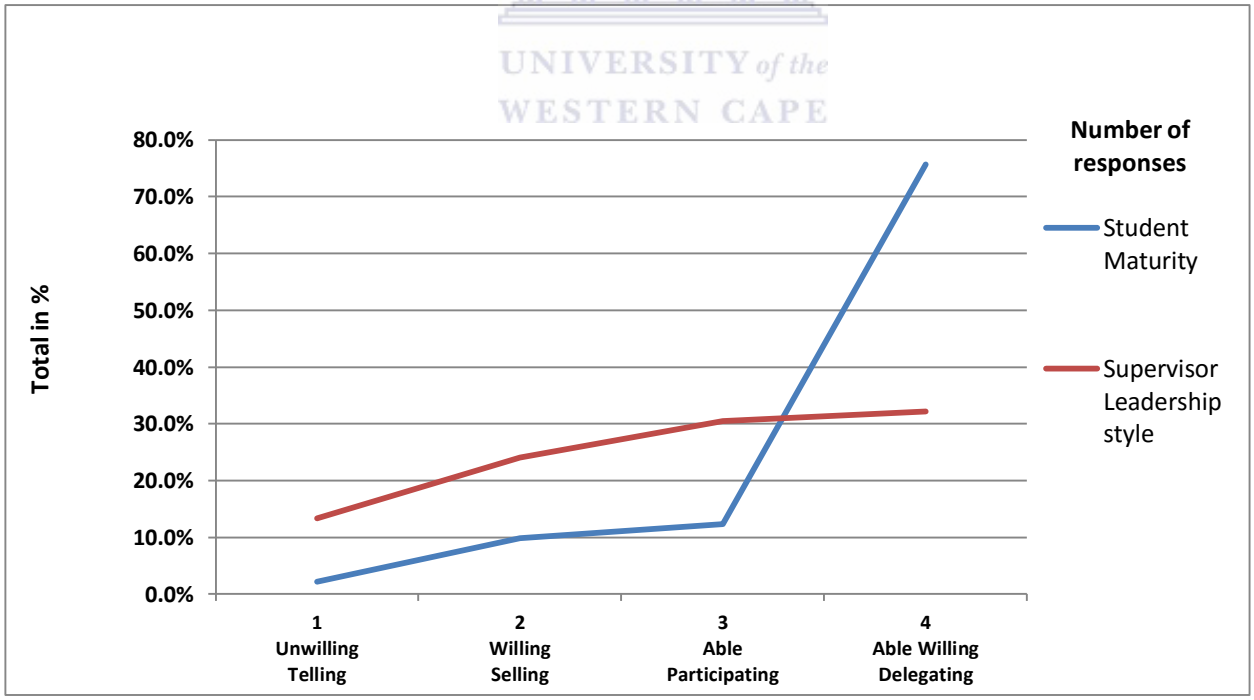

Figure 4.6: Communication with clinical facilitator about progress in clinical practice (Item 6)

In this item that related to communication with nursing students about their progress in clinical practice, the highest rate of responses by the clinical facilitators highlighted that they used a *delegation* style of leadership (being available) to learner nurses to communicate progress in the clinical learning environment (n = 131, 32.2%). On the other hand, 308 (75.7%) was the highest rate of responses by the learner nurses who indicated that they were *mature* (able and willing) to decide about communicating clinical progress with facilitators in a learning environment.

Only 9 (2.2%) of the learner nurses stated that they were *immature* (unable and unwilling) to communicate their clinical progress in practice. On the other hand, 54 (13.3%) of the clinical facilitators' responses indicated that they *told* (telling style) learners to communicate progress with them in a practice setting.

Only 40 (9.8%) of the learner nurses indicated that they were *somewhat mature* (willing but did not have the skills) to communicate their clinical progress. Nearly a quarter (n = 98, 24.1%) of the clinical facilitators' responses demonstrated a *selling* style of leadership (guidance) to learner nurses who needed to communicate their progress in a practice setting.

Likewise, 50 (12.3%) of responses by the learner nurses showed that they were *moderately mature* (able but unwilling) to communicate their clinical progress with facilitators while nearly a third (n = 124, 30.5%) of clinical facilitators' responses indicated that they *participated* (support) in talking to learner nurses about their progress in a training environment.

There was no relationship between the leadership style of clinical facilitators and maturity level of the learner nurse in the item about communicating with nursing students about their progress in clinical practice ($r = 0.00$, $p < 0.946$, Table 4.20).

4.3.1.7 Provide an empathetic understanding of problems the nursing students experience during clinical facilitation (Item 7)

With the challenges that exist in a clinical learning environment (Mannix *et al*., 2006, p. 7), a facilitator as leader should routinely empathise with nursing students (Lopez-preez *et al*., 2013, p. 1). Sawatzky *et al*. (2009, p. 260-261) and Smeltzer, Bare, Hinkle, and Cheever (2010, p. 5) also advocate a caring model in nursing education.

The mean value of 2.79 (SD = 0.938) of the 407 (100.0%) responses by the facilitators was lower and represented a broader distribution of responses around the mean value than the mean value of 3.68 (SD = 0.679) of the 407 (100.0%) learner nurses who represented a narrower spread of responses around the mean value.

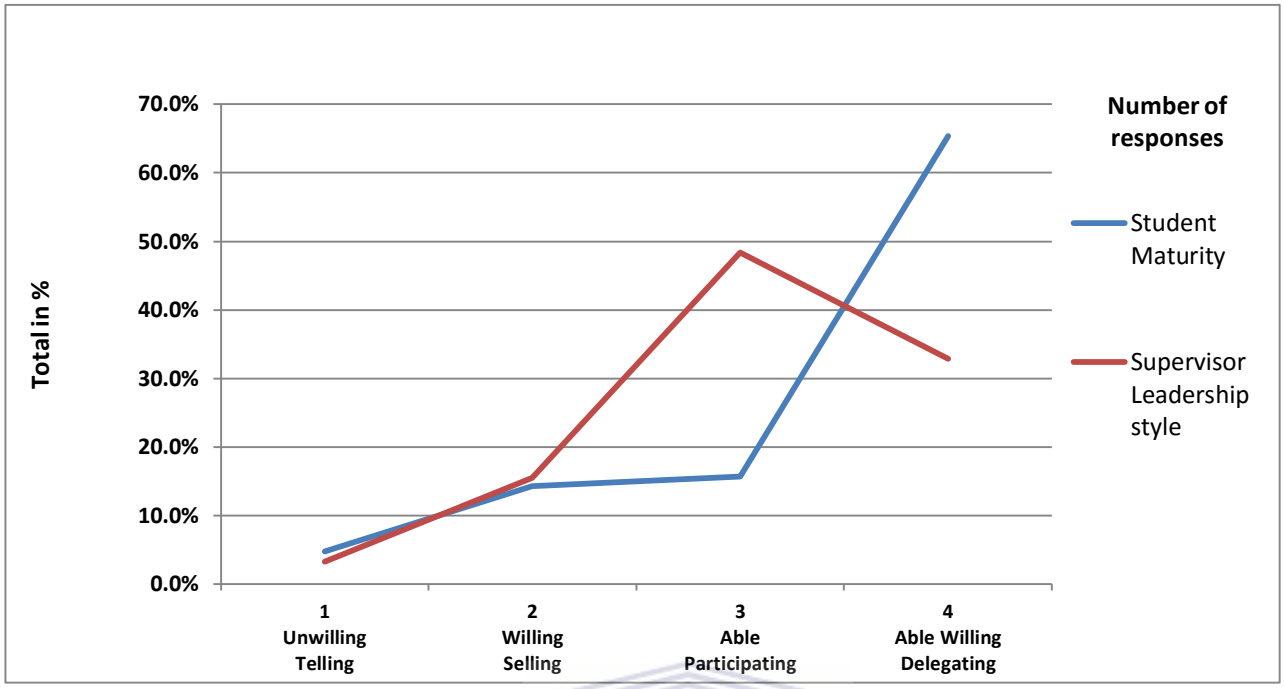

Figure 4.7: Receive empathetic understanding of problems that I experience during clinical learning (Item 7)

In Item 7, the highest rate of responses by the learner nurses indicated that they were *mature* (able and willing) to make decisions about receiving an empathetic understanding of problems they experienced during clinical learning (n = 266, 65.4%). On the other hand, the highest rate of the responses by the clinical facilitators indicated that they used a *participating* style (support) of leadership to provide an empathetic understanding of problems that learner nurses experienced in a clinical learning environment (n = 197, 48.4%).

Only 13 (3.2%) of the facilitators' responses indicated an *autocratic* leadership (telling style) to provide an emphatic understanding of problems that learners experienced during clinical learning. Nonetheless, 19 (4.7%) of the learner nurses specified that they were *immature* (unable and unwilling) to receive such empathy when they experienced problems in the clinical setting.

Similarly, 58 (14.3%) of the learner nurses demonstrated that they were *somewhat mature* (willing but did not have the skills) to receive an empathetic understanding about problems they met during clinical learning. On the other hand, 63 (15.5%) of the facilitators' responses indicated that they used a *selling* style (guiding) with those learners who experienced problems during clinical training.

Only 64 (15.7%) of the 407 (100%) learner nurses indicated that they were *moderately mature* (able but unwilling) to receive empathy for the challenges they experienced during clinical placement.

A third (n = 134, 32.9%) of the facilitators' responses pointed out that they used a *delegating* style (being available) with learner nurses who experienced problems during clinical learning. A weak positive relationship between the leadership style of the clinical facilitator and the maturity level of the learner nurses was established in the item about receiving an empathetic understanding of problems that they experienced during clinical learning ($r = 0.14$, $p < 0.005$, Table, 4.20).

4.3.1.8 Interact with the a skilled role model who is involved in daily decisions, processes, protocols, and management of a unit (Item 8)

The lowest mean value of 2.72 (SD = 0.995) of the 407 (100.0%) responses by the facilitators indicated a wider dispersions of responses than a mean value of 3.39 (SD = 0.908) of the 407 (100.0%) learner nurses that represented a narrower distribution of responses.

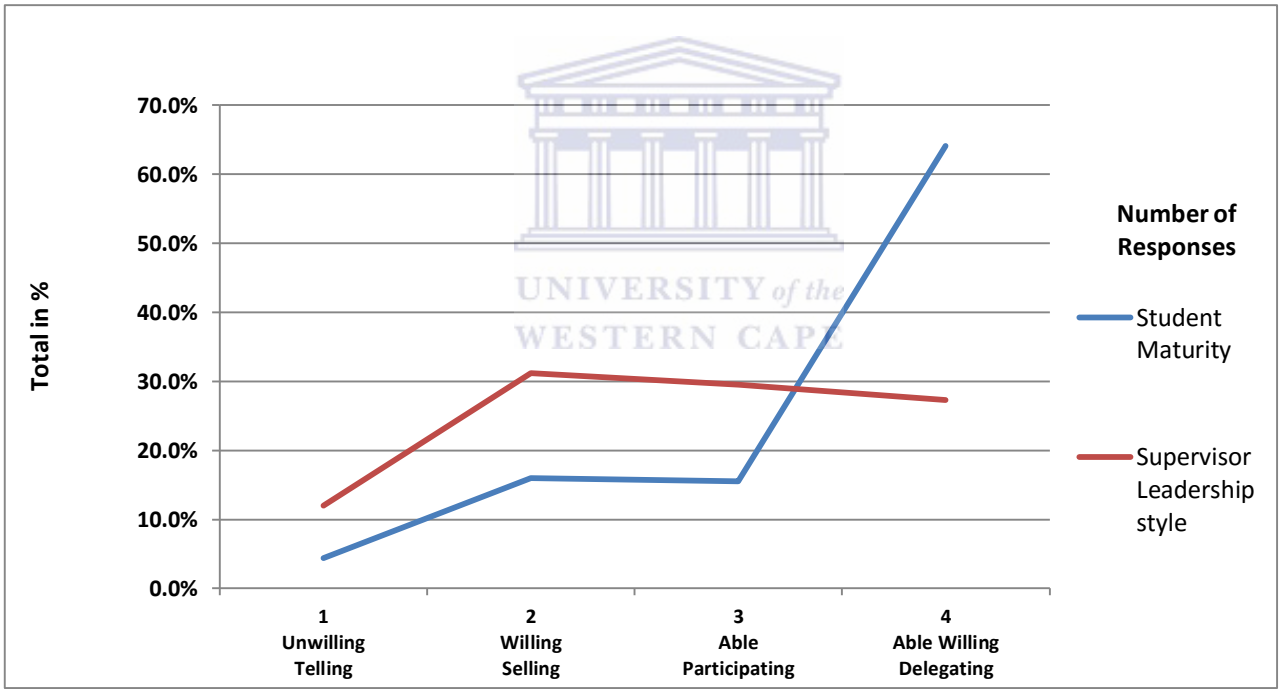

Figure 4.8: Interact with clinically skilled role models involved in daily decisions, processes, protocols, and management of a unit (Item 8)

Role-modelling is one of the most effective forms of teaching, especially when a specific behaviour is being role-modelled (Dornyei & Murphey, 2003, p. 128; Booyens, 2006, p. 171-172).

The highest rate of responses by the learner nurses indicated that they were *mature* (able and willing) to make decisions to interact with clinically skilled role models involved in daily decisions, processes,

protocols, and management of a unit (n = 261, 64.1%). On the other hand, the highest rate of responses by the clinical facilitators indicated that they used a *selling* leadership style (guiding) for learners to interact with clinically skilled role models involved in daily decisions, processes, protocols, and management of a unit (n = 127, 31.2%).

As well, 18 (4.4%) of the learner nurses highlighted that they were *immature* (unable and unwilling) to be involved with clinically skilled role models of a unit while 49 (12.0%) of the facilitators' responses indicated that they *directed* (telling style) learner nurses to be involved with role models in a unit. According to Booyes (2005, p. 125) and Lewington and Bristol (2012, p. 6), instructive leadership aims at getting tasks performed, since the one who is supervised does not understand what is supposed to be done. Hence, these learner nurses were in the same state of not knowing how to interact with skilled role models in a unit. Callaghan (2008, p. 207) and Harrison (2011, p. 92-94) are convinced that this style of leadership does not develop nursing students professionally.

On the other hand, 65 (16.0%) of the learner nurses indicated that they were *somewhat mature* (willing but did not have skills) to interact with clinically skilled role models involved in daily decisions, processes, protocols, and management of a unit in clinical practice. More than a quarter (n = 120, 29.5%) of the facilitators' responses showed that they used a *participating* style (support) for learner nurses to get involved with role models who were involved in daily decisions, processes, protocols, and management of a unit. However, only 63 (15.5%) of the learner nurses pointed out that they were *moderately mature* (able but unwilling) in the abovementioned item.

Nearly third (n = 111, 27.3%) of the facilitators responses revealed that they used **delegating** style (being available) for learners who worked together with the clinically skilled role model.

Another weak positive relationship established between the facilitator's leadership style and maturity level of the learner nurse on Item 8; Interact with clinically skilled role models involved in daily decisions, processes and management of the unit ($r = 0.12$, $p < 0.016$, Table 4.20).

4.3.1.9 Summary

From this section, Items 1, 2, 3 and 6 indicated no relationship between the leadership style of the facilitators and the maturity level of the learner nurses in respect of the relationship between the learners nurse and the facilitators as role models. On the other hand, Items 4, 5, 7 and 8, indicated a statistically weak positive correlation between the facilitators' leadership style and the learner nurses' maturity level in respect of the relationship between learner nurses and the facilitators as role models.

4.3.2 Teaching and learning activities

Tables 4.21 and 4.22 indicate the responses of the clinical facilitators and the learner nurses on Items 9-21 with regard to the component about the teaching and learning activities. Table 4.23 indicates the significance in the relationship between the learner nurses and the clinical facilitators in this regard.

Table 4.21: Teaching and learning activities of clinical facilitators

	Responses of clinical facilitators	Leadership styles											
		Tells the nursing student how to:		Guides nursing student to:		Supports nursing student to:		Is available to:		Total		$\bar{x}$	SD
		Telling		Selling		Participating		Delegating					
		1		2		3		4					
	Items	n	%	n	%	n	%	n	%	n	%		
9	Apply different teaching strategies, e.g. when educating a patient.	46	11.3	185	45.5	107	26.3	69	17.0	407	100.0	2.49	0.904
10	Teaching theory about clinical procedures.	49	12.0	157	38.6	84	20.6	117	28.7	407	100.0	2.66	1.021
11	Plan nursing student's clinical learning responsibilities around daily tasks in the unit.	43	10.6	151	37.1	101	24.8	112	27.5	407	100.0	2.69	0.988
12	Set responsibilities expected of the nursing student for the clinical environment.	52	12.8	101	24.8	152	37.3	102	25.1	407	100.0	2.75	0.974
13	Document the clinical competencies undertaken in the unit.	61	15.0	132	32.4	75	18.4	139	34.2	407	100.0	2.72	1.090
14	Attend to scheduling appointments with the nursing student.	38	9.3	52	12.8	109	26.8	208	51.1	407	100.0	3.20	0.988

15	Use the standard procedure in the unit, e.g. preparation of a patient for theatre.	85	20.9	112	27.5	119	29.2	91	22.4	407	100.0	2.53	1.057
16	Use learning strategies to enhance nursing students' knowledge about clinical nursing practice.	35	8.6	179	44.0	94	23.1	99	24.3	407	100.0	2.63	0.945
17	Follow a case-based approach in demonstrating learner nurses' clinical competencies.	25	6.1	184	45.2	105	25.8	93	22.9	407	100.0	2.65	0.899
18	Practice as a team member in a clinical practice setting.	51	12.5	136	33.4	111	27.3	109	26.8	407	100.0	2.68	1.003
19	Conduct clinical activities that promote nursing students' provisional capacity.	20	4.9	170	41.8	116	28.5	101	24.8	407	100.0	2.73	0.890
20	Evaluate nursing students in respect of competencies by the methods as stipulated by the nursing students' guide.	25	6.1	127	31.2	93	22.9	162	39.8	407	100.0	2.96	0.978
21	Provide feedback about mistakes nursing students have made during clinical competencies.	40	9.8	86	21.1	116	28.5	165	40.5	407	100.0	3.00	1.006

Table 4.22: Teaching and learning activities of learner nurses

	Responses of learner nurse	**Maturity levels**											
		Unable unwilling to		**Willing but not have the skills to**		**Able but unwilling to**		**Able willing to**		**Total**		$\bar{x}$	**SD**
		1		**2**		**3**		**4**					
	Items	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
9	Apply different teaching strategies, e.g. when educating patients.	6	1.5	72	17.7	37	9.1	292	71.7	407	100.0	3.51	0.833

	Responses of learner nurse	Maturity levels											
		Unable unwilling to		Willing but not have the skills to		Able but unwilling to		Able willing to		Total		$\bar{x}$	SD
		1		2		3		4					
	Items	n	%	n	%	n	%	n	%	n	%		
10	Apply theory taught by clinical facilitator about clinical procedures.	5	1.2	31	7.6	27	6.6	344	84.5	407	100.0	3.74	0.646
11	Plan my clinical learning responsibilities around daily tasks in a unit.	6	1.5	49	12.0	60	14. 7	292	71.7	407	100.0	3.57	0.759
12	Perform responsibilities expected of me in the clinical environment.	1	0.2	32	7.9	29	7.1	345	84.8	407	100.0	3.76	0.594
13	Document the clinical competencies undertaken in the unit.	4	1.0	23	5.7	22	5. 4	358	88.0	407	100.0	3.80	0.575
14	Attend to scheduled appointments with the clinical facilitator.	11	2.7	23	5.7	31	7.6	342	84.0	407	100.0	3.73	0.688
15	Use the standard procedures in the unit, e.g. preparation of patient for theatre.	8	2.0	42	10.3	26	6.4	331	81.3	407	100.0	3.67	0.739
16	Use learning strategies to enhance my knowledge about clinical nursing practice.	2	0.5	43	10.6	36	8.8	326	80.1	407	100.0	3.69	0.676
17	Follow a case-based approach while demonstrating my clinical competencies.	6	1.5	66	16.2	47	11.5	288	70.8	407	100.0	3.52	0.815
18	Practise as a team member in a clinical practice setting.	5	1.2	33	8.1	36	8.8	333	81.8	407	100.0	3.71	0.665
19	Conduct clinical activities that promote my professional capacity.	7	1.7	49	12.0	34	8.4	317	77.9	407	100.0	3.62	0.762

	Responses of learner nurse	Maturity levels											
		Unable unwilling to		Willing but not have the skills to		Able but unwilling to		Able willing to		Total		$\bar{x}$	SD
		1		2		3		4					
	Items	n	%	n	%	n	%	n	%	n	%		
20	Is evaluated on competencies according to the method as stipulated by the clinical facilitator.	7	1.7	36	8.8	26	6.4	338	83.0	407	100.0	3.71	0.699
21	Receive feedback on mistakes I have made during clinical competencies	7	1.7	21	5.2	20	4.9	359	88.2	407	100.0	3.800	0.608

Table 4.23: Significance in relationships between leadership style and maturity levels about the component in respect of the teaching and learning activities

	Teaching and learning activities of the facilitator and the learner nurse	Correlation (*r*)	p-value
9	Apply different teaching strategies when, e.g. educating patients.	0.03	0.498
10	Apply theory taught by clinical facilitators about clinical procedures.	0.10	0.044
11	Plan my clinical learning responsibilities around daily tasks in a unit.	0.03	0.511
12	Perform responsibilities expected of me in the clinical environment.	0.05	0.359
13	Document the clinical competencies undertaken in a unit.	0.05	0.29
14	Attend to scheduled appointments with the clinical facilitator.	0.13	0.011
15	Use the standard procedures in a unit, e.g. preparation of patient for theatre.	0.09	0.065
16	Use learning strategies to enhance my knowledge about clinical nursing practice.	0.15	0.002
17	Follow a case-based approach when demonstrating my clinical competencies.	0.12	0.018
18	Practise as a team member in a clinical practice setting.	0.13	0.009
19	Conduct clinical activities that promote my professional capacity.	0.10	0.057
20	Is evaluated on competencies according to the method as stipulated by the clinical facilitator.	0.06	0.201

	Teaching and learning activities of the facilitator and the learner nurse	Correlation (*r*)	p-value
21	Receive feedback on mistakes I have made during clinical competencies.	0.02	0.698

4.3.2.1 Apply different teaching strategies, e.g. when educating patient (Item 9)

Clinical facilitators' responses indicated a lower mean value and wider distribution around the mean value ($\bar{x}$ = 2.49; SD = 0.904) than the learner nurses who indicated a higher mean value and narrower distribution of responses ($\bar{x}$ = 3.51; SD = 0.833).

A facilitator should enhance the ability of the learner by applying a variety of teaching methods (Evans & Stevenson, 2010, p. 239-241; Kadagad, 2013, p. 80). Different teaching strategies enhance knowledge (Evans & Stevenson, 2010, p. 239-241).

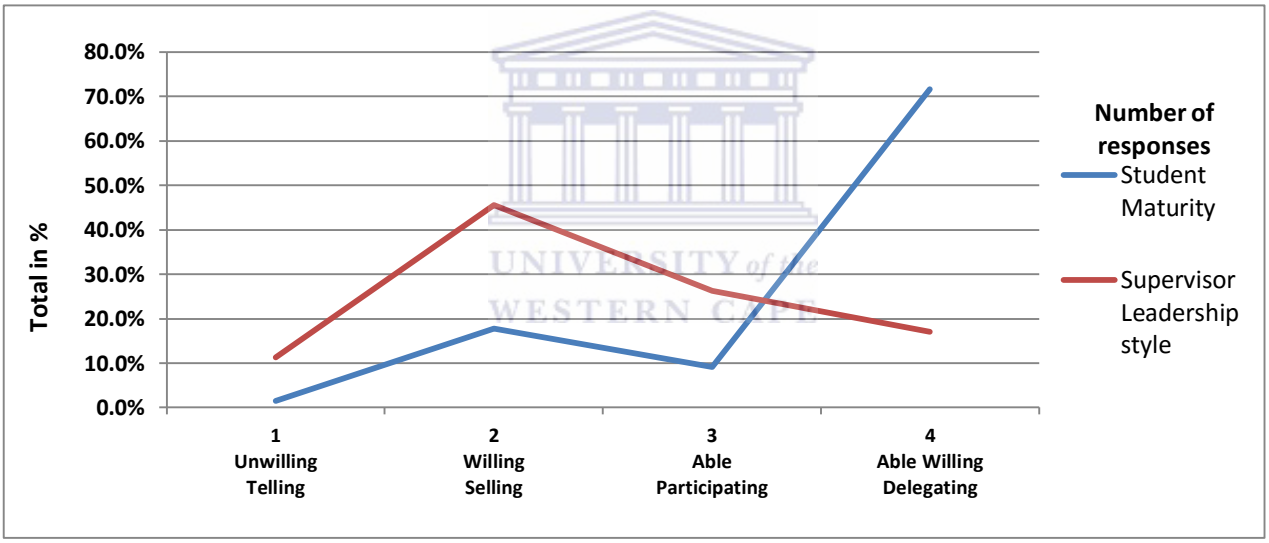

Figure 4.9: Apply different teaching strategies, e.g. when educating patient (Item 9)

The highest rate of responses by learner nurses (n = 292, 71.7%) indicated that they were *mature* (able and willing) to make decisions about applying different teaching strategies, e.g. when educating patient. On the other hand, the highest rate of responses by clinical facilitators (n = 185, 45.5%) indicated that they used a *selling* style (guidance) of leadership for learner nurses when applying different teaching strategies for educating patients in clinical practice.

Only 6 (1.5%) of the learner nurses highlighted that they were *immature* (unable and unwilling) to apply different teaching strategies when they educated patients, whereas 46 (11.3%) of the clinical facilitators'

responses indicated that they gave *orders* (telling style) to such learner nurses to use different teaching strategies for educating patients in clinical practice.

Less than a fifth (n = 72, 17.7%) of the 407 (100%) learner nurses indicated that they were *somewhat mature* (willing but did not have skills) to apply different teaching strategies when they educated patients in clinical learning. A quarter (n = 107, 26.3%) of the clinical facilitators revealed that they *participated* (supporting) with learner nurses to use different teaching strategies in clinical practice. However, close to a tenth (n = 37, 9.1%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to apply the teaching strategies.

Only 69 (17.0%) of the clinical facilitators indicated that they used a *delegating style* (being available) for learner nurses to apply teaching strategies in a clinical learning environment. The findings indicated no relationship between the leadership style of the facilitators and the maturity level of learner nurses in respect of applying different teaching strategies, e.g. when educating a patient ($r = 0.03$, $p < 0.498$, Table 4.23).

4.3.2.2 Teaching theory about clinical procedures (Item 10)

In this item about applying theory in clinical procedures, the responses of the 23 (100.0%) facilitators were widely spread around the mean value of 2.66 (SD = 1.021) compared to the responses of the learner nurses that indicated a narrower spread around the mean value of 3.74 (SD = 646) of the 407 (100.0%) learner nurses.

In clinical learning, learners are better able to understand theoretical materials through practising procedures that have been demonstrated in class (Yong, 2012, p. 55).

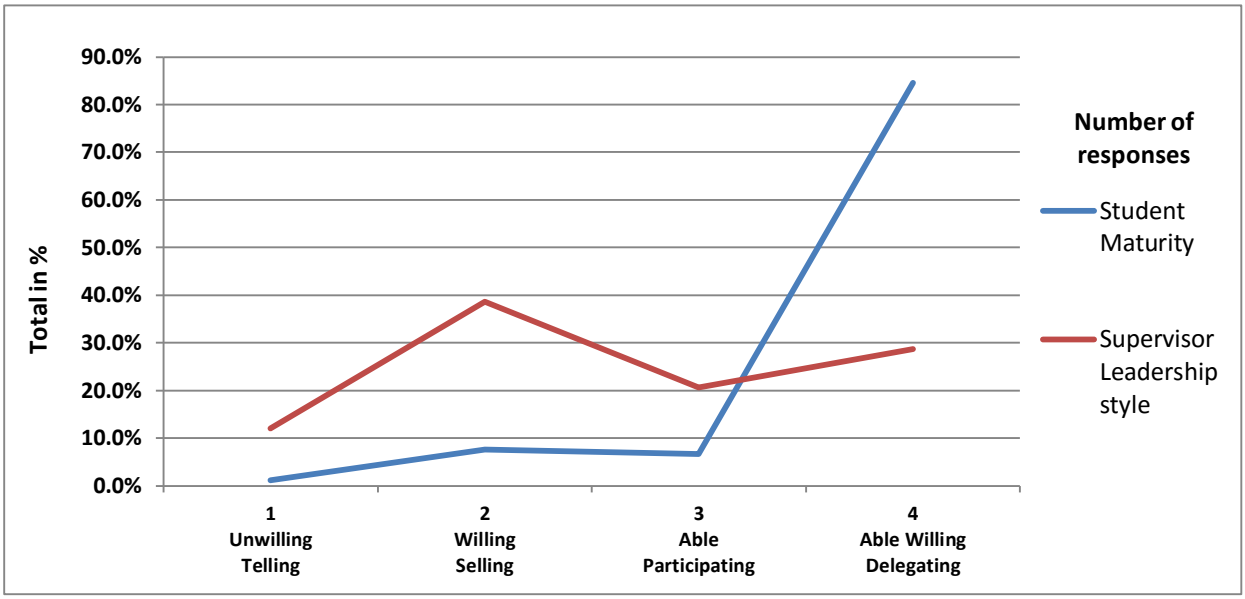

Figure 4.10: Apply theory about clinical procedures taught by clinical facilitators (Item 10)

The highest rate of responses by the learner nurses indicated that they were *mature* (able and willing) to make decisions to learn theory about clinical procedures in practice (n = 344, 84.5%), while the highest rate of responses by the clinical facilitators indicated that they used a *selling style* (guiding) of leadership for the learner nurses to learn theory about clinical procedures in practice (n = 157, 38.6%).

Furthermore, 49 (12.0%) of the responses by the clinical facilitators indicated *autocratic* behaviour (telling style) when teaching learner nurses to learn theory about clinical procedures in practice while only 5 (1.2%) of the learner nurses indicated that they were *immature* (unable and unwilling) to apply theory about clinical procedures.

Only 31 (7.6%) of the 407 (100%) learner nurses indicated that they were *somewhat mature* (willing but did not have the skills) to apply theory about clinical procedures taught by the facilitators. In respect of the teaching and learning approach, 27 (6.6%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to apply the theory of clinical procedures. However, 84 (20.6%) of the facilitators indicated that they used a *participating style* (support) of leadership for learner nurses to teach them the theory of clinical procedures. More than a quarter (n = 117, 28.7%) of the clinical facilitators indicated that they used a *delegating style* of leadership (being available) to teach learner nurses theory about clinical procedures.

The results demonstrate a weak positive relationship between the leadership style of the facilitators and the maturity level of the learner nurses in Item 10 (r = 0.10, p < 0.044, Table 4.23). The results suggest that facilitators could be considering the level of maturity of the learner nurses when they taught theory about clinical procedures.

4.3.2.3 Plan nursing students' clinical learning responsibilities around daily tasks in a unit (Item 11)

Clinical facilitators had a lower mean value and a wider distribution of responses around the mean value ($\bar{x}$ = 2.69; SD = 0.988) than their learner nurses ($\bar{x}$ = 3.57; SD = 0.759).

Munir and Nielsen (2009, p. 1834) explain that a mature learner is vision-driven and creative. However, Armstrong and Rustin (2011, p. 3) share the opinion that permissive leadership may threaten goal achievement of learning in a unit even though it is the responsibility of nursing students to plan and organise clinical teaching and evaluation thereof (Rudman, 2007, p. 41).

The highest rate of responses by the clinical facilitators indicated that they used a *selling style* (guiding) of leadership for learner nurses to plan clinical learning responsibilities around daily task in a unit (n = 151, 37.1%). On the other hand, the highest rate of responses by the learner nurses indicated that they were *mature* (able and willing) to make decisions about the mentioned Item 11 (n = 292, 71.7%).

Only 6 (1.5%) of the learner nurses showed that they were *somewhat mature* (unable and unwilling) to plan tasks around daily activities in a unit. Nevertheless, 43 (10.6%) of the responses by the clinical facilitators indicated that they *told* (telling style) learner nurses to plan responsibilities around daily tasks in a unit.

More than a tenth (n = 49, 12.0%) of the learner nurses indicated that they were *somewhat mature* (willing but did not have the skills) to plan responsibilities around daily tasks in a unit. Only 60 (14.7%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to plan their responsibilities around daily tasks in a unit. On the other hand, a quarter (n = 101, 24.8%) of the clinical facilitators indicated that they *participated* (support) with the learner nurses to plan their responsibilities around tasks in the unit.

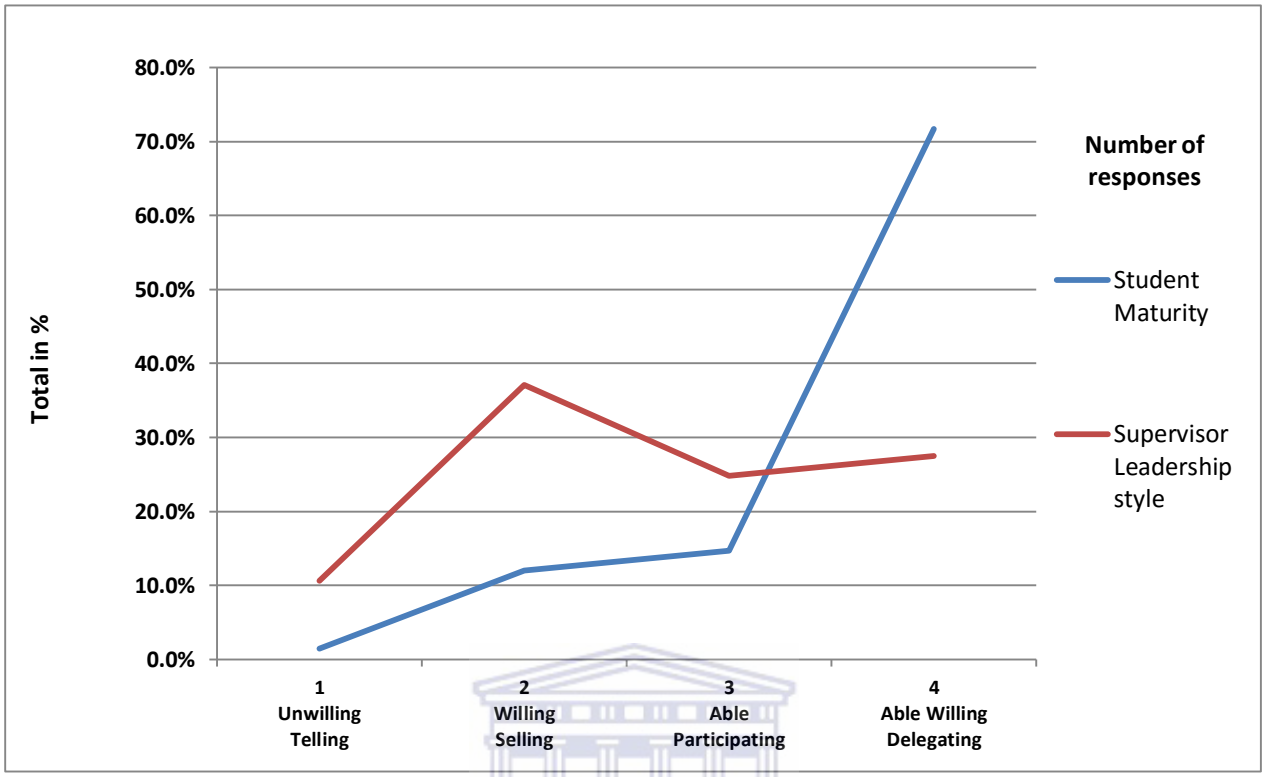

Figure 4.11: Plan clinical learning responsibilities around daily tasks in the unit (Item 11)

Slightly more than a quarter (n = 112, 27.5%) of the 407 (100%) responses by the clinical facilitators indicated that they used a *delegating style* (being available) of leadership for learner nurses to plan responsibilities around tasks in a unit.

The findings indicated no relationship between the leadership style of the facilitators and the maturity level of the learner nurses in the item about planning clinical learning responsibilities around daily tasks in a unit ($r = 0.03$, $p < 0.511$, Table 4.23).

This result might suggest that learner nurses and clinical facilitators perceived the maturity level of the learner different in respect of planning clinical responsibility in a unit. In fact, facilitators were convinced that learner nurses needed more leadership in planning their clinical responsibilities during clinical training.

4.3.2.4 Set responsibilities expected of nursing students in a clinical environment (Item 12)

A lower mean value and wider distribution of responses was obtained from the facilitators ($\bar{x} = 2.75$; SD = 0.974) than from their nursing students ($\bar{x} = 3.76$; SD = 0.594).

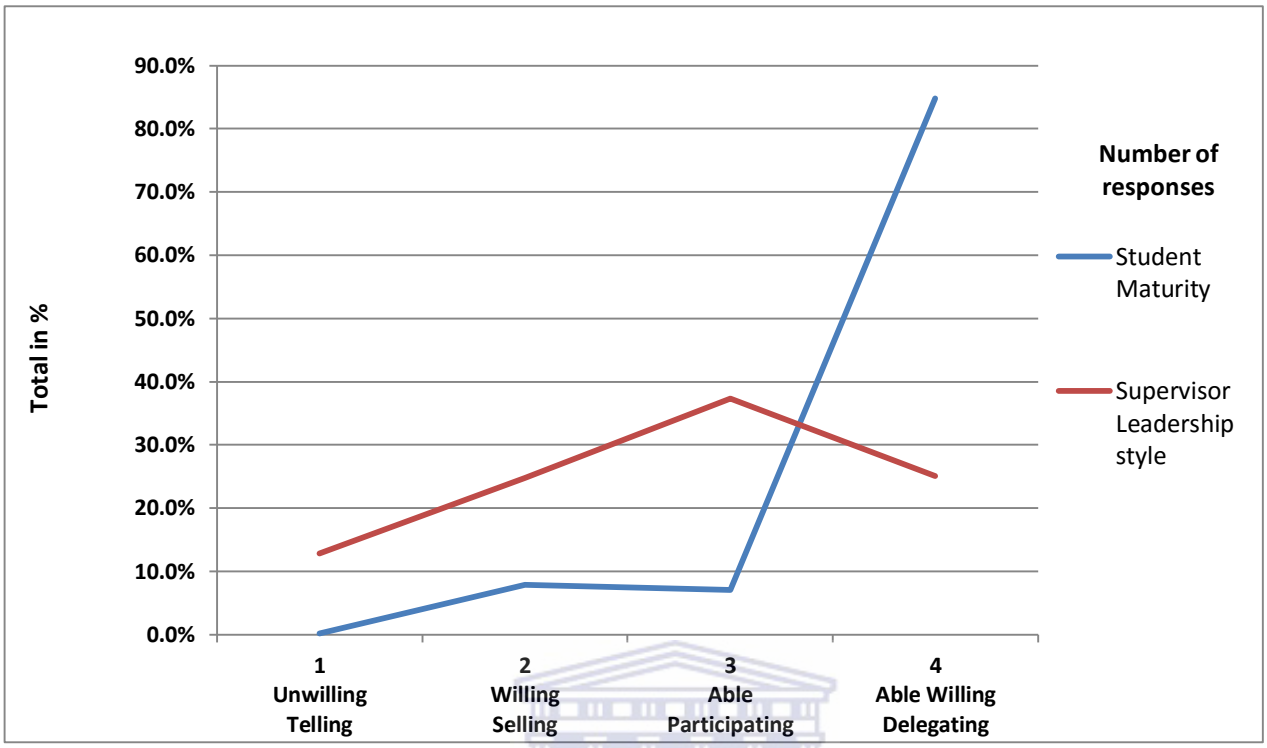

Figure 4.12: Perform responsibilities expected in a clinical environment (Item 12)

The highest rate of responses by the learner nurses (n = 345, 84.8%) indicated that they were *mature* (able and willing) to decide about performing responsibilities expected of them in clinical learning. On the other hand, the highest rate of responses by the clinical facilitators (n = 152, 37.3%) indicated that they used a *participating* (support) style of leadership for nursing students to set responsibilities expected of them in a clinical learning environment.

Only one (0.2%) learner nurse indicated that he / she was *immature* (unable and unwilling) to execute responsibilities as expected of him / her during clinical training. On the other hand, 52 (12.8%) of the clinical facilitators indicated that they *told* (telling style) learner nurses to do what is expected in a clinical learning environment.

Only 32 (7.9%) of the learner nurses indicated that they were *less mature* (willing but did not have the skills) to set responsibilities expected of them during clinical learning. However, a quarter (n = 101, 24.8%) of the clinical facilitators' responses highlighted that they used a *selling* style of leadership to learner nurses in relation to Item 12. Nearly a tenth (n = 29, 7.1%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to set responsibilities expected of them in a clinical environment. However, a quarter (n = 102, 25.1%) of the 407 (100.0%) responses by the clinical facilitators indicated they used a

delegating style (available) for learner nurses to perform responsibilities expected of them in clinical learning practice.

A weak positive relationship between the maturity level of learner nurses and the leadership style of facilitators was established in the item about performing responsibilities expected in a clinical environment ($r = 0.05$, $p < 0.359$, Table 4.23).

This result may suggest that nursing students as adults are eager to take charge of their learning. According to Witt and Kerssen-Griep (2011, p. 78), the ability and the degree nursing students shows to perform tasks expected during clinical learning indicate responsibility in clinical learning environment.

4.3.2.5 Document the clinical competencies undertaken in the unit (Item 13)

Responses by the learner nurses demonstrated a narrower distribution of responses around the mean value of 3.67 (SD = 0.575) while the responses by the facilitators indicated a wider distribution of responses around the mean value of 2.72 (SD = 1.090).

Documenting competencies undertaken in a unit is a professional responsibility and it forms part of communication in clinical learning (Falender & Shafranske, 2004, n.p.).

The highest rate of the response by clinical facilitators indicated that they *delegated* (being available) learner nurses to document clinical competencies undertaken in a unit (n = 139, 34.2%). On the other hand, the highest rate of responses by the learner nurses indicated that they were *mature* (able and willing) to decide about documenting clinical competencies undertaken in a unit (n = 358, 88.0%).

Less than a quarter (n = 61, 15.0%) of the clinical facilitators' responses indicated *autocratic* (telling style) leadership while learner nurses responded that they were *immature* (unable and unwilling) to document clinical competencies undertaken in a unit (n = 4, 1.0%).

Likewise, 23 (5.7%) of the learner nurses indicated that they were *less mature* (willing but did not have the skills) to document competencies done in a unit while nearly a third (n = 132, 32.4%) of responses by the clinical facilitators indicated to have used a *selling* style (guiding) for learner nurses to document competencies in a unit.

Only 22 (5.4%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to document clinical competencies undertaken in a unit while 75 (18.4%) of the clinical facilitators' responses

indicated that they *participated* (support) with learner nurses to document competencies carried out in a unit.

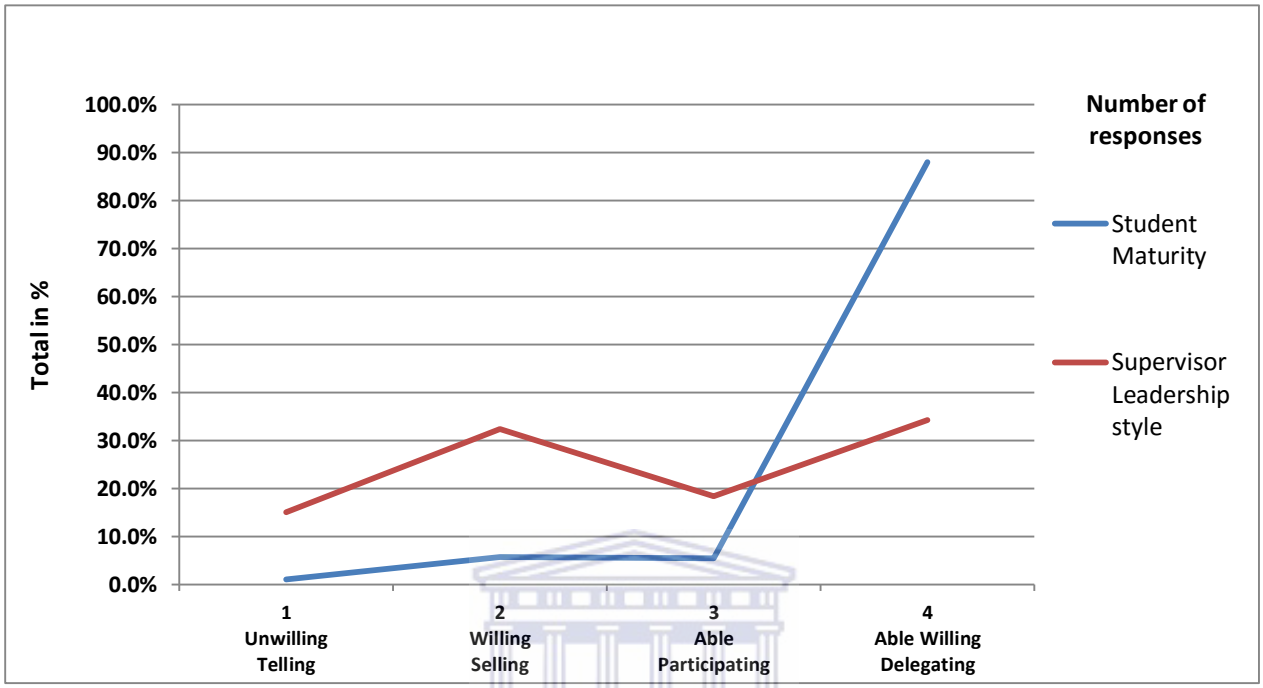

Figure 4.13: Document clinical competencies undertaken in the unit (Item 13)

The comparison in Table 4.23 indicates that there is no relationship between the leadership style of facilitators and the maturity level of learner nurses in respect of documenting clinical competencies undertaken in a unit ($r = 0.05$, $p < 0.29$).

4.3.2.6 Attend to scheduled appointments with nursing students (Item 14)

When utilising a humanistic educational philosophy, nursing students are responsible for their own learning and the educator serves as the facilitator of learning, rather than adopting an authoritarian position (Billings & Halstead, 2009 p. 210).

The responses of the learner nurses demonstrated a high mean value and narrower distribution of responses around the mean value of 3.73 (SD = 0.688). On the other hand, the responses by facilitators revealed a lower mean value and wider distribution of responses around the mean value of 3.20 (SD = 0.988).

The highest rate of responses of the facilitators indicated that they used a *delegating* style of leadership (n = 208, 51.1%), while the highest rate of responses of the learner nurses indicated that they were *mature* (able and willing) to decide about attending to scheduled appointments with facilitators (n = 342, 84.0%).

In addition, 38 (9.3%) of the facilitators' responses indicated that they *instructed* (telling style) the learner nurses to show up for their scheduled appointment in practice while only 11 (2.7%) of the learner nurses indicated that they were *immature* (unable and unwilling) to decide adhering to scheduled appointments with facilitators.

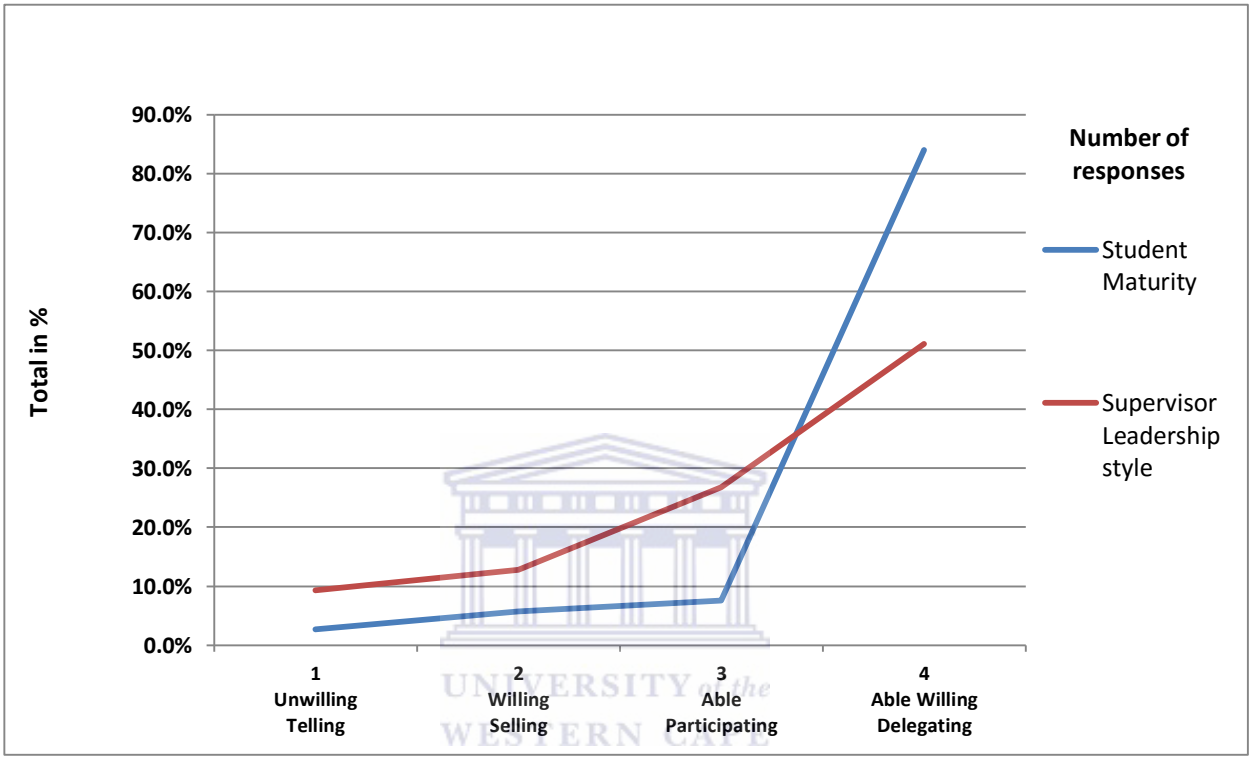

Figure 4.14: Attend to scheduled appointment with clinical facilitators (Item 14)

Nearly six per cent (n = 23, 5.7%) of the learner nurses pointed out that they were *less mature* (willing but did not have skills) to arrange appointments with clinical facilitators. However, more than a tenth (n = 52, 12.8%) of the clinical facilitators indicated that they used a *selling* style (guiding) of leadership for learner nurses to attend to scheduled appointment in clinical practice.

Only 31 (7.6%) of the learner nurses specified that they were *moderately mature* (able but unwilling) to attend appointments scheduled with facilitators. Nevertheless, a quarter (n = 109, 26.8%) of the responses by the facilitators indicated that they *participated* (support) with the learner nurses to attend scheduled appointments with them.

The statistical test indicates a very weak positive relationship between the leadership style of facilitators and the maturity level of learner nurses in terms of attending to scheduled appointments with clinical facilitators (r = 0.13, p < 0.011, Table 4.23).

4.3.2.7 Use the standard procedure in a unit, e.g. preparation of a patient for theatre (Item 15)

The 407 (100.0%) responses of the facilitators indicated a wide spread around the mean value of 2.53 (SD = 1.057) as compared to the responses of the 407 (100%) learner nurses that indicated a narrow spread of responses around the mean value of 3.67 (SD = 0.739).

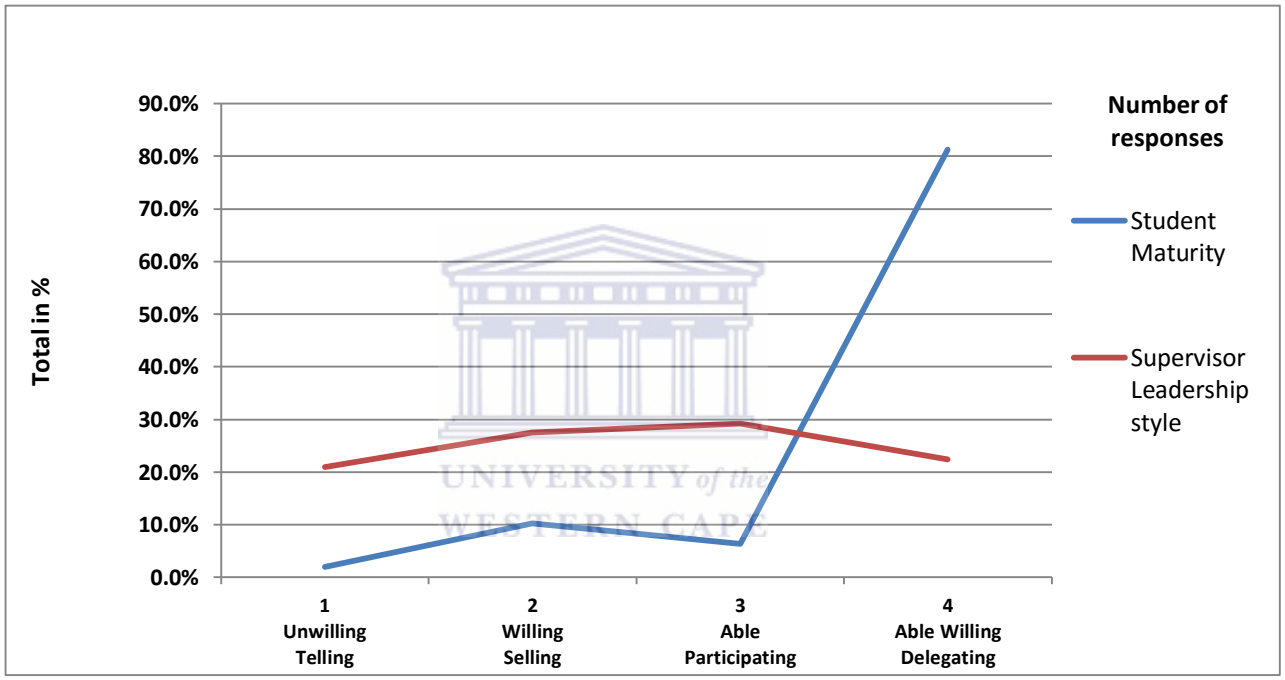

Figure 4.15: Use the standard procedure in a unit, e.g. preparation of patient for theatre (Item 15)

The highest rate of responses by the clinical facilitators indicated that they used a *participating* style of leadership for learner nurses to use standard procedures in a unit, e.g. preparing a patient for theatre (n = 119, 29.2%). On the other hand, the highest rate of responses by the learner nurses indicated that they were *mature* (able and willing) to decide about using standard procedures in a unit when they prepare a patient for theatre (n = 331, 81.3%).

Only 85 (20.9%) of the clinical facilitators pointed out that they *told* (telling style) learner nurses to use standard procedures for preparing patients for theatre. However, 8 (2.0%) of the learner nurses indicated that they were *immature* (unable and unwilling) in relation to the discussed item.

A tenth (n = 42, 10.3%) of the learner nurse indicated that they were *less mature* (willing but did not have skills) to use standard procedures for patient going to theatre. On the other hand, more than a quarter (n = 112, 27.5%) of the clinical facilitators indicated that they used a *selling* style of leadership (guiding) for learner nurses to use the standard procedures in a unit for preparing a patient for theatre.

Nonetheless, only 26 (6.4%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to decide about using standard procedures for preparing a patient for theatre. Only 91 (22.4%) of the 407 (100.0%) responses by the clinical facilitators indicated that they used a *delegating* style of leadership (being available) for learner nurses to use standard procedures in the unit, e.g. preparing a patient for theatre.

There was no relationship between the leadership style of facilitators and the maturity level of learner nurses about using the standard procedures in a unit, e.g. preparing a patient for theatre ($r = 0.09$, $p < 0.065$, Table 4.23). The result might be a signal that learner nurses needed more leadership about the use of standard procedures in a unit. According to Muller (2004, p. 135), standards of practice provide the basis for competency amongst professionals in a unit.

4.3.2.8 Use learning strategies to enhance nursing students' knowledge about clinical nursing practice (Item 16)

The lowest mean value of 2.63 (SD = 0.945) of the 407 (100.0%) responses by the facilitators indicated a wider dispersion of responses than a mean value of 3.69 (SD = 0.676) of the 407 (100.0%) learner nurses that represented a narrower distribution of responses.

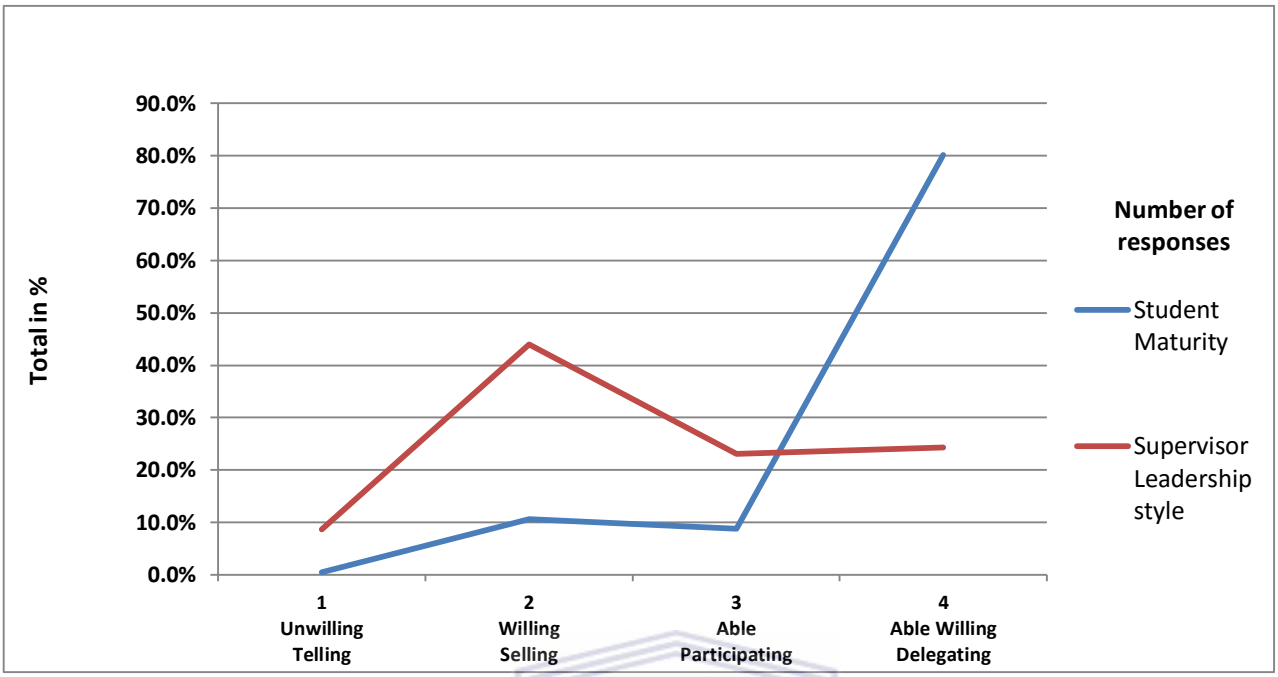

Figure 4.16: Use learning strategies to enhance knowledge about clinical nursing practice (Item 16)

The highest rate of responses by the learner nurses indicated that they were *mature* (able and willing) to decide about using learning strategies that enhanced knowledge of nursing practice (n = 326, 80.1%). On the other hand, the highest rate of responses by the clinical facilitators indicated that they used a *selling* style (guide) for learner nurses to use learning strategies that enhanced knowledge of nursing practice (n = 179, 44.0%).

Only 35 (8.6%) of the responses by clinical facilitators indicated that they *told* (telling style) learner nurses to use learning strategies to enhance knowledge of nursing practice while two (0.5%) of the learner nurses pointed out that they were *immature* (unable and unwilling) to use learning strategies that increased knowledge of nursing practice.

A tenth (n = 43, 10.6%) of the learner nurses indicated that they were *less mature* (willing but did not have skills) to use strategies that enhanced knowledge of nursing practice. Another 36 (8.8%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to apply learning strategies that enhanced knowledge of clinical practice. On the other hand, 94 (23.1%) of the responses by clinical facilitators indicated that they *participated* (support) with learner nurses to use strategies that enhanced knowledge of clinical nursing practice. Almost a quarter (n = 99, 24.3%) of the 407 (100.0%) responses by the clinical

facilitators demonstrated a *delegating* leadership style (being available) for learner nurses to use learning strategies that enhanced knowledge about nursing practice.

There was a weak positive relationship between the leadership style of clinical facilitators and the maturity level of learner nurses in this item about using learning strategies that enhanced knowledge about nursing practice in clinical learning (r = 0.15, p = 0.002, Table 4.23).

The results might imply that the learner nurses did apply learning strategies to enhance knowledge of clinical nursing practice. Studies by Po-ying (2007, p. 225) reveal that once learners are given an opportunity to try out different ways of learning and select strategies according to their own areas of strength, they learn best.

4.3.2.9 Follow a case-based approach in demonstrating learner nurses' clinical competencies (Item 17)

A case-based approach to teaching prepares learner nurses for real problems during their profession in future (Lee *et al.*, 2009, p. 4). The advantage is that it builds on learners' prior knowledge (Moore, 2009, p. 151) and develops self-directedness (Uys & Meyer, 2005, p. 16).

The lowest mean value of 2.65 (SD = 0.899) of the 407 (100.0%) responses by the facilitators was indicated with a wider dispersion of responses compared to the mean value of 3.52 (SD = 0.815) of the 407 (100.0%) learner nurses' responses that represented a slightly narrower distribution of responses.

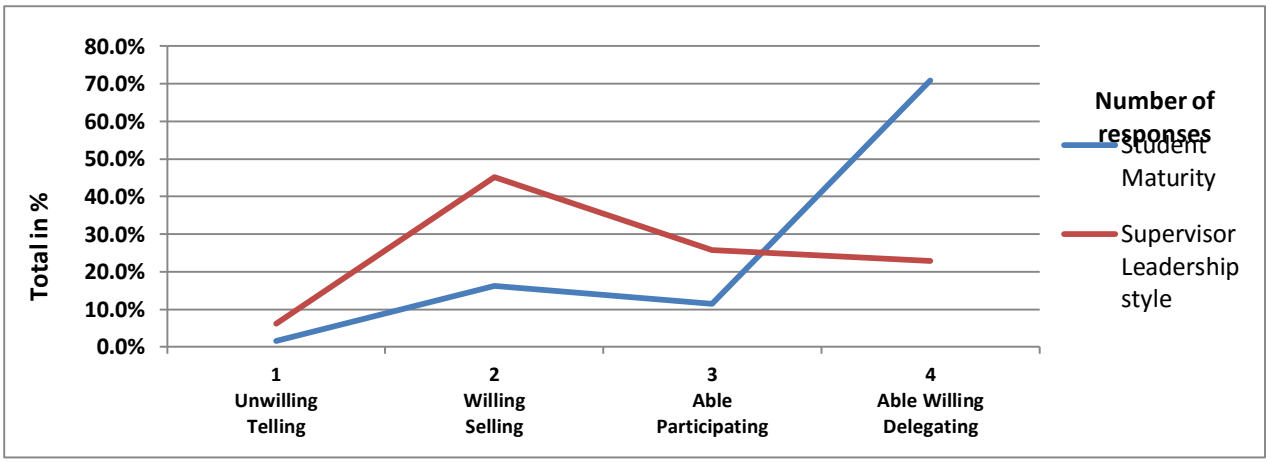

Figure 4.17: Follow a case-based approach in demonstrating clinical competencies (Item 17)

The highest rate of responses by the learner nurses indicated that they were *mature* (able and willing) to decide about using a case-based approach to demonstrate clinical competency (n = 288, 70.8%). On the other hand, the highest rate of responses by the clinical facilitators indicated that they used a *selling*

(guiding) style of leadership for learner nurses to follow a case-based approach to demonstrate clinical competency in a learning environment (n = 184, 45.2%).

A further 25 (6.1%) of facilitators' responses indicated that they *told* (telling style) learner nurses to use a case-based approach to demonstrate their clinical competencies. Only 6 (1.5%) of the learner nurses indicated that they were *immature* (unable and unwilling) to demonstrate clinical competency by using a case-based approach.

Another 66 (16.2%) of the learner nurses specified that they were *less mature* (willing but did not have skills) to follow a case-based approach as demonstration of clinical competency. A quarter (n = 105, 25.8%) of the clinical facilitators' responses indicated that they used a *participating* leadership style (support) for learner nurses to demonstrate clinical competency by following a case-based approach whereas only 47 (11.5%) of the learner nurses specified that they were *moderately mature* (able but unwilling) to demonstrate clinical competencies by following a case-based approach.

Nevertheless, 93 (22.9%) of the 407 (100.0%) responses of the clinical facilitators indicated that they used a *delegating* leadership style (being available) for learner nurses to follow a case-based approach method for demonstrating competency in clinical learning.

A weak positive relationship between the leadership style of clinical facilitators and the maturity level of learner nurses in this item about following a case-based approach to demonstrate clinical competency in the clinical learning environment was established ($r = 0.12$, $p < 0.018$, Table, 4.23). The conclusion drawn was that learner nurses were mature to follow a case-based approach to demonstrate clinical competency in a learning environment.

4.3.2.10 Practise as a team member in a clinical practice setting (Item 18)

One of the seven critical cross-field outcomes (CCFOs) identified by the South African Qualification Authority states that a learner should be able to work effectively as a team member (Meehan-Andrews, 2009, p. 25).

The mean value of 2.68 (SD = 1.003) of the 407 (100.0%) responses by the facilitators was indicated with wider a distribution of responses around the mean value than the mean value of 3.71 (SD = 0.665) of the 407 (100.0%) learner nurses that denoted a narrower distribution of responses around the mean value.

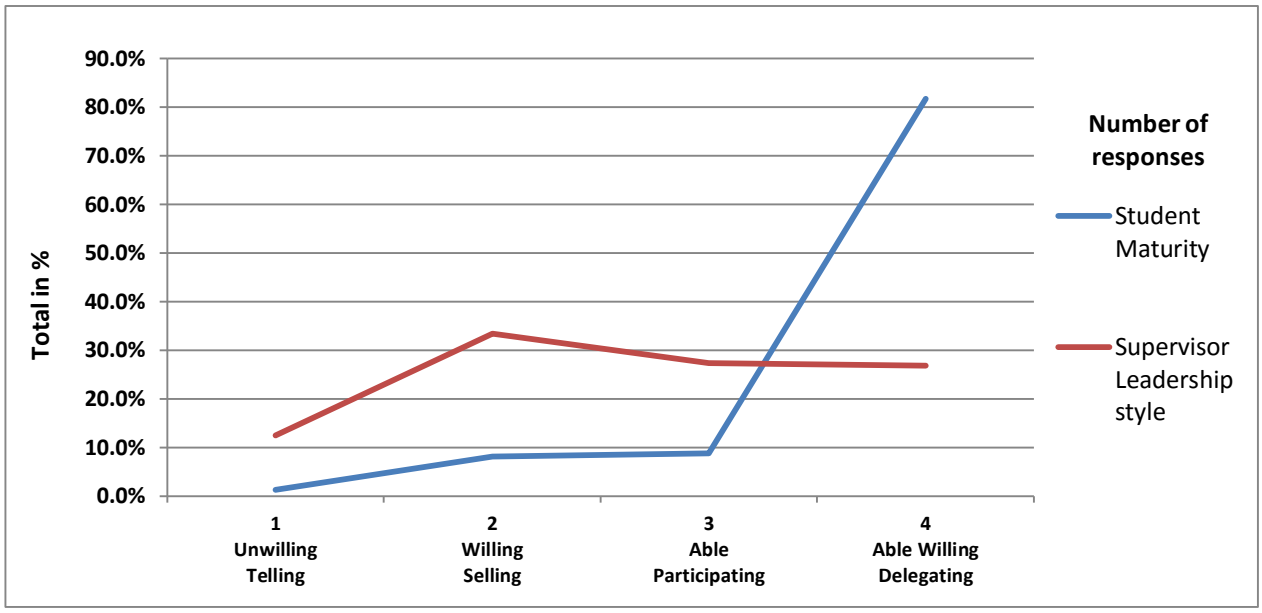

Figure 4.18: Practise as a team member in a clinical practice setting (Item 18)

The highest rate of responses by the learner nurses (n = 333, 81.8%) indicated that they were *mature* (able and willing) to decide about practising as team members in clinical training. On the other hand, the highest rate of responses by the clinical facilitators (n = 136, 33.4%) indicated that they used a *selling* style of leadership (guiding) for learner nurses who were practising as team members in clinical practice.

More than a tenth (n = 51, 12.5%) of the clinical facilitators further indicated that they *instructed* (telling style) learner nurses to practise as team in clinical practice. Only 5 (1.2%) of the learner nurses revealed that they were *immature* (unable and unwilling) to decide about practising as team members in clinical practice.

Only 33 (8.1%) of the learner nurses indicated that they were *less mature* (willing but did not have skills) to practise as team members in a practice setting.

In the same vein, 36 (8.8%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to practise as team members in clinical practice while more than a quarter (n = 111, 27.3%) of the clinical facilitators indicated that they used a *participating* style of leadership (support) for learner nurses to practise as team members in a clinical practice environment.

Over a quarter (n = 109, 26.8%) of the 407 (100%) responses by the clinical facilitators revealed that they used a *delegating* leadership style (being available) for learner nurses to practise as teamwork members in a clinical setting.

There was a weak positive relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses to the item about practising as team members in a clinical learning environment (r = 0.13, p < 0.009, Table, 4.23).

4.3.2.11 Conduct clinical activities that promote nursing students' professional capacity (Item 19)

According to Harrington and Harrington (2008, p. 70), authentic clinical activities develop nursing students' knowledge and enhance professional capability (Michael, Driessen, Muijtjens, Van Gaal, Bossaert & De Winter, 2009, p. 2).

The mean value of 2.73 (SD = 0.890) of the 407 (100.0%) responses by the facilitators was lower and represented a broader distribution of responses around the mean value than the mean value of 3.62 (SD = 0.762) of the 407 (100.0%) learner nurses that represented a narrower spread of responses around the mean value.

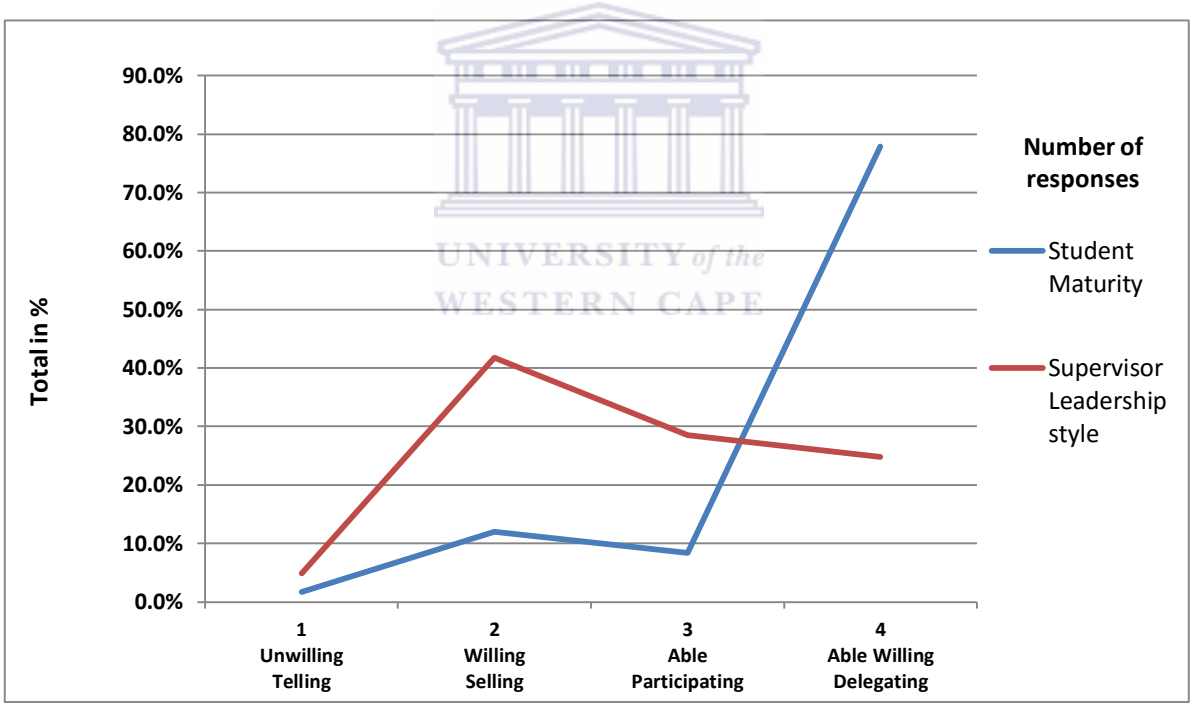

Figure 4.19: Conduct clinical activities that promote nursing students' professional capability (Item 19)

In Item 19, the highest rate of responses by the learner nurses (n = 317, 77.9%) indicated that they were *mature* (able and willing) to decide about conducting clinical activities that promoted professional capacity in a clinical learning environment. On the other hand, the highest rate of responses by the clinical facilitators

(n = 170, 41.8%) indicated that they used a *selling* (guiding) style of leadership for learner nurses to conduct clinical activities that promoted professional capacity.

A fifth (n = 20, 4.9%) of the clinical facilitators' responses indicated that they *informed* (telling style) learner nurses to conduct clinical activities that promoted professional capacity. However, 7 (1.7%) of the learner nurses indicated that they were *immature* (unable and unwilling) to conduct activities that promoted professional capacity. Only 49 (12.0%) of the learner nurses indicated that they were *less mature* (willing but did not have the skills) to conduct clinical activities that promoted professional knowledge.

More than a quarter (n = 116, 28.5%) of the clinical facilitators' responses indicated that they used a *participating* style (support) for learner nurses to conduct clinical activities that promoted their professional capacity while only 34 (8.4%) of the learner nurses indicated that they were *less mature* (able but unwilling) to conduct activities that promoted professional capacities. A quarter (n = 101, 24.8%) of the 407 (100.0%) responses of the clinical facilitators indicated a *delegation* leadership style (being available) for learner nurses to conduct clinical activities that promoted professional capacity of learner nurses.

There was no relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in the item about conducting clinical activities that promoted professional capacity (r = 0.10, $p < 0.057$, Table, 4.23). These results could be indicating that learner nurses experienced challenges in a clinical learning environment that might have prevented them from conducting activities that promoted professional capacity.

4.3.2.12 Evaluation of competencies according to the method stipulated by the clinical facilitator (Item 20)

Evaluation would be unsuccessful when learners are not evaluated according to set methods (Darling-Hammond, 2012, p. iv). The 407 responses of the facilitators were widely spread around the mean value of 2.96 (SD = 0.978) compared to the 407 responses of the learner nurses that indicated a narrow spread of responses around the mean value of 3.71 (SD = 0.699).

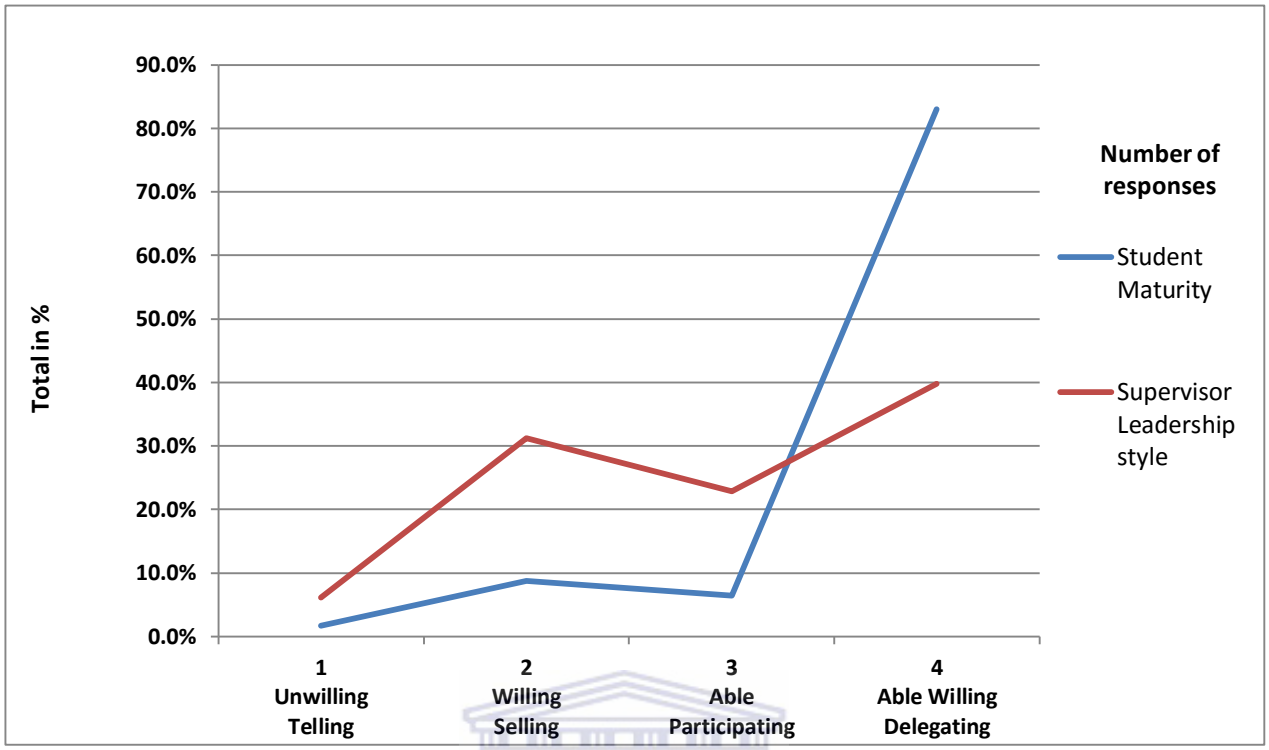

Figure 4.20: Evaluation of competencies according to the method stipulated by the clinical facilitator (Item 20)

The highest rate (n = 162, 39.8%) of the 407 (100.0%) responses by the facilitators indicated that they used a *delegating* leadership style (being available) for learner nurses to evaluate whether learner nurses executed competencies according to the methods stipulated. On the other hand, the highest rate (n = 338, 83.0%) of the 407 (100%) learner nurses indicated that they were *mature* (able and willing) to decide whether to execute competencies according to the methods stipulated by the facilitators.

Only 25 (6.1%) of the clinical facilitators' responses indicated that they *told* (telling style) the learner nurses to execute competencies according the methods as stipulated for evaluation purposes. However, 7 (1.7%) of the learner nurses indicated that they were *immature* (unable and unwilling) to be evaluated in relation to competencies according to the methods stipulated by the facilitators.

Only 36 (8.8%) of the learner nurses' responses indicated that they were *less mature* (willing but did not have the skills) to be evaluated in relation to competencies according to the methods stipulated by the facilitators. However, close to a third (n = 127, 31.2%) of the clinical facilitators' responses indicated that they used a *selling* style (guiding) for learner nurses to be evaluated in relation to competencies according to the methods as stipulated by them.

Less than a quarter, 93 (22.9%) of the facilitators' responses indicated that they used a *participating* style (support) for learner nurses to be evaluated in relation to competencies as stipulated. Only 26 (6.4%) of the learner nurse's responses indicated that they were *moderately mature* (able but unwilling) to be evaluated in relation to those competencies.

There was no relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in the item about being evaluated in relation to competencies according to the methods stipulated by the clinical facilitators ($r = 0.06$, $p = 0.201$, Table 4.23).

4.3.2.13 Provide feedback about mistakes nursing student made during clinical competencies (Item 21)

Both verbal and written feedback must be constructive to a learner about aspects that do not meet the required professional standards (Mckenna *et al.*, 2011, p. 235).

The responses of the 407 facilitators were widely spread around the mean value of 3.00 (SD = 1.006) compared to the responses of the 407 learner nurses that represented a narrow spread of responses around the mean value of 3.80 (SD = 0.608) for Item 21.

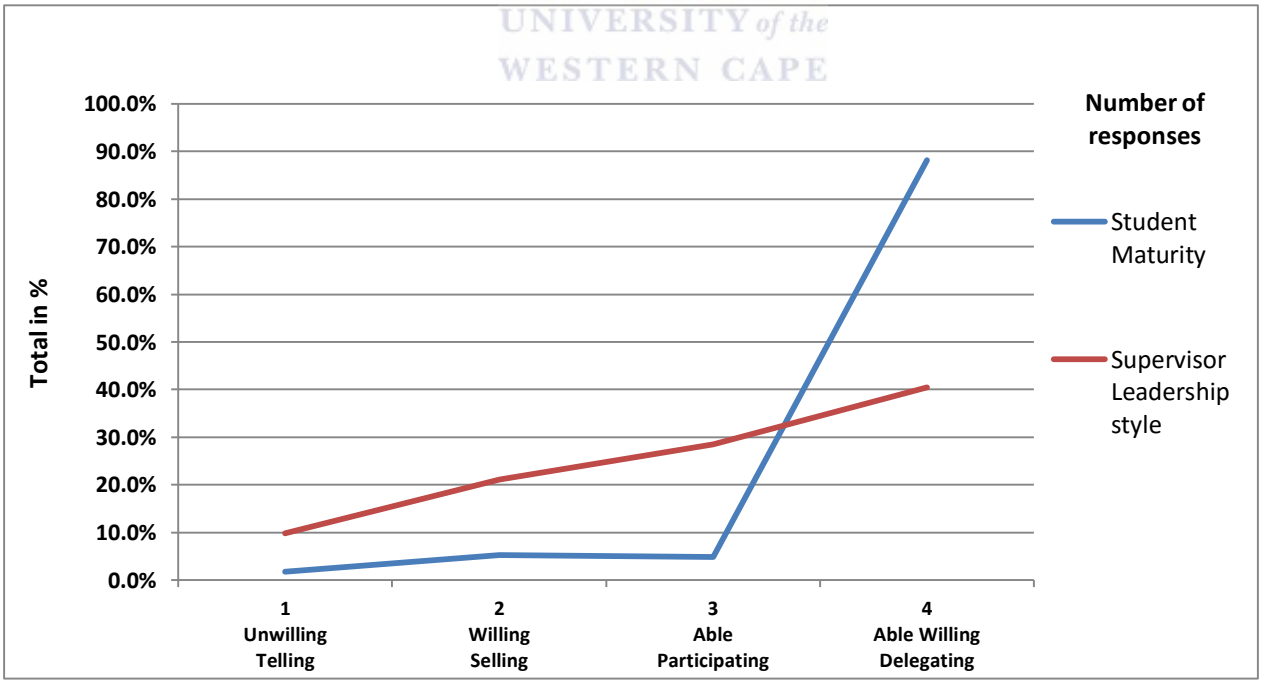

Figure 4.21: Receive feedback about mistakes made during clinical competencies (Item 21)

The majority (n = 359, 88.2%) of the 407 (100.0%) learner nurses indicated that they were *mature* (able and willing) to decide about receiving feedback about mistakes they had made during clinical learning. However, the highest rate (n = 165, 40.5%) of the 407 (100.0%) responses by the clinical facilitators showed that they used a *delegating* leadership style (being available) for learner nurses to provide feedback about mistakes they had made during clinical learning.

Almost a third (n = 116, 28.5%) of the responses by the clinical facilitators indicated that they used a *participating* style (support) for learner nurses to provide feedback about mistakes learners had made during clinical practice. Only 20 (4.9%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to receive such feedback about mistakes made during clinical learning.

Furthermore, a minority (n = 21, 5.2%) of the learner nurses indicated that they were *less mature* (willing but did not have the skills) to receive feedback about the mistakes made during clinical practice. On the other hand, 86 (21.1%) of the clinical facilitators' responses indicated that they used a *selling* style (guiding) for learner nurses to receive feedback about mistakes they had made during clinical practice.

Only 7 (1.7%) of the learner nurses indicated that they were *immature* (unable and unwilling) to receive feedback about mistakes made during clinical practice. On the other hand, a tenth (n = 40, 9.8%) of the clinical facilitators' responses indicated that they *instructed* (telling style) learner nurses about feedback about the mistakes they had made during clinical learning.

There was no significant relationship between the leadership style of the clinical facilitators and the maturity level of the learners 1n Item 21 ($r = 0.02$, $p < 0.698$, Table 4.23).

4.3.3 Teaching techniques / principles

Tables 4.24 and Table 4.25 indicate the responses of the facilitators and the learner nurses on items 22-29 regarding the component, the teaching techniques / principles. Table 4.26 indicates the significance in the teaching techniques / principles of the clinical facilitator and learner nurses.

Table 4.24: Teaching techniques / principles from the perspective of clinical facilitators

	Responses of clinical facilitators	Leadership styles											
		Tells the nursing student how to: Telling		Guides nursing student to: Selling		Supports nursing student to: Participating		Is available to: Delegating		Total		$\bar{x}$	SD
		1		2		3		4					
	Items	n	%	n	%	n	%	n	%	n	%		
22	Demonstrate a nursing technique by using a visual presentation to learner nurses.	40	9.8	125	30.7	167	41.0	75	18.4	407	100.0	2.68	0.886
23	Practise competencies that have been demonstrated to learner nurses.	28	6.9	163	40.0	115	28.3	101	24.8	407	100.0	2.71	0.918
24	Prepare an assignment as requested.	50	12.3	111	27.3	123	30.3	122	30.0	407	100.0	2.78	1.010
25	Use opportunities to reflect on clinical experiences.	44	10.8	134	32.9	136	33.4	93	22.9	407	100.0	2.68	0.944
26	Have group discussions about, e.g. a patient scenario.	40	9.8	132	32.4	124	30.5	111	27.3	407	100.0	2.75	0.965
27	Volunteer to demonstrate competencies to colleagues during clinical facilitation.	47	11.5	152	37.3	142	34.9	66	16.2	407	100.0	2.56	0.897
28	Choose a good learning environment, e.g. a sick patient to demonstrate skills acquired.	30	7.4	197	48.4	102	25.1	78	19.2	407	100.0	2.56	0.883
29	Be creative in preparing demonstration of competency.	45	11.1	144	35.4	119	29.2	99	24.3	407	100.0	2.67	0.965

Table 4.25: Teaching techniques / principles from the perspective of learner nurses

	Responses of the learner nurses	Maturity levels											
		Unable and unwilling to:		Willing but not have the skills to:		Able but unwilling to:		Able and willing to:		Total		$\bar{x}$	SD
		1		2		3		4					
	Items	n	%	n	%	n	%	n	%	n	%		
22	Demonstrate a nursing technique that was used during a visual presentation by the clinical facilitator.	6	1.5	39	9.6	37	9.1	325	79.9	407	100.0	3.67	0.708
23	Practise competencies that have been demonstrated to me by the clinical facilitator.	4	1.0	26	6.4	27	6.6	350	86.0	407	100.0	3.78	0.601
24	Prepare an assignment as requested by clinical facilitator.	17	4.2	33	8.1	51	12.5	306	75.2	407	100.0	3.59	0.810
25	Use opportunities to reflect on my clinical experiences with the clinical facilitator.	7	1.7	33	8.1	44	10.8	323	79.4	407	100.0	3.68	0.696
26	Have group discussions about, e.g. a patient scenario.	17	4.2	48	11.8	45	11.1	297	73.0	407	100.0	35.3	0.859
27	Volunteer to demonstrate competencies to colleagues during clinical facilitation.	13	3.2	46	11.3	79	19.4	269	66.1	407	100.0	3.48	0.818
28	Choose a good learning environment, e.g. a sick patient to demonstrate skills required.	9	2.2	49	12.0	54	13.3	295	72.5	407	100.0	3.56	0.788
29	Be creative in preparing to present a competency, e.g. advice to the patient.	5	1.2	39	9.6	46	11.3	317	77.9	407	100.0	3.66	0.701

Table 4.26: Significance of relationships between leadership style and maturity levels in relation to teaching techniques / principles

	Teaching techniques / principles for the learner and the facilitator	Correlation (*r*)	p-value
22	Demonstrate nursing techniques used during a visual presentation by the clinical facilitator to me.	0.06	0.251
23	Practise competencies that have been demonstrated to me by the clinical facilitator.	0.08	0.118
24	Prepare an assignment as requested by clinical facilitator.	0.10	0.042
25	Use opportunities to reflect on my clinical experiences with my clinical facilitator.	-0.01	0.909
26	Have a group discussion about, e.g. a patient scenario.	0.01	0.924
27	Volunteer to demonstrate competencies to colleagues during clinical facilitation.	0.01	0.886
28	Choose a good learning environment, e.g. a sick patient to demonstrate skills acquired.	0.10	0.044
29	Is creative in preparation to present competencies to a clinical facilitator, e.g. advice to patient.	0.09	0.08

4.3.3.1 Demonstrate a nursing technique by using a visual presentation by the facilitator (Item 22)

The results in the Item 22 indicated a wider distributions of responses of facilitators around the mean value of 2.68 (SD = 0.886) than distributions of responses around the mean value 3.67 (SD = 0.708)of learner nurses.

In clinical learning, nurses come across real nursing situations as opposed to academic learning. They learn nursing techniques / skills and procedures as demonstrated by a facilitator (Henderson, *et al.*, 2009, p. 177).

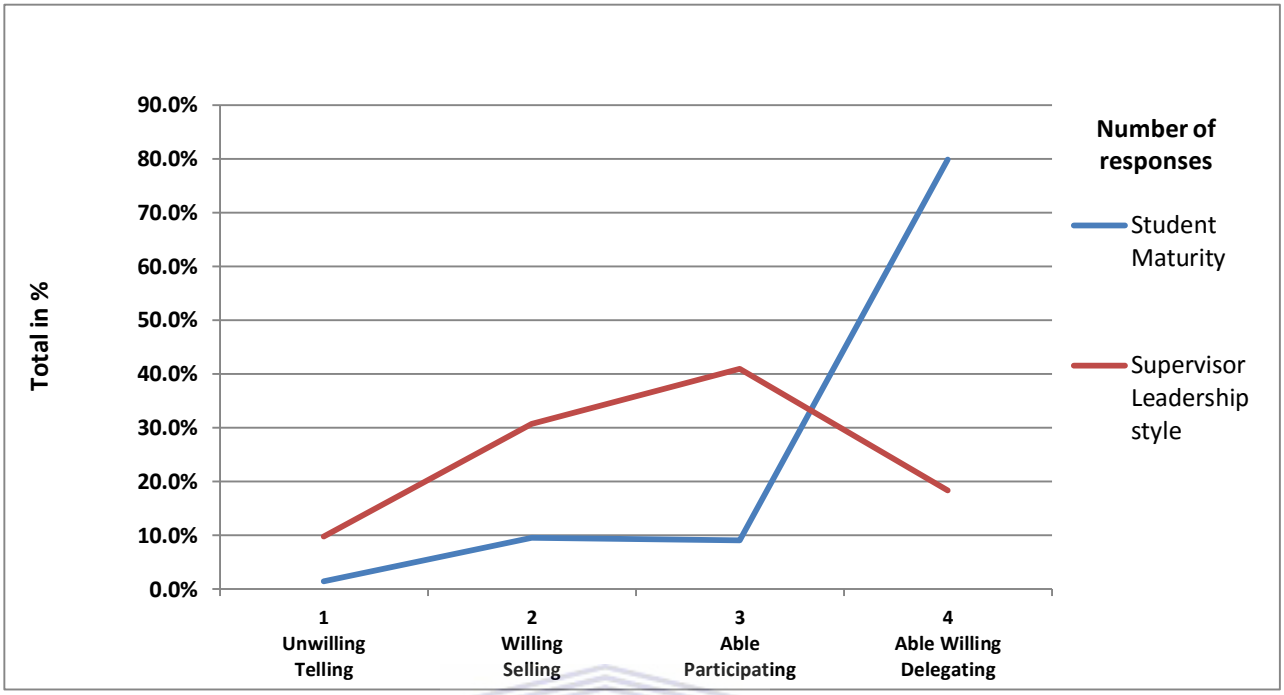

Figure 4.22: Demonstrate a nursing technique by using a visual presentation by a clinical facilitator (Item 22)

The highest rate of responses by the learner nurses (n = 325, 79.9%) indicated that they were *mature* (able and willing) to decide about demonstrating a nursing technique during a visual presentation by a clinical facilitator. On the other hand, the highest rate of responses by the clinical facilitators (n = 167, 41.0%) indicated that they used a *participating* (support) style of leadership for learner nurses while demonstrating a nursing technique by using a visual presentation.

Only 6 (1.5%) of the learner nurses indicated that they were *immature* (unable and unwilling) to decide about demonstrating a nursing technique used by a clinical facilitator. Nevertheless, 40 (9.8%) of the responses by clinical facilitators indicated that they *informed* (telling style) learner nurses to carry out a nursing technique as demonstrated to them by means of a presentation.

A tenth (n = 39, 9.6%) of the learner nurses showed that they were *less mature* (willing but they did not have skills) to carry out a nursing technique as demonstrated while nearly a third (n = 125, 30.7%) of the responses by clinical facilitators pointed out that they used a *selling* style of leadership (guiding) for learner nurses to carry out a nursing technique as demonstrated.

Almost a tenth (n = 37, 9.1%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to carry out the nursing technique as demonstrated by the clinical facilitator. Only 75 (18.4%) of

the 407 responses by the clinical facilitators indicated that they used a *delegation* style of leadership (being available) for learner nurses in relation to carrying out a nursing technique as demonstrated during a visual presentation.

The findings in Table 4.26 indicate no relationship between the leadership style of the facilitators and the maturity level of the learner nurses in relation to carrying out a nursing technique as demonstrated during a visual presentation by the clinical facilitator ($r = 0.06$, $p < 0.251$). This could be related to learner nurses not having enough opportunities to practice skills / techniques that were presented to them by clinical facilitators.

4.3.3.2 Practise competencies that have been demonstrated to learner nurses (Items 23)

According to Feldman (2011, p. 288), to achieve confidence and self-actualisation, learners should practise procedures demonstrated to them with the aim of them becoming the best professional nurses in future.

The distributions of responses of the 407 (100.0%) responses by the facilitators were widely spread around the mean value of 2.68 (SD = 0.886) compared to the distributions of responses by 407 (100.0%) learner nurses that presented a narrower spread of responses around the mean value of 3.78 (SD = 0.601).

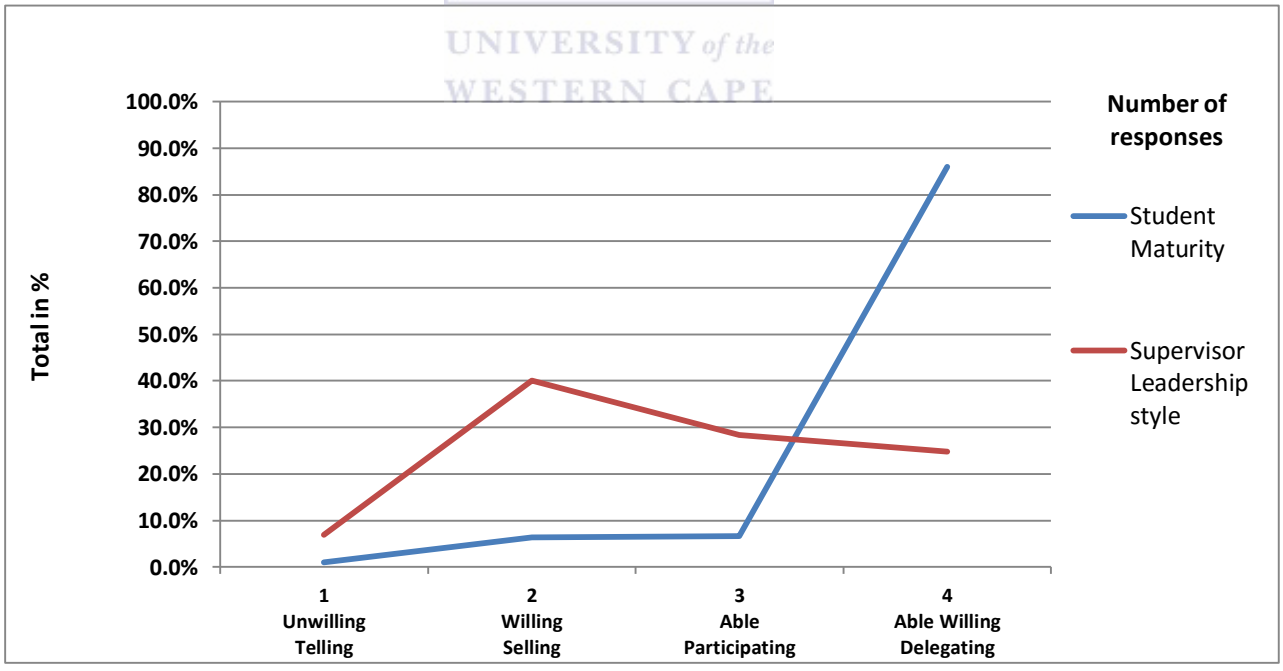

Figure 4.23: Practise competencies that have been demonstrated by the clinical facilitator (Item 23)

The highest rate of responses by the clinical facilitators indicated that they used a *selling* leadership style (guiding) for learner nurses to practise competencies that had been demonstrated to them (n = 163, 40.0%). On the other hand, the highest rate of learner nurses' responses indicated that they were *mature* (able and willing) to decide about practising competencies demonstrated by the clinical facilitator (n = 350, 86.0%).

Only 28 (6.9%) of the responses by the clinical facilitators indicated that they *told* (telling style) learner nurses to practise competencies that had been demonstrated to them. However, 4 (1.0%) of the learner nurses specified that they were *immature* (unable and unwilling) to practise competencies demonstrated to them.

Likewise, a small minority (n = 26, 6.4%) of the learner nurses indicated that they were *less mature* (willing but did not have the skills) to practise competencies as demonstrated by clinical facilitators. Nearly a third (n = 115, 28.3%) of responses by the clinical facilitators indicated that they *participated* (support) with the learner nurses who practised competencies that had been demonstrated to them in a clinical practice environment. However, a small minority (n = 27, 6.6%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to practise the competencies that had been demonstrated to them by the clinical facilitators. A quarter (n = 101, 24.8%) of the 407 (100.0%) responses by the facilitators indicated that they used a *delegation* style of leadership (being available) for learner nurses to practise competencies that had been demonstrated to them in clinical learning.

The findings in Item 23 indicate no relationship between the leadership style of the facilitators and the maturity level of the learner nurses ($r = 0.08$, $p < 0.118$, Table 4.26). These results could be suggesting that learner nurses were not allowed enough time to practise competencies that had been demonstrated to them in a clinical learning environment.

4.3.3.3 Prepare an assignment as requested by the facilitator (Item 24)

The mean value of 2.78 (SD = 1.010) of the 407 (100.0%) responses by the clinical facilitators was lower and represented a broader distribution of responses while the mean value of 3.59 (SD = 0.810) of the 407 (100.0%) learner nurses indicated a higher and narrower spread of responses around the mean value.

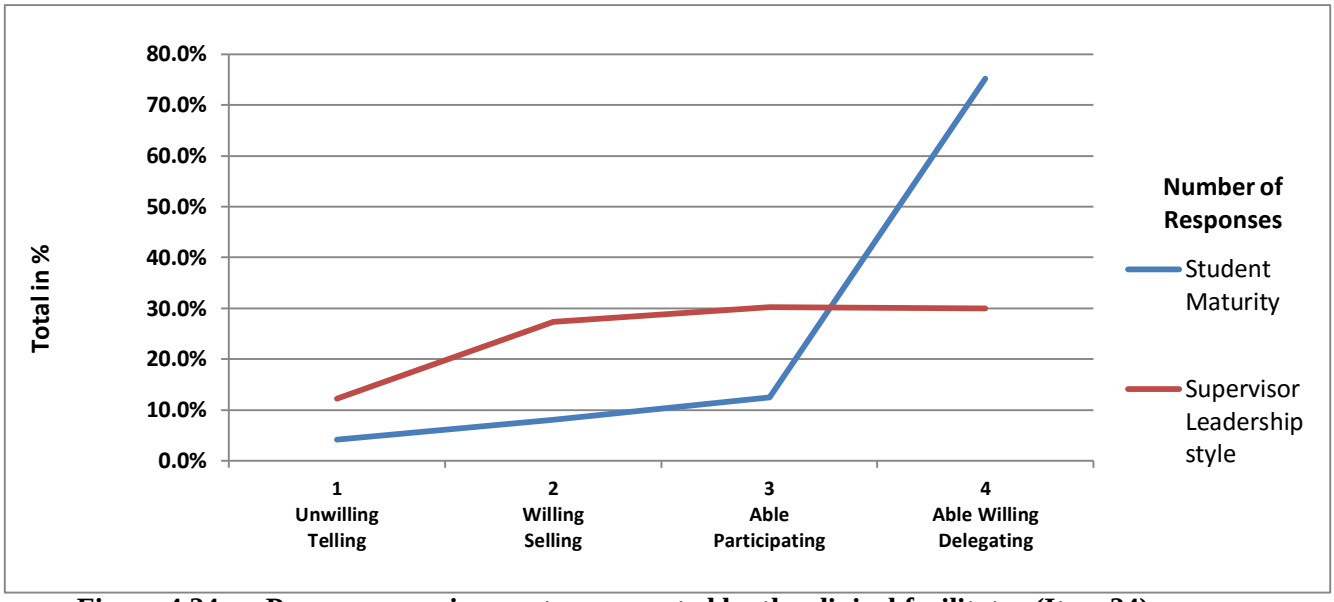

Figure 4.24: Prepare an assignment as requested by the clinical facilitator (Item 24)

The highest rate of the learner nurses' responses (n = 306, 75.2%) indicated that they were *mature* (able and willing) to decide about assignments as requested by their clinical facilitators. On the other hand, the highest rate of responses by clinical facilitators indicated that they used a *participating* leadership style (support) for learner nurses to prepare assignments as requested (n = 123, 30.3%).

Only 50 (12.3%) of the responses by the clinical facilitators highlighted that they *instructed* (telling style) learner nurses to prepare assignments as requested. However, 17 (4.2%) of the learner nurses pointed out that they were *immature* (unable and unwilling) to prepare assignments as requested by their clinical facilitators.

Over a quarter (n = 111, 27.3%) of the responses by the clinical facilitators indicated that they used a *selling* style of leadership (guiding) for learner nurses to prepare assignments as requested. However, 33 (8.1%) of the learner nurses indicated that they were *less mature* (willing but did not have the skill) to prepare assignments as requested by clinical facilitators.

More than a tenth (n = 51, 12.5%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to prepare assignments as requested by clinical facilitators. On the other hand, almost a third (n = 122, 30.0%) of the 407 (100.0%) responses by the facilitators indicated that they used a *delegation* style of leadership (being available) for learner nurses to prepare assignments as requested.

The results demonstrate a weak positive relationship between the leadership style of the facilitators and the maturity level of the learner nurses to prepare an assignment as requested by the clinical facilitator ($r = 0.10$,

p < 0.042, Table 4.26). Thus, it meant that the learner nurses and the facilitators agreed about the maturity level of the learner nurse to prepare assignments as requested.

4.3.3.4 Use opportunities to reflect on my clinical experiences with the clinical facilitator (Item 25)

In a participating style of leadership, a leader actively engages followers to think creatively and reflect on their experiences (Howitz *et al.*, 2008, p. 50). Therefore, it is appropriate to say a leader with a participating style of leadership assists learners to reflect upon what had been seen and heard in clinical learning (Lopez-preez *et al.*, 2013, p. 1).

The distribution of responses of the 407 (100.0%) responses by the facilitators were widely spread around the mean value of 2.68 (SD = 0.944) while the distribution of responses of the 407 (100.0%) learner nurses showed a narrower spread of responses around the mean value of 3.68 (SD = 0.696).

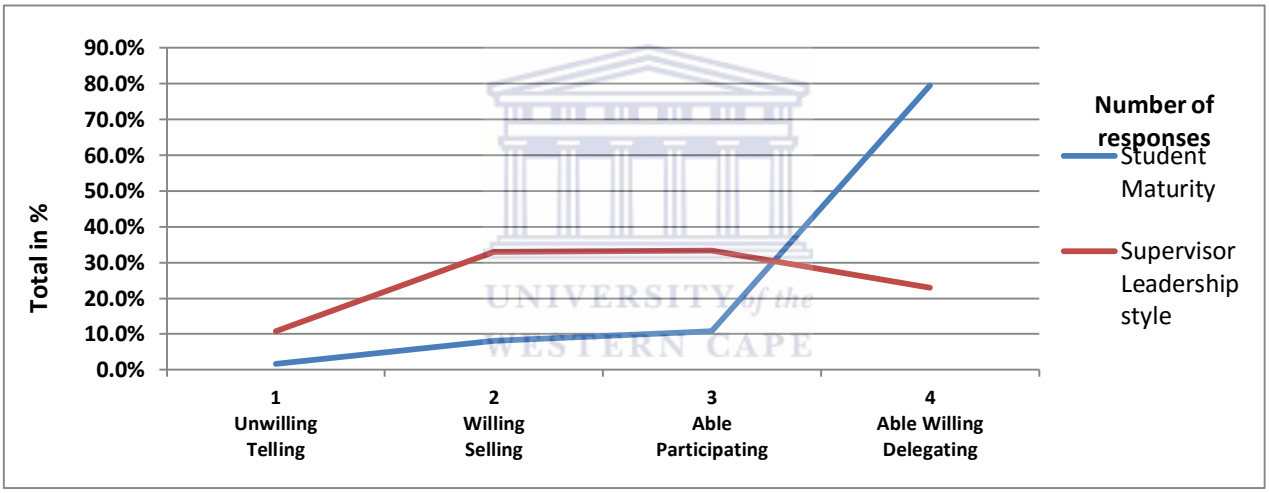

Figure 4.25: Use opportunities to reflect on clinical experiences with the clinical facilitator (Item 25)

The highest rate of responses by the clinical facilitators (n = 163, 33.4%) indicated that they *participated* with the learner nurses to use every opportunity to reflect on clinical experiences. On the other hand, the highest rate of the learner nurses (n = 323, 79.4%) indicated that they were *mature* (able and willing) to decide about using opportunities to reflect on clinical experiences.

Only 7 (1.7%) of the learner nurses pointed out that they were *immature* (unable and unwilling) to use opportunities for reflecting on clinical experiences with clinical facilitators while a tenth (n = 44, 10.8%) of responses by the clinical facilitators highlighted that they *informed* (telling style) learner nurses to use opportunities that arose to reflect on clinical experiences.

A third (n = 134, 32.9%) of responses by the clinical facilitators indicated that they used a *selling* style of leadership for learner nurses to use opportunities to reflect on clinical experiences while only 33 (8.1%) of the learner nurses showed that they were *less mature* (willing but did not have skill) to reflect on clinical experiences with clinical facilitators.

A tenth (n = 44, 10.8%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to use opportunities for reflecting on clinical experiences. Less than a quarter (n = 93, 22.9%) of the 407 (100%) responses by the facilitators showed that they used a *delegation* style of leadership (being available) for learner nurses to use opportunities for reflecting on clinical experiences.

There was no relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in the item about using opportunities to reflect on clinical experiences with the clinical facilitator (r = -0.01, p < 0.909, Table 4.26). These results could be suggesting that learner nurses lacked skills about using reflection as a learning method to enhance competency in clinical learning.

4.3.3.5 Have group discussions about, e.g. a patient scenario (Item 26)

A group discussion method of learning is supported in literature studies (Elbousty & Bratt, 2010, p. 7; Dungy & Whitaker, 2010, p. 208). In this method, members learn more effectively by collaborating, solving learning problems collectively, and constructively criticising one another.

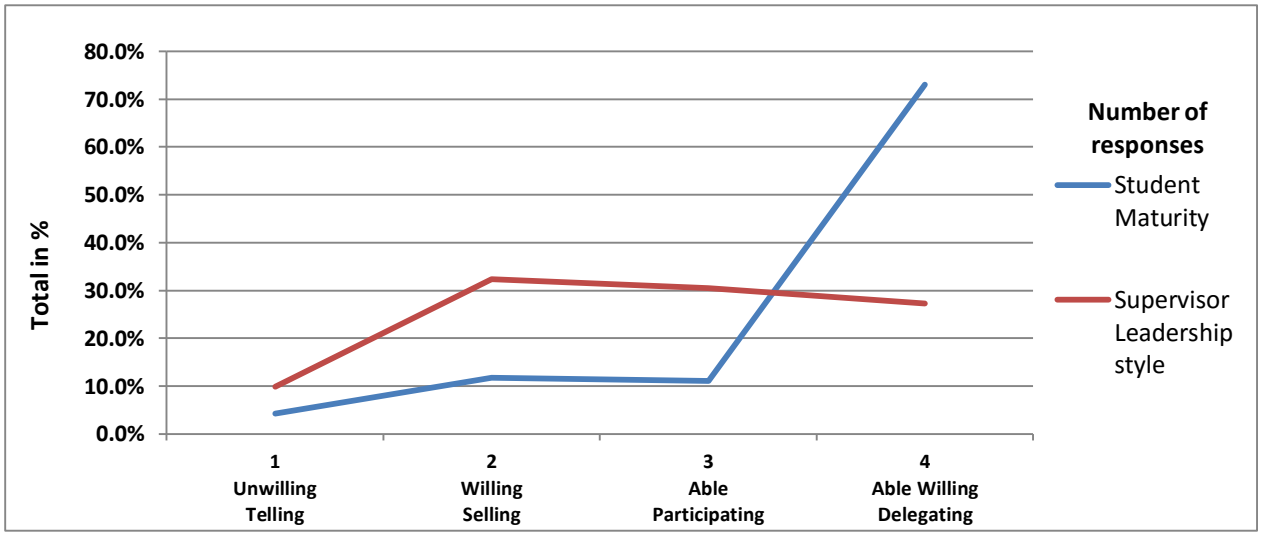

Figure 4.26: Have group discussions about, e.g. a patient scenario (Item 26)

The 407 (100.0%) responses by the clinical facilitators were widely spread around the mean value 2.75 (SD = 0.965) as compared to the responses of the 407 (100.0%) learner nurses that indicated narrow spread around the mean value of 3.53 (SD = 0.859).

The highest rate of responses by the clinical facilitators indicated that they used a *selling* style of leadership (guiding) for learner nurses to have group discussions about patient scenarios (n = 132, 32.4%). On the other hand, the highest number of the learner nurses showed that they were *mature* (able and willing) to decide about having discussions about patients in clinical learning (n = 297, 73.0%).

Only 17 (4.2%) of the learner nurses indicated that they were *immature* (unable and unwilling) to discuss the patient scenario in groups while 40 (9.8%) of responses by the clinical facilitators indicated that they *ordered* (telling style) learner nurses to discuss patients in groups.

Only 48 (11.8%) of the learner nurses indicated that they were *less mature* (willing but did not have the skills) to discuss patient collaboratively during a clinical practicum. Nearly a third (n = 124, 30.5%) of responses by the clinical facilitators indicated that they used a *participating* leadership style for learner nurses to have group discussions about patients while 45 (11.1%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to discuss patients collectively.

Nonetheless, slightly more than a quarter (n = 111, 27.3%) of the 407 (100%) responses by the clinical facilitators highlighted that they used a *delegation* style of leadership (being available) for learner nurses who had group discussions about patient scenarios in a practice setting.

There was no relationship between the leadership style of the clinical facilitator and the maturity level of the learner nurses about having group discussions about, e.g. a patient scenario (r = 0.01, p < 0.924, Table 4.26). These results could be suggesting that learner nurses were not utilising group discussions as a method for their learning.

4.3.3.6 Volunteer to demonstrate competencies to colleagues during clinical facilitation (Item 27)

The 407 (100.0%) responses by the clinical facilitators were widely dispersed around the mean value of 2.56 (SD = 0.897) as compared to the responses of the 407 (100.0%) learner nurses that indicated a slightly smaller dispersion around the mean value of 3.48 (SD = 0.818).

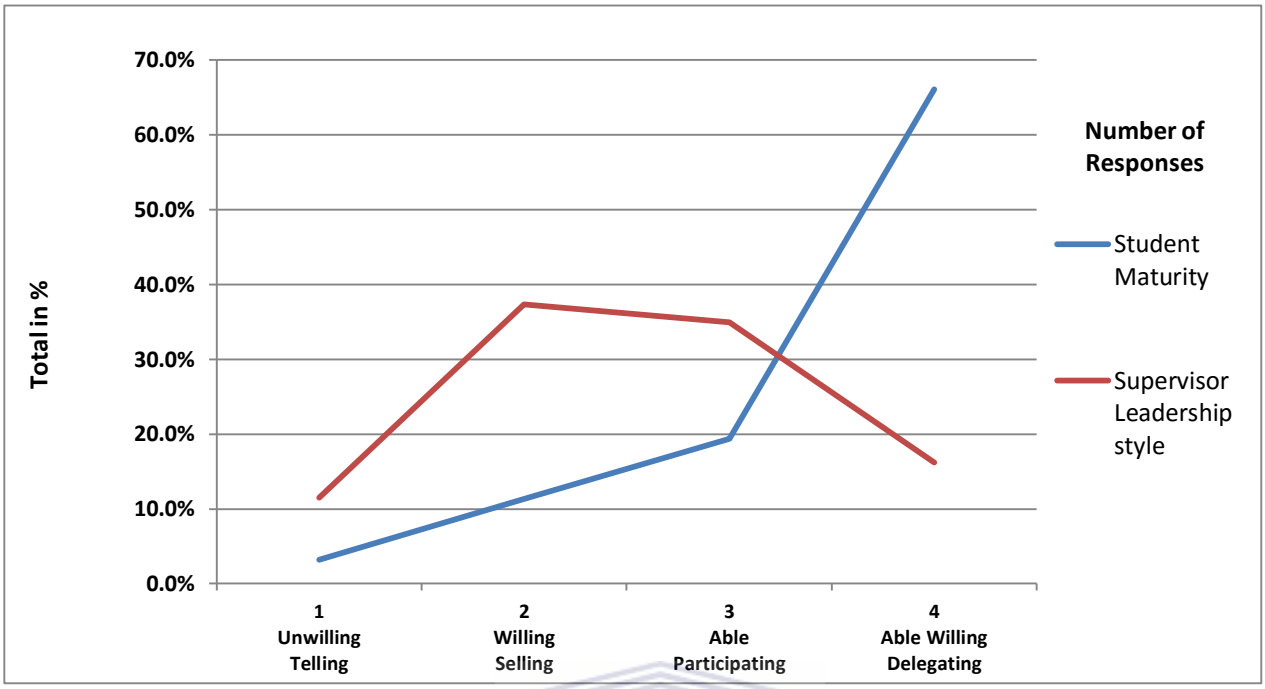

Figure 4.27: Volunteer to demonstrate competencies to colleagues during clinical facilitation (Item 27)

The highest rate of responses by the clinical facilitators (n = 152, 37.3%) indicated that they used a *selling* style of leadership for learner nurses to volunteer to demonstrate competencies to colleagues in clinical learning. On the other hand, the highest number of learner nurses (n = 269, 66.1%) indicated that they were *mature* (able and willing) to decide about volunteering a demonstration competency to colleagues during clinical facilitation.

More than a tenth (n = 47, 11.5%) of responses by the clinical facilitators indicated that they *ordered* (telling style) learner nurses to voluntarily demonstrate a competency to fellow learner nurses. Only 13 (3.2%) of the learner nurses revealed that they were *immature* (unable and unwilling) to demonstrate willingly the competencies to peers during clinical facilitation.

More than a tenth (n = 46, 11.3%) of the learner nurses showed that they were *less mature* (willing but did not have skills) to demonstrate competencies to colleagues during clinical facilitation.

A third (n = 142, 34.9%) of responses by the clinical facilitators indicated that they *participated* with the learner nurses who willingly demonstrated competencies to colleagues during clinical learning while only 79 (19.4%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to volunteer themselves to demonstrate competency to classmates during clinical facilitation. On the other

hand, 66 (16.2%) of the 407 (100.0%) responses by the clinical facilitators indicated that they used a *delegation* style of leadership (being available) for learner nurses who volunteered to demonstrate competencies during clinical facilitation.

Results for this item indicate no relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in respect of volunteering to demonstrate competencies to colleagues during clinical facilitation ($r = 0.01$, $p < 0.886$, Table 4.26). The results may imply that learner nurses were hesitant to willingly demonstrate competencies to colleagues.

4.3.3.7 Choose a good learning environment, e.g. a sick patient to demonstrate skills acquired (Item 28)

The advantage of having a good learning environment is discussed by Evans and Stevenson (2010, p. 239-241). Nursing students are able to apply theoretical nursing knowledge skills to a real clinical setting (Shields *et al.*, 2012, p. 4). The mean value of 2.56 (SD = 0.883) of the 407 (100.0%) responses by the facilitators was indicated with a wider distribution of responses around the mean value compared to the mean value of 3.56 (SD = 0.788) of the 407 (100.0%) learner nurses that represented a narrower distribution of responses around the mean value.

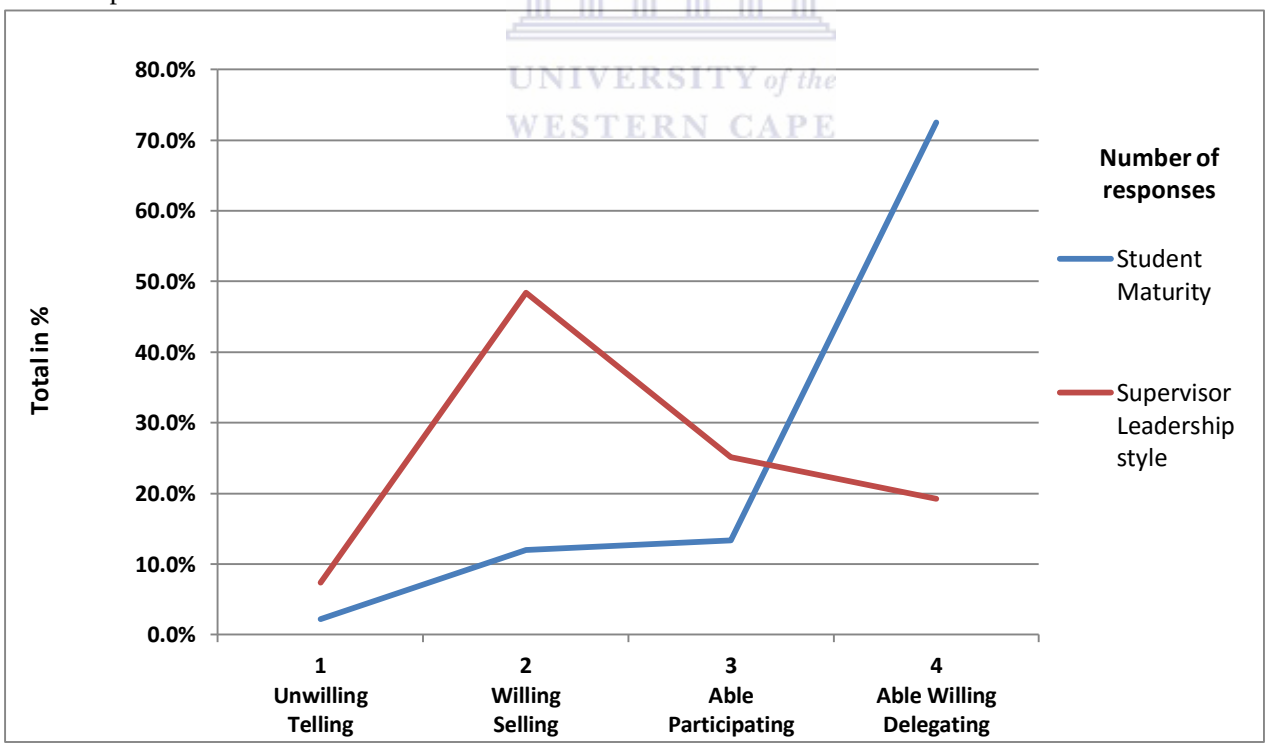

Figure 4.28: Choose a good learning environment, e.g. sick patient to demonstrate skills acquired (Item 28)

Nearly three quarters (n = 295, 72.5%) of the learner nurses indicated that they were *mature* (able and willing) to decide about choosing a good learning environment for demonstrating the skills acquired. On the other hand, the highest rate of responses by the clinical facilitators indicated that they used a *selling* leadership style (guiding) for learner nurse to choose a good learning environment for demonstrating the skill acquired (n = 197, 48.4%).

Likewise, 9 (2.2%) of the learner nurses indicated that they were *immature* (unable and unwilling) to choose a good learning environment to demonstrate the skill acquired. On the other hand, 30 (7.4%) responses by the clinical facilitators pointed out that they *told* (telling style) learner nurses to choose a good learning environment for demonstrating the skill acquired. Nonetheless, 49 (12.0%) of the learner nurses indicated that they were *less mature* (willing but did not have the skill) to choose a good learning environment for demonstrating the skill acquired.

Furthermore, a quarter (n = 102, 25.1%) of responses by the clinical facilitators showed that they *participated* (support) with learner nurses to choose a good learning environment for demonstrating the skill acquired. Only 54 (13.3%) of the learner nurses highlighted that they were *immature* (able but unwilling) to choose a good learning environment for a demonstration. However, only 78 (19.2%) of the 407 (100.0%) responses by the clinical facilitators revealed that they used a *delegation* style of leadership (being available) for learner nurses to select a good learning environment for demonstrating skills acquired in a clinical learning environment.

There was a weak positive relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in the item about choosing a good learning environment for demonstrating the skill acquired ($r = 0.01$, $p < 0.044$, Table 4.26).

4.3.3.8 Be creative in preparing to present a competency, e.g. advice to patient (Item 29)

A positive feeling towards an environment initiates positive emotions of nursing students; hence the ability to act in a creative way is augmented in clinical practice (Uusiautti, 2013, p. 1).

The mean value of 2.67 (SD = 0.965) of the 407 (100.0%) responses by the facilitators was lower and represented a broader distribution of responses around the mean value than the mean value of 3.66 (SD = 0.701) of the 407 (100.0%) learner nurses that represented a narrower spread of responses around the mean value.

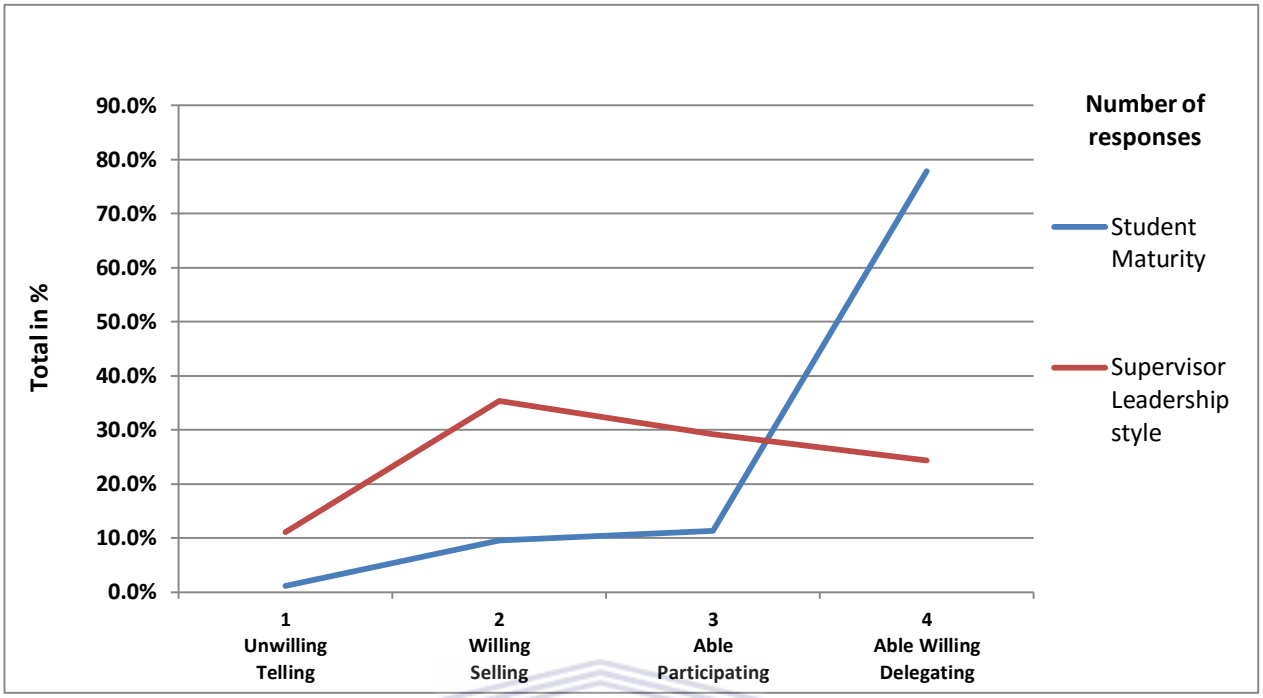

Figure 4.29: Be creative in preparing to present a competency, e.g. advice to a patient (Item 29)

In Item 29, the highest response rate of the learner nurses indicated that the learner nurses were *mature* (able and willing) to decide about being creative in preparing to present a competency, e.g. advising a patient (n = 317, 77.9%). On the other hand, the highest rate of responses by the clinical facilitators indicated that they used a *selling* style of leadership for learner nurses to be creative in preparing to present a competency, e.g. advising a patient (n = 144, 35.4%).

Only 5 (1.2%) of the learner nurses indicated that they were *immature* (unable and unwilling) to be creative in preparing to present a competency, for example advice to a patient. However, 45 (11.1%) responses by the clinical facilitators indicated that they *informed* (telling style) learner nurses to be creative as they prepare a demonstration of a competency in the clinical environment.

A tenth (n = 39, 9.6%) of the learner nurses indicated that they were *less mature* (willing but did not have the skills) to be creative while they prepared a demonstration of a competency. More than a quarter (n = 119, 29.2%) of responses by the clinical facilitators indicated that they *participated* with the learner nurses to be creative as they presented a demonstration of a competency in a clinical setting. On the other hand, more than a tenth (n = 46, 11.3%) of the learner nurses revealed that they were *moderately mature* (able but unwilling) to be creative as they prepare a presentation of a competency. A quarter (n = 99, 24.3%) of the 407 (100.0%) responses of the clinical facilitators indicated that they used a *delegation* style of leadership

(being available) for learner nurses who were creative in preparing to present competency in clinical learning.

There was no relationship between the leadership style of the facilitators and the maturity level of the learner nurses in the item about being creative in preparing to present a competency, for example giving advice to a patient in clinical learning ($r = 0.09$, $p < 0.08$, Table 4.26).

4.3.4 Clinical practices

Tables 4.27 and Table 4.28 indicate the responses of the facilitators and the learner nurses on items 30-32 regarding the component clinical practices. Table 4.29 indicates the significance in the clinical practices of the clinical facilitator and learner nurses.

Table 4.27: Clinical practices for clinical facilitators

	Responses of the clinical facilitator	Leadership styles											
		Tells the nursing student how to: Telling		Guides nursing student to: Selling		Supports nursing student to: Participating		Is available to: Delegating		Total		$\bar{x}$	SD
		1		2		3		4					
	Items	n	%	n	%	n	%	n	%	n	%		
30	Learn about aspects relevant to professional role.	66	16.2	117	28.7	128	31.4	96	23.6	407	100.0	2.62	1.016
31	Deal with the unexpected events, e.g. a terminally ill patient in clinical practice.	19	4.7	126	31.0	179	44.0	83	20.3	407	100.0	2.80	0.814
32	Complete the required competencies expected from them during clinical practice.	19	4.7	137	33.7	108	26.6	142	35.0	407	100.0	2.92	0.933

Table 4.28: Clinical practices for learner nurses

	Responses of learner nurses	Maturity levels											
		Unable unwilling to:		Willing but not have the skills to:		Able but unwilling to:		Able willing to:		Total		$\bar{x}$	SD
		1		2		3		4					
	Items	n	%	n	%	n	%	n	%	n	%		
30	Learn about aspects relevant to my professional role.	5	1.2	38	9.3	39	9.6	325	79.9	407	100.0	3.68	0.692
31	Deal with unexpected events, e.g. a terminally ill patient in clinical practice.	14	3.4	94	23.1	50	12.3	249	61.2	407	100.0	3.31	0.941
32	Complete the required competencies expected from me during clinical practice.	2	0.5	18	4.4	27	6.6	360	88.5	407	100.0	3.83	0.509

Table 4.29: Significance of relationships between leadership style and maturity levels in relation to clinical practice

	Clinical practices for the facilitators and the learners	Correlation (*r*)	p-value
30	Learn about aspects relevant to my professional role.	0.11	0.028
31	Deal with unexpected events, e.g. a terminally ill patient for nursing students' clinical practice.	0.03	0.548
32	Complete the required competencies expected from nursing students during clinical practice.	0.01	0.788

4.3.4.1 Learn about aspects relevant to professional role (Item 30)

According to Michaels *et al.* (2009, p. 2), clinical teaching should address real world relevance of professional practice and learners should be able to acquire skills relevant to their professional role (Peter, 2008, p. iii).

The results indicated a lower mean value and wider distribution of responses of facilitators around the mean value of 2.62 (SD = 1.016) than their counterparts that indicated a high mean value of 3.68 (SD = 0.692) and a narrower distribution of responses around the mean value.

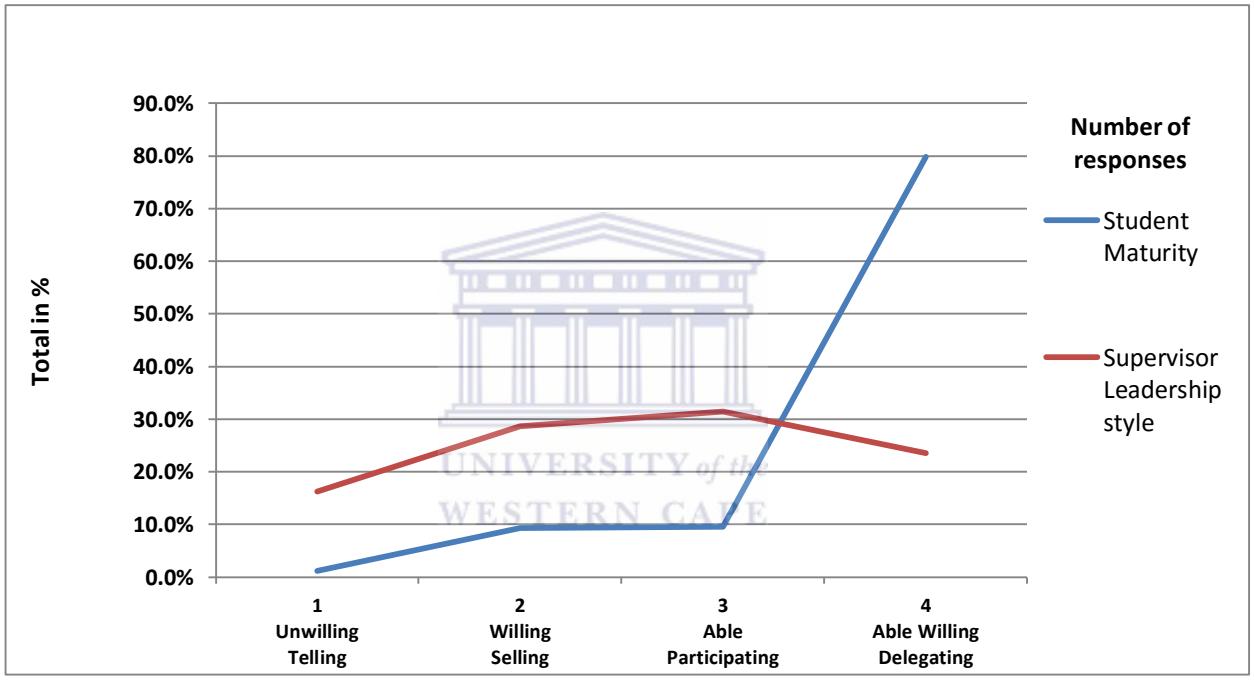

Figure 4.30: Learn about aspects relevant to professional role (Item 30)

The highest rate (n = 325, 79.9%) of learner nurses' responses indicated that they were *mature* (able and willing) to decide to learn about aspects relevant to the professional role in a clinical environment. On the other hand, the rate of responses by the clinical facilitators (n = 128, 31.4%) indicated that they used a *participating* leadership style (support) for learner nurses to learn about aspects relevant to their professional role.

Sixty-six (16.2%) responses by the clinical facilitators indicated that they *told* (telling style) learner nurses to learn about aspects relevant to their professional role in a clinical learning environment while 5 (1.2%) of the learner nurses indicated that they were *immature* (unable and unwilling) to learn about their professional role.

Furthermore, nearly a tenth (n = 38, 9.3%) of the learner nurses indicated that they were *less mature* (willing but did not have the skills) to learn about aspects relevant to their professional role. However, more than a quarter (n = 117, 28.7%) of responses by the clinical facilitators indicated that they used a *selling* leadership style (guiding) for learner nurses to learn about aspects relevant to their professional role in a clinical setting. However, 39 (9.6%) of the learner nurses revealed that they were *moderately mature* (able but unwilling) to learn about aspects relevant to their professional role.

Nearly a quarter (n = 96, 23.4%) of the 407 (100.0%) responses by the clinical facilitators indicated that they used a *delegation* style of leadership (being available) for learner nurses to learn about aspects relevant to their professional role.

The results in Table 4.29 demonstrate a weak positive relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in the item in relation to learning about aspects relevant to their professional role in a clinical learning environment ($r = 0.11$, $p < 0.028$, Table 4.29).

4.3.4.2 Deal with unexpected events, e.g. a terminally ill patient in clinical practice (Item 31)

In shared clinical leadership, nursing students are able to add inputs and action to decision making (Ngcobo & Tikly, 2008, p. 12). They are also able to learn and deal with terminally ill patients (Feldman, 2011, p. 288; Lopez-Preez *et al.*, 2013, p. 1).The distribution of responses of the 407 (100.0%) learner nurses were widely spread around the mean value of 3.31 (SD = 0.941). On the other hand, the distribution of the 407 (100.0%) responses by the facilitators presented a narrower spread of responses around the mean value of 2.80 (SD = 0.814).

The highest rate of learner nurses' responses indicated that they were *mature* (able and willing) to decide about dealing with unexpected events, in clinical learning environment (n = 249, 61.2%). On the other hand, the highest rate of responses by clinical facilitators indicated that they used a *participating* leadership style (support) for learner nurses who dealt with unexpected events in clinical learning (n = 179, 44.0%).

A small minority (n = 19, 4.7%) of the responses by the clinical facilitators indicated that they *instructed* (telling style) learner nurses how to deal with terminally ill patients in clinical practice while 14 (3.4%) of the learner nurses indicated that they were *immature* (unable and unwilling) to deal with unexpected events in clinical learning.

Furthermore, 94 (23.1%) of the learner nurses indicated that they were *less mature* (willing but did not have the skills) to deal with terminally ill patients in clinical practice. Nearly a third (n = 126, 31.0%) of the

responses by the clinical facilitators highlighted that they used a *selling* leadership style (guiding) for learner nurses who dealt with unexpected events in a practice setting.

Only 50 (12.3%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to deal with terminally ill patients in a clinical learning environment. Less than quarter (n = 83, 20.3%) of the 407 (1000.0%) responses by the clinical facilitators revealed that they used a *delegation* style of leadership (being available) for learner nurses who dealt with unexpected events, for example terminally ill patients in a clinical learning environment.

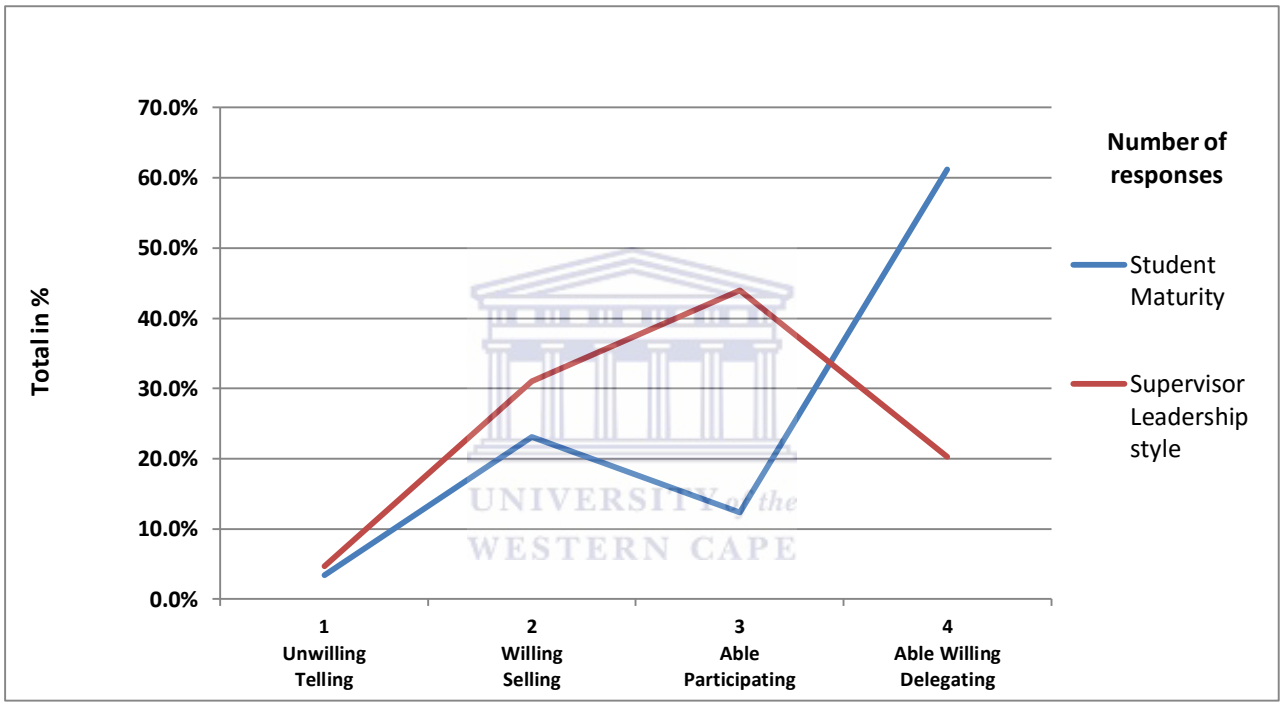

Figure 4.31: Deal with an expected events, e.g. a terminally ill patient in clinical practice (Item 31)

The findings indicate that there is no relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in Item 31 (r = 0.03, p < 0.548, Table 4.29). These results could be suggesting that learner nurses were not yet competent in clinical practice.

4.3.4.3 Complete the required competencies expected from nursing students in clinical practice (Item 32)

The mean value of 2.92 (SD = 0.933) of the 407 (100.0%) responses by the facilitators was indicated with a wider distribution of responses around the mean value compared to the mean value of 3.83 (SD = 0.509)

of the 407 (100.0%) learner nurses that was indicated by a narrower distribution of responses around the mean value.

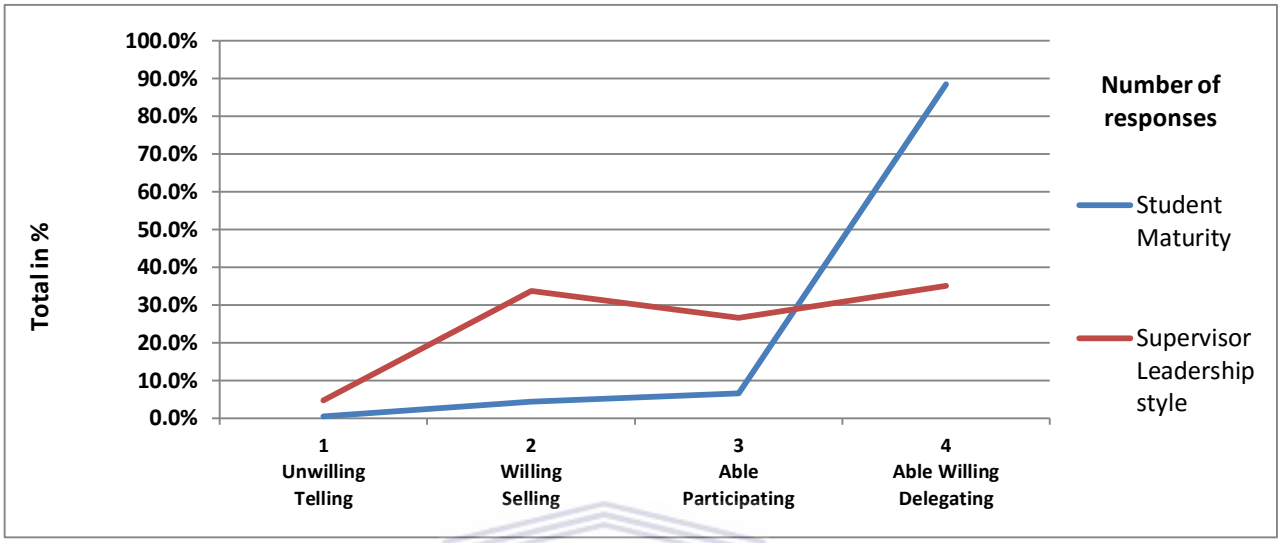

Figure 4.32: Complete the required competencies expected from nursing students in clinical practice (Item 32)

The highest rate of the learner nurses' responses (n = 360, 88.5%) indicated that they were *mature* (able and willing) decide whether to complete the required clinical competencies as expected of them. On the other hand, the highest rate of responses by the clinical facilitators indicated that they used a *delegating* leadership style for learner nurses to complete the required competencies in the clinical learning environment (n = 142, 35.0%).

Only 2 (0.5%) of the learner nurses indicated that they were *immature* (unable and unwilling) on the mentioned item. However, a small minority (n = 19, 4.7%) of the responses by the facilitators indicated that they gave *orders* (telling style) to learner nurses to complete their clinical competencies as expected of them.

A third (n = 137, 33.7%) of responses by the clinical facilitators indicated that they used a *selling* style (guiding) for learner nurses to complete clinical competencies during clinical practice. Only 18 (4.4%) of the learner nurses showed that they were *less mature* (willing but did not have the skills) to finish the required clinical competencies expected of them in practice. A quarter (n = 108, 26.6%) of responses by the clinical facilitators indicated that they used a *participating* leadership style (support) for learner nurses to complete their required clinical competencies while 27 (6.6%) of the learner nurses indicated that they were *moderately mature* (able but unwilling) to complete their clinical competencies.

The results indicate no relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in the item about completing the required competencies expected of them in clinical practice (r = 0.01, p < 0.788, Table 4.29). The results may mean that learner nurses struggled to complete clinical competencies expected of them in clinical practice for many reasons.

4.3.5 The relationship between leadership style of the facilitators and the maturity level of the learner nurses by components

Tables 4.30 and 4.31 emphasise the mean values of the four components of the questionnaire about the leadership style of the clinical facilitators and the maturity level of the learner nurses respectively.

Table 4.30: Leadership style of the facilitators

Components of the questionnaire					
	1	2	3	4	
	The relationship between the clinical facilitators and the learner nurses	Teaching and learning activities of clinical facilitators	Teaching techniques / principles in clinical practice for clinical facilitators	Clinical facilitator's clinical practice	General leadership style
$\bar{x}$	2.76	2.74	2.67	2.78	2.73
SD	0.71	0.71	0.65	0.80	0.66

Table 4.31: Maturity level of the learner nurses

Components of the questionnaire					
	1	2	3	4	
	The relationship between the clinical facilitators and the learner nurses	Teaching and learning activities for the learner nurses	Teaching techniques / principles for the learner nurses	Learner nurses' clinical practice	General maturity level
$\bar{x}$	3.54	3.68	3.62	3.61	3.62
SD	0.53	0.44	0.50	0.55	0.43

The highest mean value in the four components of the questionnaire for the leadership style of the clinical facilitators was obtained for the section about clinical practice ($\bar{x}$ = 2.78, SD = 0.80). On the other hand, while the highest mean value for the maturity level of the learners was obtained for the section about the teaching and learning activities for the learner nurses. Higher mean values were obtained for the learner nurses in all the items ($\bar{x}$ = 3.62, SD = 0.43) while clinical facilitators obtained a lower mean value for the items ($\bar{x}$ = 2.73, SD = 0.66).

Table 4.32: Significance of relationship between the leadership style of the facilitators and maturity level of the learner nurses according to component

	Components of the questionnaire	Number of responses of the learner nurse and the clinical facilitators	Correlation (*r*)	p-value
1	**The relationship of the facilitator and the learner nurse**			
	Learner nurse	407	0.15	0.003
	Clinical facilitator	407		
2	**Teaching and learning activities**			
	Learner nurse	407	0.17	0.001
	Clinical facilitator	407		
3	**Teaching techniques / principles**			
	Learner nurse	407	0.07	0.148
	Clinical facilitator	407		
4	**Clinical practices**			
	Learner nurse	407	0.06	0.197
	Clinical facilitator	407		

Table 4.33: Significance of the general leadership style of the facilitators and the learner nurses' maturity level

Leadership style and maturity level	No. of learner nurses' and facilitators' responses	Correlation (r)	p-value
	407	0.15	0.002

The general mean value of 2.73 (SD = 0.66) of the 407 (100.0%) responses by the clinical facilitators indicated that they used a *participating* style of leadership (support) to lead / facilitate learner nurses in a clinical learning environment of the Western Cape hospitals. However, the general mean value of 3.62 (SD = 0.43) of the 407 (100.0%) learner nurses indicated that they were *mature* (able and willing) to make decisions in a clinical learning environment.

The general findings (Table 4.33) indicate that there was a weak positive relationship between the leadership style used by the clinical facilitators and the maturity level of the learner nurses in a clinical learning environment of the Western Cape hospitals ($r = 0.15$, $p < 0.002$, Table 4.33). This may suggest that clinical facilitators had established the amount of prior knowledge of the learner nurses. In that way, they were able to relate the maturity level of the learner nurses to a particular leadership style.

4.4 CONCLUSION

The findings of the study indicate that there was a weak positive relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in a clinical learning environment. Chapter 5 concludes the study, makes relevant recommendations, and points out some limitations of the study.

CHAPTER 5
CONCLUSIONS, RECOMMENDATIONS, AND LIMITATIONS

5.1 INTRODUCTION

This chapter outlines conclusions and makes relevant recommendations. The purpose of the study was to explore and describe the relationship between the leadership style of clinical facilitators and the maturity level of learner nurses in a clinical learning environment at hospitals in the Western Cape Province. The study was conducted according to the Hersey-Blanchard Theory.

5.2 CONCLUSIONS

The respondents were mainly female. This is similar to the studies by Dyck, Oliffe, Phinney and Garrett (2009, p. 649), and Kessels and Steinmayr (2012, p. 235) who undeniably emphasise the fact that the nursing sector is predominantly female and it is likely that male nurses would remain a minority in the nursing profession for many years to come. Most learner nurses indicated that they were mature (able and willing) while the clinical facilitators indicated that they focused more on the selling and participation styles of leadership. The general results indicated that there was a weak positive relationship ($r = 0.15$) between the leadership style of the clinical facilitators and the maturity level of learner nurses.

The researcher was of the view that learner nurses over-estimated their maturity level in the items in the same way as Nash, Sacre, Calleja and Lock (2010, p. 670) found in their study that respondents overrated themselves. Le Roux (2007, p. 83) establishes that fourth-year level nursing students are still immature / incompetent towards the end of their nursing programme.

Nursing schools are judged by their results and the quality of learner nurses they produce. The quality of learner nurses is influenced by, amongst other things, good leadership during the training period. The clinical facilitator, through the effective exercise of his / her leadership, motivates learner nurses to make good decisions in the clinical learning environment. In the majority of items, the leadership style of the clinical facilitator was indicated as a *selling style* to a *participating* style of leadership. This trend of leadership styles is not unusual and do assist individuals and organisations to achieve their goals (Huber, 2010, p. 17-19).

5.2.1 The relationship between the clinical facilitators and the learner nurses in the clinical learning environment

The general mean value of 2.76 (SD = 0.71) of the 407 (100.0%) responses by the clinical facilitators (Table 4.30) indicated that they used a participating leadership style (supporting) for learner nurses to establish a relationship in a clinical learning environment. On the other hand, the general mean value of 3.54 (SD = 0.53) of the 407 (100.0%) learner nurses (Table 4.31) denoted that they were mature (able and willing) to decide about establishing a continual relationship with their clinical facilitators in a clinical learning environment. Hence, the results demonstrated that there was a weak positive relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in the component about *the relationship between the clinical facilitators and the learner nurses in a clinical learning environment* ($r = 0.15$, $p < 0.003$, Table 4.32). It was concluded that there was an insignificant relationship between clinical facilitators' leadership style and the maturity level of the learner nurses.

5.2.2 Teaching and learning activities by the clinical facilitators and the learner nurses

A similar trend occurred in the second component of the questionnaire; the mean value of 3.68 (SD = 0.44) of the 407 (100.0%) learner nurses (Table 4.31) denoted that learner nurses were mature (able and willing) to decide about applying the teaching and learning activities in a clinical learning environment. However, the mean value of 2.74 (SD = 0.71) of the 407 (100.0%) responses by the clinical facilitators (Table 4.30) indicated that they used a participating style of leadership (supporting) to learner nurses in their teaching and learning activities in clinical training.

The same pattern of having a weak positive relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses was once more revealed in this component about *teaching and learning activities by the clinical facilitators and the learner nurses* ($r = 0.17$, $p < 0.001$, Table 4.32). Congruent to the previous component, a weak relationship between clinical facilitators' leadership style and the maturity level of the learner nurses was established. It could be concluded that the leadership style merged somewhat with maturity level of the learner nurses during teaching and learning in a clinical practice environment.

5.2.3 Teaching techniques / principles of the facilitators and the learner nurses in a clinical learning environment

The mean value of 2.67 (SD = 0.65) of the 407 (100.0%) responses by clinical facilitators (Table 4.30) indicated that they used a participating leadership style (supporting) for learner nurses in relation to their

teaching techniques / principles in a clinical practice environment. Nevertheless, the mean value of 3.62 (SD = 0.50) of the 407 (100.0%) learner nurses (Table 4.31) indicated that they were mature (able and willing) to decide about applying the correct teaching techniques / principles to clinical learning. The findings indicated that there was no relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in the component about *teaching techniques / principles in a clinical learning environment* (r = 0.07, p < 0.148, Table 4.32). This might suggest that learner nurses found it somewhat difficult to recognise the teaching techniques / principles used by clinical facilitators.

5.2.4 Clinical practices of the facilitators and the learner nurses in a clinical learning environment

The mean value of 2.78 (SD = 0.80) of the 407 (100.0%) responses by the clinical facilitators (Table 4.30) indicated that they used a participating style of leadership (supporting) for learner nurses in relation to the clinical practice component. However, the mean value of 3.61 (SD = 0.55) of the 407 (100.0%) learner nurses (Table 4.31) indicated that they were mature (able and willing) to make decisions during clinical practice. Similar to the preceding component, the findings indicated that there was no relationship between the leadership style of the clinical facilitators and the maturity level of the learner nurses in respect of the *clinical practice component* (r = 0.06, p < 0.197, Table 4.32). This might suggest that learner nurses were inexperienced, perhaps due to a lack of enough time spent in clinical practice.

5.3 RECOMMENDATIONS

It is important that clinical facilitators as leaders develop the capability to identify the demands of the situation and then to decide about implementing a suitable leadership response. They need to acknowledge the level of readiness of learner nurses to perform academic tasks with the purpose of deciding about the direction, guidance, and support they can provide to learner nurses. Some situations presuppose dependence on the clinical facilitators while other situations allows for greater independence of the nursing students (Booyens, 2012, p. 435). Huber (2010, p. 16) adds that an effective leader should interrelate the leadership style and the given situation or maturity level of the followers. In that manner, learner nurses as followers can respond positively to the clinical facilitators' leadership when they realise that their maturity levels are acknowledged.

5.3.1 Nursing education

Clinical facilitators as leaders could have more impact on learners' academic performance when they allow learner nurses to actively contribute to the teaching and learning process in a clinical learning environment; in this case, informing the leadership of facilitators in a democratic and participative manner. However, this

objective can only be achieved when the clinical facilitators establish the maturity level of learner nurses. Hence, the researcher recommends that in order to improve learner nurses' academic performance, it is vital that a school of nursing provides in-service leadership training for clinical facilitators to enable them to provide quality training to learner nurses.

5.3.1.1 The relationship between the facilitators and the learner nurses

The existence of a relationship between the learner nurses and their clinical facilitators is important to support learner nurses' ability to achieve the teaching and learning objectives / goals. Learner nurses should be allowed to share their knowledge and feelings, thoughts, and abilities with the facilitators to establish an effective learning environment. According to Bolkan and Goodboy (2011, p. 13), when relationships between the supervisors and learners are healthy, the supervisors can be more than educators; as supporters, they can empathise with nursing students in clinical learning because the environment can be stressful to learners. The relationship should develop over time.

5.3.1.2 Teaching and learning activities

The process of clinical teaching and learning empowers learner nurses with clinical knowledge that supports and promotes professional practice. Effective teaching and learning in a clinical environment is bound to occur when learner nurses participate in clinical activities, take responsibilities expected of them, and also when the teaching and learning activities / leadership of clinical facilitators encourage a welcoming learning environment where every learner nurse is able to express his / her thoughts.

It is recommended that learner nurses should be responsible for their own learning and facilitators need to be democratic in their leadership approaches. They should not be perceived as dictators who simply disseminate information to learners but rather as democratic leaders. In democratic leadership, clinical facilitators reason with nursing students to empower them with knowledge about theory and practice (Meyer, Naudé, Shangase & Niekerk, 2011, p. 207). According to McKimm and Jollie (2007, n.p), this leadership approach is learner-centred and it develops self-directedness in nursing students.

Another important aspect of teaching and learning in clinical learning is providing feedback to learner nurses. Feedback allows learner nurses to make the necessary changes (Dungy & Whitaker, 2010, p. 225). It also alerts learner nurses about their progress and ways in which they could improve. The researcher, therefore, recommends a teaching and learning environment that allows timely feedback to learner nurses that affords them an opportunity to improve the application of their knowledge.

5.3.1.3 Teaching techniques / principles in a clinical learning environment

The undergraduate nurse training at the University of the Western Cape comprises a combination of various teaching methods to deliver a comprehensive theoretical understanding of nursing and opportunities for learner nurses to learn and practice hands-on nursing skills / techniques.

It is, therefore, recommended that the main teaching strategy used in undergraduate nursing education should lean towards PBL and self-directed methods. PBL prepares learner nurses for real world problems and provides a stimulus for critical thinking (De Young, 2009, p. 151). Learner nurses spend much of their time under the guidance of an instructor; they work as a team to reflect on clinical experience and discuss patient scenario collaboratively. This learning process is more self-driven and intends to assist learner nurses with succeeding in a profession that is constantly changing due to new research and practice methods. Rather than simply memorising information, learner nurses are taught how to think critically, assess situations, work as a team, and be creative.

5.3.1.4 Clinical learning environment

Clinical practice is an important component of nursing education (Miguel & Rogan, 2012, p. 115). It ensures that learner nurses become safe practitioners and are socialised into the nursing profession. In this environment, learner nurses encounter real life situations that develop their cognitive, psychomotor, and affective skills (Kapucus & Bulut, 2011. p. 1149). The researcher recommends that clinical practice is extended to allow more life experience to support learner nurses' learning in a clinical learning environment.

5.3.2 Clinical facilitation

The researcher recommends that clinical facilitators receive some training in educational leadership once they have been employed to supervise learner nurses. A clinical facilitator who is trained in educational leadership has a greater opportunity to lead learner nurses successfully than one who has not been trained.

5.3.3 Nursing research

The behaviour of clinical facilitators as leaders is one of the factors that stimulate the success of learner nurses. It is, therefore, recommended by the researcher that learner nurses' perceptions of clinical facilitators' leadership skills in clinical supervision should be established. Moreover, a study should be conducted that interrogates the maturity level of the learner nurses in the BCur programme (2nd, 3rd and 4th year levels) independent for one another because the researcher is of the view that the results may yield some important information.

The same study should be conducted at other universities / colleges to establish whether their findings would differ, or would be similar to the conclusions of this study (Section 5.2). According to Jacobs, MacKenzie, and Botma (2013, p. 4) the aim of nursing education is to produce competent nurse practitioners. For this reason, the researcher recommends that the importance of the role of clinical facilitators as leaders needs to be reviewed with regard to supporting and guiding learner nurses in a clinical environment and facilitating them to apply classroom knowledge to the practical setting.

5.4 LIMITATIONS

The study did not focus on the maturity levels of different levels of learner nurses (2nd, 3rd and 4th year learner nurses) independent from one another but rather on the general maturity level of learner nurses. It should be kept in mind that learner nurses' maturity levels at different academic year levels could differ. However, this study sought to determine whether a relationship existed between the maturity level of learner nurses and the leadership style of clinical facilitators.

Furthermore, the 2nd year (n = 156) and 3rd year (n = 144) learner nurses were more than the fourth-year level learner nurses (n = 107) which might have had an influence on the outcomes of the study.

The researcher played a large motivational role in encouraging clinical facilitators to complete instruments for those learner nurses who took part in the study. The researcher could not involve all the clinical facilitators because some of them were busy with research projects at the time of the study.

The gathering of data by means of paired questionnaires was a time consuming and a major task. Nonetheless, the researcher persisted until all the questionnaires were completed.

5.5 CONCLUSION

A quantitative study was conducted to investigate the relationship between the leadership style of clinical facilitators and the maturity level of learner nurses in a clinical learning environment. Most learner nurses indicated that they were mature (able and willing) while the clinical facilitators indicated that they focused more on the selling and participation styles of leadership. The general results indicated that there was a weak positive relationship ($r = 0.15$) between the leadership style of the clinical facilitators and the maturity level of learner nurses.

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ANNEXURE A: ETHICS COMMITTEE APPROVAL TO CONDUCT THE STUDY

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

25 October 2012

To Whom it May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by: Mr E Lejaha (School of Nursing)

Research Project: The relationship between leadership styles of clinical facilitators and maturity levels of learner nurses in the clinical learning environment of Western Cape hospitals

Registration no: 12/9/24

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Private Bag X17, Bellville 7535, South Africa
T: 27 21 959 2988/2948, F: 27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

ANNEXURE B: INFORMATION SHEET

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21 959 2274, Fax: 27 21 959 2271

Email: elejaha@gmail.com

INFORMATION SHEET

Project title: The relationship between leadership styles of clinical facilitators and maturity levels of learner nurses in the clinical learning environment of Western Cape hospitals.

What is this study about?

I, Edwin Lejaha, am registered for a Master's degree in Nursing Science 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 facilitating learner nurses at the University of the Western Cape. The purpose of this study is to explore and describe the relationship between the leadership styles of clinical facilitators and maturity levels of learner nurses in the clinical learning environment of Western Cape hospitals.

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

Questionnaires will be handed out to you to complete. The researcher will collect the completed questionnaires, placed in the sealed envelope provided, from you. Written consent for the questionnaires is needed. Questionnaires 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 my supervisor, statistician, and the researcher will have access to this information.

Would my participation in this study be kept confidential?

We will do everything within our power to keep your personal information confidential. The questionnaires will be completed anonymously. It would prevent any other person from linking specific data to you. All information obtained will be stored under lock and key for five years after publication of the results. The publication of the results of the project, will not mention any names of respondents.

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 significance of the study is that the results could be useful to the nursing schools with the purpose of reviewing the support and guidance of the learners nurses by clinical facilitators in a clinical learning environment.

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 neither be penalised in any way, nor will you forfeit any benefits to which you otherwise qualify.

How do I get my questions answered?

This research is being conducted by Edwin Lejaha, registered at the University of the Western Cape. If you have any questions about the research study itself, please contact:

Edwin Lejaha

P.O. Box 90

Roma

0180

Lesotho

Cell Phone: 078 444 6073

Email: elejaha@gmail.com

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

Head of Department

Prof Yinka Adejumo

Tel: 021 959 3024

Email: oadejumo@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Prof Hester Klopper

Tel: 021 959 2631

Email: hklopper@uwc.ac.za

University of the Western Cape

Private Bag X17

Bellville 7535

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

ANNEXURE C: WRITTEN INFORMED CONSENT SURVEY

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21 959 2274, Fax: 27 21 959 2271

Email: elejaha@gmail.com

INFORMED CONSENT FORM

Title of the research project: The relationship between leadership styles of clinical facilitators and maturity levels of learner nurses in the clinical learning environment of Western Cape hospitals.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Respondent's name …….

Respondent's signature …….

Witness …….

Date …….

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

Study Coordinator

Prof Karien Jooste

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2274

Cell: 082 897 2228

Fax: (021) 959 2271

Email: kjooste@uwc.ac.za

ANNEXURE D: PERMISSION LETTER TO THE UNIVERSITY

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21 959 2274, Fax: 27 21 959 2271

Email: elejaha@gmail.com

Head of Department

Prof Yinka Adejumo

REQUESTING PERMISSION TO CONDUCT A RESEARCH STUDY AT THE UNIVERSITY OF THE WESTERN CAPE

I hereby request to conduct a research study in the School of Nursing at the University of the Western Cape. The study is entitled: *The relationship between leadership styles of clinical facilitators and maturity levels of learner nurses in the clinical learning environment of Western Cape hospitals.* This study is part of the requirements for acquiring a Master's degree in Nursing Science. The study will be done under the supervision and guidance of Professor K. Jooste of the School of Nursing, University of the Western Cape.

Data collection will be conducted by using a questionnaire. Questionnaires will be handed out to all the learner nurses and their respective clinical facilitators at the time. Respondents will complete them in their own time; it will take about 30 minutes to complete. The researcher will adhere to the rights of respondents to privacy and confidentiality. The identity of all respondents will be protected; the questionnaires will be allocated code numbers. The name of the university will not appear in the research report. All records will be kept for five years after publication of the results before it will be destroyed. Only the supervisor, researcher, independent coder, and statistician will have access to the data. The respondents will not be coerced into participation and should they wish to withdraw at any time during the study, their wish will be

respected. The researcher will ensure adherence to the highest standards of research planning, implementation, and reporting.

If you have any questions about the research study itself, please contact:

Edwin Lejaha

P.O. Box 90

Roma

0180

Lesotho

Cell Phone: 078 444 6073

Email: elejaha@gmail.com

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

Head of Department

Prof Yinka Adejumo

021 959 3024

Email: oadejumo@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Prof Hester Klopper

021 959 2631

Email: hklopper@uwc.ac.za

University of the Western Cape

Private Bag X17

Bellville 7535

Head of Department

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

ANNEXURE E: QUESTIONNAIRE TO THE CLINICAL FACILITATORS

Student no.							

Instructions:

Mark with an **X** in the response box to indicate your answer.

SECTION A: BIOGRAPHICAL AND DEMOGRAPHIC INFORMATION

Indicate your responses to each item by marking the most applicable block with a cross (**X**)

1. Gender:

Male ☐

Female ☐

2. Age:

≤ 25 years ☐

26 years ☐

27 years ☐

28 years ☐

≥ 29 years ☐

3. Highest Qualification:

3 years General Nursing ☐

3- 4 year in comprehensive diploma ☐

BCur Nursing ☐

Postgraduate Diploma in Nursing Education ☐

MCur Nursing ☐

Doctorate degree ☐

Other ☐

4. Have you ever attended any workshop training for acting as a clinical facilitator?

Yes ☐

No ☐

5. Experience in clinical facilitation of learner nurses:

< 12 months ☐

1 year ☐

2 years ☐

3 years ☐

≥ 4 years ☐

6. Home language (Mark with an X)

English	Afrikaans	isiZulu	isiXhosa	Sesotho	Sepedi	Setswana	siSwati	isiNdebele	Xitsonga	Tshivenda	Other

SECTION B

For the questions on the following pages, indicate your response with an (**X**) and use the following scale:

1 = Tell the nursing student how to:

2 = Guide the nursing student why to:

3 = Support the nursing student to:

4 = Am available when the nursing student asked to be assisted with making decisions in the clinical learning environment.

No.	I, as the clinical facilitator	Tells the nursing student how to:	Guides the nursing student through the process of how to:	Supports the nursing student to:	Am Is available when the nursing student asked to:
		1	2	3	4
The relationship of the clinical facilitator and the nursing student					
1	Establish a continual relationship with nursing students for teaching and learning.				
2	Sign a supervisory contract with the nursing students with regard to their clinical accompaniment.				
3	Set specific goals for obtain nursing student teaching and learning in a unit.				
4	Identify nursing student learning needs according to the clinical practice experience required.				
5	Perform nursing duties in a clinical setting to fulfil individual nursing student learning needs.				
6	Communicate with nursing students about their progress in clinical practice.				
7	Provide empathetic understanding of problems the nursing students experience during clinical facilitation.				
8	Interact with a clinically skilled role model who is involved in daily decisions, processes, protocols, and management of a unit.				
Teaching and learning activities					
9	Apply different teaching strategies when, e.g. educating patients.				
10	Teach theory about clinical procedures.				

11	Plan the nursing students' clinical learning responsibilities around daily tasks in a unit.				
12	Set responsibilities expected of the nursing students for the clinical environment.				
13	Document the clinical competencies undertaken in a unit.				
14	Attend to scheduled appointments with nursing students.				
15	Use the standard procedures in a unit, e.g. preparation of a patient for theatre.				
16	Use learning strategies to enhance nursing students' knowledge about clinical nursing practice.				
17	Follow a case-based approach in demonstrating clinical competencies to nursing students.				
18	Practise as a team member in a clinical practice setting.				
19	Conduct clinical activities that will promote nursing students' professional capacity.				
20	Evaluate nursing students on competencies by the method as stipulated.				
21	Provide feedback on mistakes nursing students have made during clinical competencies.				
Teaching techniques / principles					
22	Carry out a nursing technique, by using a visual presentation to nursing students.				
23	Practise competencies that have been demonstrated to nursing students.				

24	Prepare an assignment for nursing students as requested.				
25	Use opportunities to reflect on clinical experiences with nursing students.				
26	Have a group discussion about, e.g. a specific patient scenario.				
27	Allow nursing students to volunteer to demonstrate competencies to colleagues during clinical facilitation.				
28	Choose a good learning environment, e.g. a sick patient to demonstrate skills acquired.				
29	Is creative in preparing to present a competency to the clinical facilitator, e.g. advice to a patient.				
Clinical practice					
30	Learn about aspects relevant to nursing students' professional role.				
31	Deal with unexpected events, e.g. a terminally ill patient during nursing students' clinical practice.				
32	Complete the required competencies expected from nursing students during my clinical practice.				

ANNEXURE F: QUESTIONNAIRE TO THE NURSE LEARNERS

Student no							

Instructions:

Mark an **X** in the response box to indicate your answer.

SECTION A: BIOGRAPHICAL AND DEMOGRAPHIC INFORMATION

Indicate your responses to each item by marking the most applicable block with a cross (**X**).

1. Gender:

Male ☐

Female ☐

2. Age:

≤ 19 years ☐

20 years ☐

21 years ☐

22 years ☐

≥ 23 years ☐

3. Home language (Mark with an X)

English	Afrikaans	isiZulu	isiXhosa	Sesotho	Sepedi	Setswana	siSwati	isiNdebele	Xitsonga	Tshivenda	Other

4. Year of study

1st Year ☐

2nd Year ☐

3rd Year ☐

4th Year ☐

5. **Did you repeat any year of study?**

Yes ☐

No ☐

If yes, please indicate which year: ……..

SECTION B

For the questions on the following pages, indicate with **(x)** how able and willing you are to make decisions in the clinical learning environment.

Use the following scale:

1 = Unable and unwilling to

2 = Willing but do not have the skills to

3 = Able but unwilling to

4 = Able and willing to

No.	I, as the nursing student	Unable and unwilling to:	Willing but do not have the skills to:	Able but unwilling to:	Able and willing to:
		1	2	3	4
The relationship of the clinical facilitator and the nursing student					
1	Establish a continual relationship with the clinical facilitator for teaching and learning in clinical practice.				
2	Sign a supervisory contract with the clinical facilitator with regard to my clinical accompaniment.				
3	Set specific goals to be obtained during my teaching and learning in a unit.				
4	Identify my learning needs according to the clinical practice experience required.				
5	Perform specific nursing duties in a clinical setting to fulfil my individual learning needs.				
6	Communicate with the clinical facilitator about my progress in clinical practice.				
7	Receive empathetic understanding in relation to problems I experience during my clinical facilitation.				
8	Interact with a clinically skilled role model who is involved in the daily decisions, processes, protocols, and management of a nursing unit.				
Teaching and learning activities					
9	Apply different teaching strategies when, e.g. educating patients.				
10	Apply theory taught by the clinical facilitator in clinical procedures.				
11	Plan my clinical learning responsibilities around my daily tasks in a unit.				

12	Perform the responsibilities expected of me in the clinical environment.				
13	Document the clinical competency undertaken in a unit.				
14	Attend to scheduled appointments with the clinical facilitator.				
15	Use the standard procedures in a unit, e.g. preparation of a patient for theatre.				
16	Use learning strategies to enhance my knowledge about clinical nursing practice.				
17	Follow a case-based approach in demonstrating my clinical competencies.				
18	Practise as a team member in a clinical practice setting.				
19	Conduct clinical activities that will promote my professional capacity.				
20	Be evaluated on competencies by the method as stipulated by the clinical facilitator.				
21	Receive feedback on mistakes I have made during clinical competencies.				
Teaching techniques / principles					
22	Carry out a nursing technique, after it has been demonstrated in a visual presentation by the clinical facilitator.				
23	Practise competencies that have been demonstrated to me by the clinical facilitator.				
24	Prepare an assignment as requested by clinical facilitator.				
25	Use opportunities to reflect on my clinical experiences with my clinical facilitator.				

26	Have a group discussion about, e.g. a specific patient scenario.				
27	Volunteer to demonstrate competencies to colleagues during clinical facilitation.				
28	Choose a good learning environment, e.g. a sick patient to demonstrate skills acquired.				
29	Am creative in preparing to present a competency, e.g. advice to a patient, to the clinical facilitator.				
Clinical practice					
30	Learn about aspects relevant to my professional role.				
31	Deal with unexpected events, e.g. a terminally ill patient in my clinical practice.				
32	Complete the required competency expected from me during my clinical practice.				