UNIVERSITY OF THE WESTERN CAPE

FACULTY OF COMMUNITY HEALTH SCIENCE

RESEARCH REPORT

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A SERVICE LEARNING PEDAGOGY FOR AN UNDERGRADUATE BACHELOR OF NURSING CURRICULUM

Thesis submitted in fulfilment of the requirements for the degree
Doctor of Philosophy in the School of Nursing,
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Supervisor: Professor Hester Julie

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ABSTRACT

Globally, healthcare curricula are being transformed to serve societal needs and strengthen the provision of healthcare services towards ensuring Primary Health Care. Community Engagement and its typology were deemed significant to redress the nature of healthcare services, as well as the nature of the nursing curriculum, in order to develop socially accountable graduates. SL is known as a philosophy and an approach to community development and pedagogy. In this current study, the primary focus of SL was viewed as pedagogy, with the intention of fostering skills and values associated with accountability.

A qualitative multimethod study was conducted, using a conceptual framework that blended with Kotter's organisational change model, to guide the research approach and the principles to curriculum development. The study comprised two phases, which pursued five objectives. Under *Phase 1*, a document analysis was used to map the curriculum, at the micro level of an undergraduate Bachelor of Nursing curriculum, was devised to communicate the aspects that inform the learning and teaching practices, as well as formulate the Community Engagement (CE) typology, currently imbedded in an undergraduate Bachelor of Nursing curriculum, that would constitute a draft SL pedagogy. The SL pedagogy were reflected in the aspects that inform the learning and teaching practices, the typology of CE, and the Higher Education Quality Committee (HEQC) indicators for the quality management of the SL elements, based on the finding of Objective 1 and Objective 2. The third objective, comprised of a self-assessment exercise that was performed, using the Community Engagement Grading Rubric (CEGR) that was developed for this current study to determine the potential of modules. *Phase 2* involved two objectives, in which the fourth objective explored, analysed, and interpreted the experiences of the nurse educators, regarding their learning and teaching practices which were used to validate the draft SL pedagogy. Finally, Objective 5 was initiated to finalise SL pedagogy within an undergraduate Bachelor of Nursing curriculum.

The main findings of this study, therefore, were used to illustrate the SL pedagogy, which is characterised by scaffolding and constructive alignment in all aspects of the learning and teaching practices, including the graduate attributes. The main elements of the SL pedagogy provided insights into the essence of the pedagogy, the concepts and beliefs about learning, the epistemological rationale, the political realities of the curriculum, and guidance on the process

of developing the curricular practices. This study makes several significant and unique contributions to nursing education. Firstly, it demonstrates the development of curricula required to transform the way we socialise undergraduate nurses to be social responsive through learning and teaching activities. The CEGR was developed to classify curriculums in terms of its transformative nature. It also demonstrates how CE and SL indicators transform curricula towards achieving social justice through curricular practices.

KEYWORDS

Curriculum development

Community engagement

Nursing education

Pedagogy

Service learning

Transformation

Undergraduate Bachelor of Nursing

ACRONYMS & ABBREVIATIONS

BNUR:	Bachelor of Nursing:
CE:	Community Engagement
CEGR:	Community Engagement Grading Rubric
CEU:	Community Engagement Unit
CHE:	Council of Higher Education
CHESP:	Community Higher Education Service Partnerships
CoC:	City of Cape Town
CPU:	Conceptualisation, Production and Usability model
CSL:	Capstone Service Learning
DBSL:	Discipline Based Service Learning
DHET:	Department of Higher Education and Training
DoE:	Department of Education
DoH:	Department of Health
EL:	Experiential Learning
FCHS:	Faculty of Community and Health Sciences
HEI:	Higher Education Institutions
HEQC:	Higher Education Quality Committee
HEQF:	Higher Education Quality Framework
HESA:	Higher Education South Africa
ICT:	Information Communication Technology

IOP:	Institutional Operational Plan
NDP:	National Development Plan
PC:	Primary Care
PD:	Performance Descriptors
PHC:	Primary Health Care
SANC:	South African Nursing Council
SL:	Service Learning
SoN:	School of Nursing
UHC:	Universal Health Coverage
WHO:	World Health Organization
WIL:	Work Integrated Learning

DECLARATION

I, Jeffrey Cornè Hoffman, student number 2138228, declare that:

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

Jeffrey Corné Hoffman
PhD candidate

This thesis has been read and approved for submission by:
Prof. Hester Julie

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Prof. H. Julie (Research Supervisor)

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1. Introduction

As Community Engagement (CE) has featured on the agendas of most governments (Butin, 2006), academia in Higher Education (HE) has been reminded increasingly that the "social good" is integral to the mandate, which society has entrusted to universities (Higher Education Quality Committee [HEQC], 2006, p. 4). It is this global call for the incorporation of *social good* in curricula (Boelen, Dharamsi, & Gibbs, 2012; Preston, Larkins, Taylor, & Judd, 2016) that provided the impetus for the SL movement in academia. Similarly, the transformation agenda of the post-apartheid South African legislation, has compelled South African Higher Education to become more accountable to the needs of society (Republic of South Africa [RSA], Department of Education [DoE], 1997, 2001; Republic of South Africa [RSA], Department: The Presidency, 2011). These national imperatives guided the structural discourses, as the government attempted to transform South Africa [SA] into a more democratic society, by linking national legislative frameworks with policy imperatives, such as epistemological transformation through public good and critical citizenry (Lazarus, Erasmus, Hendricks, Nduna, & Slamat, 2008, p. 58).

Governments formed coalitions with academia, intending to use education as a vehicle to expedite social justice for disempowered communities (Stirling, Wilson-Prangley, Hamilton, & Olivier, 2016). This implied that HEIs (Higher Education Institutions) had to review how scholarship and knowledge were conceived, constructed, and transmitted, to support the ideology of redressing past inequalities (Hall, 2010). Consequently, the SL movement explored and developed various CE curricular activities (see Figure 1.1), based on the respective visions, missions, and educational philosophies of leading HEIs (Butin, 2006, p. 479; HEQC, 2006, p. 17). However, a major critique against the praxis of SL (see Figure 1.2), in the early days of the SL movement, was the perceived lack of scholarship (Butin, 2006). Due to this contestation, the SL movement shifted the discourse to the scholarship of engagement (Boyer, 1996; Irby, Cooke, & O'Brien, 2010; Watson, Hollister, Stroud, & Babcock, 2011; Kliewer, 2013; Julie, 2014). Engaged teaching, engaged research, and engaged service, therefore, are heralded as legitimacy markers for universities, to address the

pervasive knowledge-to-action gap (Beaulieu, Breton, & Brousselle, 2018), especially related to social justice issues. The essence of this perspective is captured in the following statement by Boyer (1996, pp. 19–20):

> *"At one level, the scholarship of engagement means connecting the rich resources of the university to our most pressing social, civic, and ethical problems. Campuses would be viewed by both students and professors not as isolated islands, but as staging grounds for action. But, at a deeper level, I have this growing conviction that what's also needed is not just more programs, but a larger purpose, a larger sense of mission, a larger clarity of direction in the nation's life as we move toward century twenty-one. Increasingly, I'm convinced that ultimately, the scholarship of engagement also means creating a special climate in which the academic and civic cultures communicate more continuously and more creatively with each other, enriching the quality of life for all of us."*

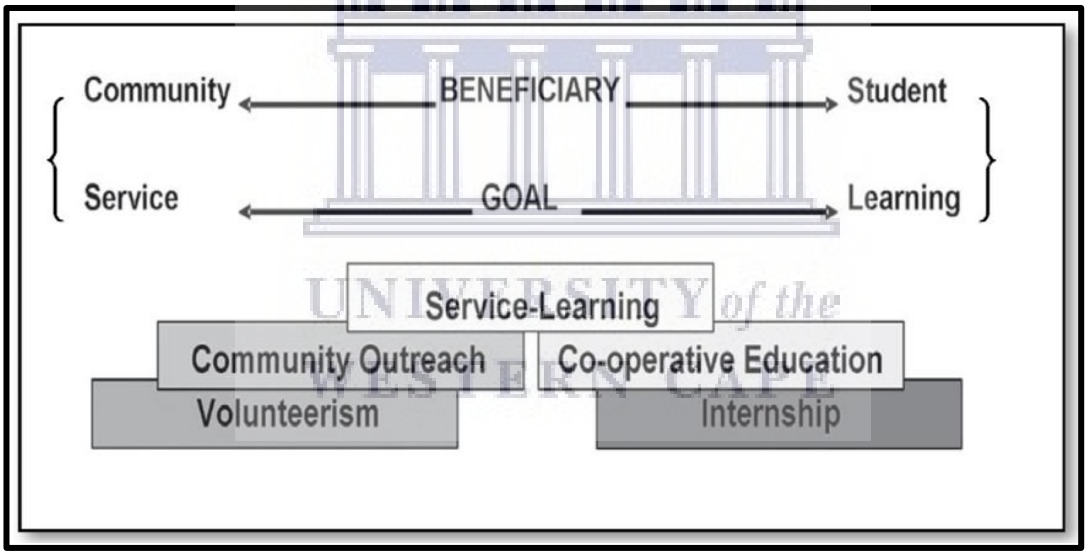

Figure 1.1: Types of community engagement (Furco, 1996)

The CE typology in Figure 1.1 demarcates the dominant forms of CE, differentiated, primarily, by the goals and primary beneficiaries of the service delivered (HEQC, 2006; Lazarus et al., 2008; Hall, 2010). HEQC (2006, p. 11) states that CE could take on many different forms, in the context of higher education (see Figure 1.1). These could include distance education, community-based research, participatory action research, professional community service and service learning (Furco, 1996). In its fullest sense, community engagement is the combination and integration of teaching and learning (e.g. service learning), professional community service by academic staff, and participatory action research, applied

simultaneously to identified community development priorities. In short, CE is described as the integration of service with learning, including research applied to the identified community development needs.

In Figure 1.1, SL is positioned at the centre on the CE continuum, as it creates a perfect balance between the service provided and the envisaged learning, denoting, as well as authenticating the shared contextual element in SL, as pedagogy in higher education (Stanton & Erasmus, 2013). Its dominance expands, due to its potential to serve both students and the community, in terms of its goals and beneficence, if curriculised in HE (Osman & Petersen, 2013). In addition, these practices in higher education contributed, meaningfully, to the transformational change in society. Subsequently, HEIs have adopted CE as the third pillar in the South African higher education system, thereby providing the impetus for engagement to occur, through SL.

SL in HE is defined as "a course-based, credit-bearing educational experience in which students participate in an organised service activity that meets identified community goals" (Bringle & Hatcher, 1996, p. 222). In addition, students reflect on the service activity in a specific way, to gain further understanding of the course content, a broader appreciation of the discipline, and an enhanced sense of civic responsibility (Bringle & Hatcher, 1995, p. 112). The Higher Education Quality Committee [HEQC, 2004, p. 26) also describes SL as applied learning, which is directed at specific community needs, and integrated into an academic programme and curriculum. It could be credit-bearing and assessed, and may, or may not, occur in a work environment. Both definitions refer to community, as well as academic needs; however, the HEQC's definition places more emphasis on the needs of the community, which highlights the political connotation to the rationale for engaging SL in higher education in South Africa (Stanton & Erasmus, 2013, p. 17). SL embraces a continuum of acts, comprising a range of learning and teaching practices, focused on service and learning (Bartleet, Bennett, Marsh, Power, & Sunderland, 2014; Mergler, Carrington, Kimber, Bland, & Boman, 2017). Potentially, the tenets inherent in SL, could invigorate academia, redefine scholarship, and involve society in a meaningful discourse about the role of higher education in societal affairs (Castle & Osman, 2003; Butin, 2006; Bender, 2008; Stanton & Erasmus, 2013).

Despite the dominance of SL in higher education in South Africa, SL is known for challenging HEIs, because it requires the reconceptualization of the curricula, the disciplinary training needs, as well as the role of educators in knowledge creation (Heffernan, 2001). Implicit to

the above statements of potentiality, is the supposition that SL requires a structured curriculum approach. This often requires a transition into more democratic ways of managing the curriculum, through learning and teaching activities. However, this transition requires curriculum developers to be cognisant of the politics of health and healthcare delivery in a nursing curriculum (Republic of South Africa [RSA], Department of Health [DoH], 2012).

1.2. Contextualisation of SL as pedagogy

SL curricula are distinguished from others, as the learning content intentionally focuses on developing graduate attributes, related to social justice and social responsiveness (Boelen et al., 2012; Preston et al., 2016). The ultimate aim of the SL curricula is to engineer social transformation, by implementing the social accountability mandate of HEIs (Boelen et al., 2012). In South Africa, the government provided policy guidelines (Higher Education Quality Committee [HEQC], 2004), as well as curriculum resources (HEQC, 2006), to facilitate the institutionalisation of SL in Higher Education (Osman & Petersen, 2013, p. 6)

However, the design of SL curricula was hampered by the diverse praxis of SL, observed as reflected in the service and learning matrix, developed by Sigmon (1997). The four quadrants (Figure 1.2), presents the variety of *learning and service goals* that could, potentially, be *emphasised* in a SL curriculum. The difference in emphasis of service in the curriculum is also linked, intricately, to the ethos and philosophy of the HEI. Another common contextual difference, prominent in the academic discourse, is whether the beneficiaries of the service, espoused in the curriculum outcomes, should be an external community to the HEI campus community, or not (HEQC, 2006).

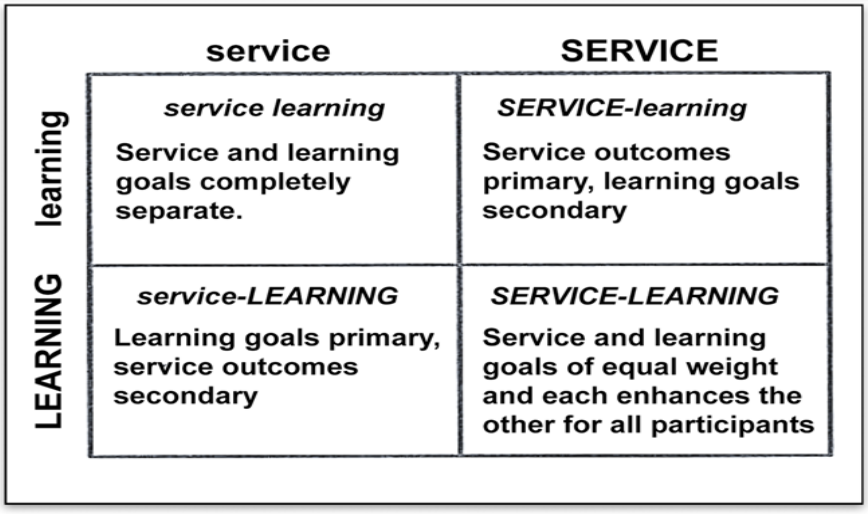

Figure 1.2: Service and learning matrix (Adapted from Sigmon, 1997, p. 3)

The incorporation of social justice issues in the curriculum, and stepping outside the *learning outcomes and learning content* prescribed by professional bodies are contested at various levels. However, it has dire consequences for the curriculum, *when the perspective of SL implementers, and educators, conflicts with that of the organisation* (Julie, Adejumo, & Frantz, 2015:). It could be concluded that SL praxis in the curriculum, as reflected in Figure 1.2, is dependent on whether SL is conceptualised as a philosophy, pedagogy, or a model for community development, by the curriculum developers (Corporation for National and Community Service [CNCS], 2011).

In this current study, the emphasis is on pedagogy; however, pedagogy is a contested term that involves activities, in which the learner adapts his/her behaviour. Watkins and Mortimore (1999, p. 3) define pedagogy as "any conscious activity by one person designed to enhance learning in another". Pedagogy, therefore, could be acknowledged as "a sustained process, through which somebody(s) acquires new forms, or develops existing forms, of conduct, knowledge, practice, and criteria, from somebody(s), or something, deemed to be an appropriate provider and evaluator" (Bernstein, 2001, p. 78).

1.3. SL pedagogy in higher education

Although curriculum and pedagogy are two separate concepts, they are connected, integrally, in the development of educational programmes (Wyse, Hayward, & Pandya, 2015). These authors state that *pedagogy* deals with the transmission of knowledge, whereas *curriculum* relates to the validity of knowledge. These two concepts make education an agency of socialisation in its epistemological foundation (Wyse et al., 2015). Descriptions commonly used in nursing education to distinguish between these concepts, is that *curriculum* is the total effort of the programme to bring about desired outcomes in educational institutions (Ramasubramaniam & Grace, 2015, p. 76). Presently, more than ever before, nurses should be prepared to meet the dynamic healthcare needs of society. To produce competent nurses, who can provide basic nursing, their education and training have to be rigorous, to meet the demanding needs of the healthcare system.

Pedagogy in the curriculum refers to the structuring of learning and teaching strategies, and activities, to achieve learning outcomes (Westbrook et al., 2013). According to Fry, Ketteridge, & Marshall (2008, p. 134), pedagogy promotes student learning, by providing

feedback to the student, to improve his/her performance (*pedagogy also determines what, and how students learn*). It includes the learning and teaching strategies, methods, activities, as well as the way assessment is structured, to achieve learning outcomes. *SL as a pedagogy* is imbedded in the field of experiential education (HEQC, 2006). The learning cycle is constructed to include concrete experiences, reflective observations, abstract conceptualisations, and active experimentation (Stanton & Erasmus, 2013; McKinnon, Smedley, & Evert, 2016). Additionally, SL pedagogy is geared at developing students to become reflective practitioners and critical consumers of knowledge (Osman & Petersen, 2013).

The purpose of SL pedagogy, therefore, is to create a learning and teaching environment that promotes community service and authentic learning, and allows students and community members to work, jointly, towards solving identified community challenges. Consequently, in SL, the community is placed, intentionally, at the centre of learning and teaching in the knowledge construction process (Eckenfels, 2009). A hallmark of SL pedagogy is that all community engagement curricular activities are designed specifically, as "students need to learn through and from their service experiences in working with community members" (Osman & Petersen, 2013, p. 6). In this current study, a community is operationalised as a group of people, who live in the same geographic location, with a particular characteristic in common. The notion exists that a community "includes other groupings of people sharing common characteristics or interests" and purposes (Macqueen et al., 2001, p. 1929).

The experiential learning cycle of SL is imbedded in theories of constructivism, critical socialism, and social cognitive theory (Osman & Petersen, 2013, p. 194). Consequently, SL is often viewed as a transformative pedagogy because of its focus on issues of power and social justice (Osman & Petersen, 2013, p. 12). However, it should be noted that SL can only be transformative, if a fundamental shift occurs, away from the conceptualisation of learning that is disconnected from the challenges of everyday issues in society. This implies that curricular outcomes and content should be relevant, and address the challenges expressed in the needs of the community. However, the envisioned transformation through SL does not always transpire, as challenges, related to curriculum issues, may arise. These factors may be related to the lack of institutional support, resistance to curricular changes, and the readiness of educators to implement SL pedagogy (Heffernan, 2001; Julie, 2014).

1.4. Embedding social good in the curriculum

As an agency of socialisation, the curriculum should be responsive to the needs of society, and its educational practices should express this intention (Wyse et al., 2015). Boelen et al. (2012) concur, as advocated in their social accountability framework, with defined standards for the social obligation scale. The social obligation scale provides clear parameters for interventions to be acknowledged as contributing to social accountability, in terms of health equity. In addition, they differentiate between *social responsibility, responsiveness and accountability* institutions. According to Boelen et al. (2012), a *socially responsible* institution embeds the reasons for health disparity in its curriculum, while a *socially responsive* institution engages students in longitudinal community-based activities throughout the curriculum, assessing their competencies to care for the most vulnerable people, and encouraging graduates to settle and work in underserved areas (Boelen et al., 2012, p. 184). *Socially accountable* institutions extend this brief to include advocacy, ensuring the employment of their graduates in the health system. Therefore, socially accountable institutions engage with health authorities and communities to: (1) ensure an enabling working environment for graduates to serve in underserved areas, and (2) participate in improving the management of health services (Boelen et al., 2012, p. 184).

1.5. SL in nursing education

The overall aim for nursing, as reflected in the SL movement, is to improve the standards of global nursing education (Edmonson, McCarthy, Trent-Adams, McCain, & Marshall, 2017). In the United States of America (USA), SL has been implemented to impact the development of students through an interconnected relationship with society (Stanton & Erasmus, 2013). This notion of SL intentionally provides students with opportunities to become active citizens, as well as bridge cross-cultural and economic differences, in an increasingly diverse society (Hatcher & Erasmus, 2008; Stanton & Erasmus, 2013). Similarly, in Australian Higher Education, SL has gained momentum as an emerging pedagogy, following the paradigm of the USA. Recent developments indicate that Australian higher education institutions are moving towards developing models that integrate SL into health professional training (Jones, McAllister, & Lyle, 2016). The SL movement in Tanzania aimed at nursing students, accentuated global SL experiences, to enhance self-awareness, increase cultural competence, and improve the standards of global nursing education (Kreye & Oetker-Black, 2013).

In the South African context, the following concerns capture the current status, regarding the operationalisation of social accountability in the nursing curriculum. In South Africa, it is acknowledged that the higher education sector is constrained (ill equipped) to implement the curriculum, to meet national needs (Boughey, 2010). Further nursing specific literature revealed that:

> *There seems to be a thin line between the idealism of nursing education transformation and the realities in the profession. The South African Nursing Council needs to uphold the responsibility towards social positioning of the profession. It should focus on the critical analysis of radical, social, economic, future trends and legislation to bring about social change with the implementation of the new qualifications* (Matalaka, 2016, p. 9).

The above direct quotation indicates that a critical review should be conducted on how regulation (R174), which replaces regulation (R425) that governs the bachelors of nursing degree, will shape graduates, in terms of the skills and competencies required, to negotiate what is required by society. The new qualifications are part of transformation, which was effected through the Nursing Strategy for South Africa (Republic of South Africa [RSA]. Department of Health [DOH], 2008) that came into effect with a vision to articulate how nursing education and training, practice, resources, social positioning, regulation and leadership, fit together to support the South Africa's health system. According Matlakala (2016), this requires a fundamental change in the delivery of the current professional nurse qualification, in terms of how the curriculum will negotiate its core purpose. This change will require revision in the structure of undergraduate nursing curricula, which will necessitate that institutions train nurses to assume a primary healthcare approach, or a community-based curriculum (Bezuidenhout, Human, & Lekhuleni, 2013; Friedman, 2019). This envisioned change will represent the first four-year nursing curriculum of its kind, to train nurses for work in Primary Health Care in South Africa (Friedman, 2019). The effect of these changes is envisaged to transform healthcare towards a District Health System, offering health promotion and preventative services, through community outreach, home-based services, as well as other primary care services (Republic of South Africa [RSA], Department of Education [DoE], 2011; Republic of South Africa [RSA], Department of Health [DoH], 2019).

1.6. SL curriculum approaches

Advocates of SL claim that it is an overarching transformative approach within higher education, based on the potential of SL to: (a) transform pedagogy; (b) facilitate democratic and socially just politics in higher education; and (c) redirect the inward focus of academic elitism towards greater public good (Butin, 2006; Osman & Petersen, 2013). Consequently, HEIs have adjusted their respective institutional policies, plans and strategies with the intention of institutionalising CE and SL in their academic programmes (Bender, 2007; Hall, 2010; Smith-Tolken & Williams, 2011; Julie, 2014; Kruger, Nel, & Van Zyl, 2015).

The Council of Higher Education (CHE) of SA recognises five SL approaches, namely: discipline-based service learning; problem-based service learning; capstone service learning modules; service internships; and undergraduate and postgraduate community-based action research (Council on Higher Education [CHE] & Higher Education Quality Committee [HEQC], 2006). *Discipline-based service learning* is commonly used in psychology, sociology, agriculture and nursing. It requires students to have a presence in a community, for a full semester, as well as reflect on their experiences, regularly, throughout the semester. It was anticipated that this would instil in them the required core skills, which would allow them to reflect.

Problem-based service learning is bit more advanced than *discipline-based service learning*, as it requires students to work in consultation with the community. Students mainly assume the role of consultant, to understand a particular community problem, and draw on fundamental knowledge, previously gained from developed core skills, associated with their field of interest. Subsequently, they make recommendations to the community, to develop a solution to the identified community problem.

Capstone service learning modules extend further, and could be viewed as the first two types, combined. They are offered to students in their final year, exclusively, during which year the students perform relevant community service, in the community, for the primary purpose of synthesising their understanding of the discipline field. They could be regarded as the modules that encapsulate the main purpose of a degree, and therefore, are offered in the final year. In addition, they could be regarded as the modules that help the students to make the transition from theory to practice.

Service internships, and undergraduate and postgraduate *community-based action research* are not discussed, as they extend beyond the parameters of the scope of this current study. They are viewed as useful for post basic courses, as they are more intense than the previous three module types discussed (HEQC, 2006, p. 40).

The type of approach to the development of a SL curriculum, is closely intertwined with the institutionalisation of SL (Furco, 2002; HEQC, 2006). SL institutionalisation, at the curriculum level, is usually evident in SL scholarship programmes and SL curricula (Furco, 2002; HEQC, 2006; Maphalala, 2012; Stanton-Nichols, Hatcher, & Cecil, 2015). Service learning curricula require careful consideration, which would include balancing institutional indicators, such as graduate attributes, as well as societal and developmental needs. However, curriculum designers should pay careful attention to the selection of appropriate curriculum design tools, especially when the intention is to institutionalise SL in a programme.

1.7. SL curriculum design tools

Constructive alignment and scaffolding are advocated for the management of learning activities, to ensure that the complexity level is incremental, and extends over the entire duration of a curriculum. *Constructive alignment* is the design and structuring of learning and teaching activities, which includes whatever students are intended to learn, as well as how they should express their learning (Biggs, 2014). The learning and teaching activities should relate to institutional outcomes, while programme outcomes should be stated clearly, before teaching takes place. Therefore, the teaching component should be designed to engage students in learning activities that optimise their chances of achieving the desired outcomes, and assessment tasks should be designed to enable clear judgment, regarding the success or failure of those outcomes (Simper, 2020). S*caffolding* is the "depiction of any instructional method that provides strong initial support that is gradually removed as the learner moves toward independence" (Smagorinsky, Clayton, & Johnson, 2015, p. 71).

Scaffolding and constructive alignment are regarded as essential curriculum design tools because it provides a clear pathway to structure learning and teaching opportunities within a curriculum for graduates to develop professionally, as they advance through the curriculum. It also allows the educator to demarcate skills and competencies within modules that the students should achieve, progressively, throughout the educational programme. In addition, it

will provide the unique opportunity to develop a typology of the community engagement activities within the programme (Delen, Liew, & Willson, 2014; Biggs, 2014). These two concepts will be applied in the data analysis stages of this current study. It will create meaning through the search for patterns in the module guides that could be used to scaffold the content. These patterns will relate to learning and teaching methods, content covered, time allocated to cover module outcomes, and praxis requirement.

However, SL pedagogy could only contribute meaningfully to transformational change in society, if the curriculum is developed and implemented consistently across a programme, using SL pedagogy as intended in this current study (Fitzgerald, Bruns, Sonka, Furco, & Swanson, 2012). Therefore, the nursing curriculum will be reviewed against standards, which ensure that social responsiveness is achieved through the objectives of the curriculum, by critically reviewing the professional competencies and institutional outcomes, as captured in the UWC graduate attribute, relating to responsiveness.

1.8. SL implementation framework developed for nursing

Globally, healthcare curricula are being transformed to develop socially accountable graduates, who are equipped to serve societal needs (Armstrong & Rispel, 2015; Menon & Castrillon, 2019). Advocates of SL claim that, as an overarching transformative approach within higher education, SL could, potentially, (a) transform pedagogy; (b) facilitate democratic and socially just politics in higher education; and (c) redirect the inward focus of academic elitism towards greater public good (Butin, 2006; Osman & Petersen, 2013). Consequently, HEIs in SA adjusted their respective institutional policies, plans, and strategies with the intention of institutionalising CE and SL in their academic programmes (Bender, 2007; Hall, 2010; Smith-Tolken & Williams, 2011; Julie, 2014; Kruger, Nel & Van Zyl, 2015). The assumption was that the tenets of CE and SL would be evident in the macro, as well as the micro curriculum (Furco, 2002; HEQC, 2006).

Institutionalisation of SL is a multifaceted construct that occurs at different levels, namely, institutional, faculty, departmental, curriculum, and course (Furco, 2002; HEQC, 2006). The institutionalisation of SL, at academic curriculum level, is usually evident in a SL course as the appropriate measures taken in the development of a curriculum, and the faculty, to provide a supportive and an enabling environment to facilitate SL curriculum development, as well as

SL scholarship programmes and curricula (Furco, 2002; HEQC, 2006a; Maphalala, 2012; Stanton-Nichols, Hatcher, & Cecil, 2015).

Consequently, a baseline study was conducted in a School of Nursing (SoN) at a HEI in the Western Cape, because this SoN referenced social justice and social responsiveness as key values in its mission statement (Julie, 2014; University of the Western Cape [UWC], 2015b). Subsequently, Julie (2014) developed an implementation framework, to guide the institutionalisation of SL in the undergraduate nursing curriculum. The framework identified five prescriptive elements, namely: (1) Assessing readiness for SL institutionalisation; (2) Developing a contextual SL definition; (3) Developing a SL pedagogical model; (4) Developing a monitoring and evaluation system for SL institutionalisation; and (5) Developing SL capacity and scholarship (Figure 1.3).

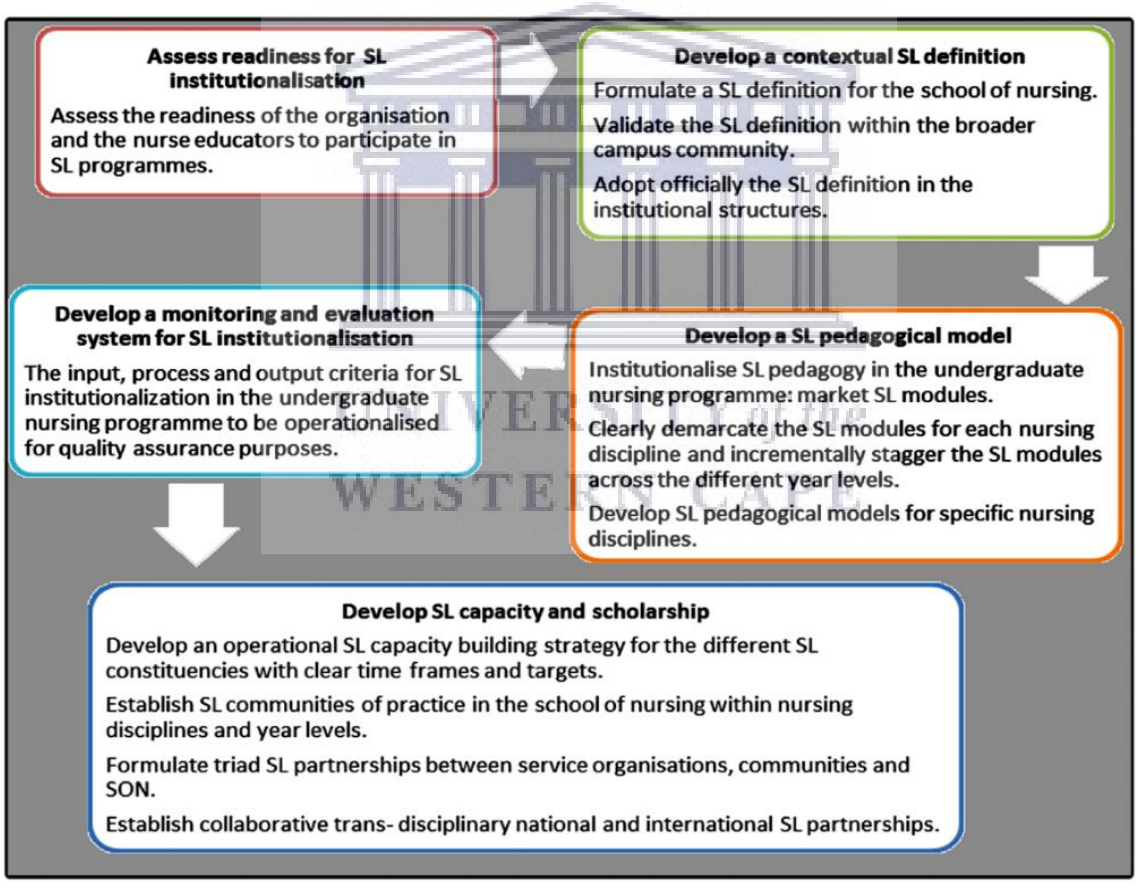

Figure 1.3: Prescriptive elements of SL implementation framework (Julie, 2014, p. 209)

This baseline study investigated whether the critical success factors for SL institutionalisation, developed by Furco (2002), or better known in South African terminology as SL good practice indicators, were operationalised in the HEI. The study concluded that the HEI, at institutional level, had created an enabling environment for the SoN to institutionalise SL. However, the

implementation of SL pedagogy in the undergraduate nursing curriculum was hampered by the readiness of the staff (Julie, Adejumo, & Frantz, 2015). The nursing educators were not ready for SL institutionalisation, due to a lack of SL scholarship, as well as a willingness to remediate the self-identified SL theory/practice disparities (Julie, 2014). A follow-up study, conducted by Hendricks (2018) reported that SL institutionalisation in this SoN, remained at the critical mass-building phase. The prevalent conceptual confusion was identified as a major concern, because SL institutionalisation hinges on a shared understanding of SL (Julie, 2014). Therefore, a contextual definition of SL was constructed for the SoN, through a democratic process with nursing, to eliminate the conceptual confusion, and provide guidelines for the mainstreaming of SL (Julie, 2014). Ramasasa (2018, p. 58) conducted a follow-up study and refined the SL definition, originally developed by Julie (2014). These findings further confirmed the need to embed SL pedagogy within the undergraduate nursing curriculum.

1.9. Problem statement

The directive from the CHE stipulates that SL should form an integral part of learning, teaching, as well as research, and be incorporated into the national quality assurance systems (Council on Higher Education [CHE], 2016). Consequently, this specific HEI established a designated CE Unit to fulfil this brief, as well as provide institutional guidelines for SL curricula. Currently, this HEI advocates SL as engaged scholarship in its mission statement, and the CE model, depicted in Figure 1.4 (University of the Western Cape [UWC], 2016), is underpinned by values of a social justice that places a high premium on the co-creation of knowledge in a reciprocal fashion (Community Engagement Unit [CEU], 2015).

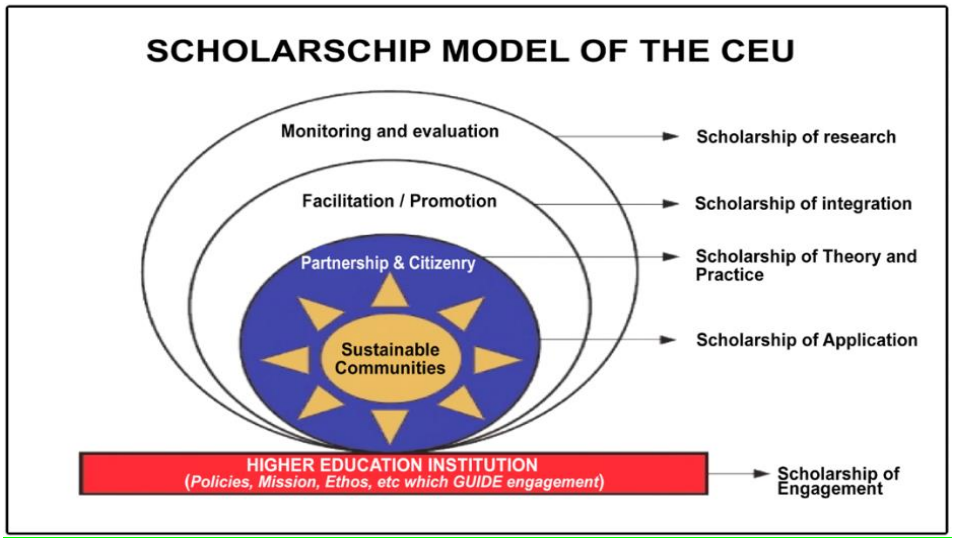

Figure 1.4: Community Engagement model (UWC, 2016)

In the Figure 1.4 CE model, the necessary guidelines for SL at the institutional level are illustrated. However, the envisioned curriculum transformation does not always ensue, for a variety of reasons, which includes, organisational factors, institutional commitment, and transformative practices (Furco 2002; Brukardt, Holland, Percy, & Zimpher, 2004; Butin, 2006). A primary reason often cited is that, at the institutional level, the guidelines are not explicit, in terms of how to institutionalise SL practices. Therefore, Julie (2014) developed a SL implementation framework (Figure 1.4 above) to facilitate the institutionalisation of SL in the undergraduate Bachelor of Nursing curriculum for the SoN (Julie, 2014).

To date, only the first two prescriptive elements have been achieved, from the following five proposed prescriptive elements:

1. Assessing readiness for SL Institutionalisation;
2. Developing a conceptual SL definition;
3. Developing a SL pedagogy;
4. Developing a monitoring and evaluation system for SL institutionalisation;
5. Developing SL capacity and scholarship.

Research reports are available on the readiness assessment for SL institutionalisation (Julie, 2014; Hendricks, 2018), and the development of a contextual SL definition for SoN (Julie, 2014; Ramasasa, 2018). Anecdotal evidence in the SoN confirmed the empirical findings of these studies conducted in SoN. It was evident that SL was implemented inconsistently in the undergraduate Bachelor of Nursing curriculum. The SL pedagogy was utilised only in one module at the 4th year level of the undergraduate curriculum. This raised concern, in terms of the mission statement of the HEI to develop social responsive graduates, and the structured, coherent, implementation of SL across the undergraduate Bachelor of Nursing curriculum.

Despite the development of a Service Learning (SL) implementation framework for institutionalising SL in the undergraduate nursing curriculum, there were concerns about inconsistent implementation of SL, to transform curricula, as well as learning and teaching practices, to produce socially accountable graduates. It became evident that the next prescriptive element, namely, the development of a SL pedagogy, was imperative. Therefore, in this current study, the researcher set out to develop a SL pedagogy for the undergraduate nursing curriculum, as per the recommendation of the baseline study, conducted in 2014 for this SoN.

1.10. Aim of study

To develop a SL pedagogy for the undergraduate Bachelor of Nursing curriculum.

1.11. Objectives for study

The following five objectives were formulated for this current study.

Phase 1:

1. To develop a curriculum map at the micro level of an undergraduate Bachelor of Nursing curriculum.
2. To formulate the CE typology, currently imbedded in an undergraduate Bachelor of Nursing curriculum.
3. To develop the draft SL pedagogy, as reflected in the aspects that inform the learning and teaching practices, the typology of CE, as well as the indicators to manage the quality of the SL elements, based on the findings of Objectives 1 and 2.

Phase 2:

1. To explore, analyse, and interpret the experiences of the nurse educators, regarding their learning and teaching practices;
2. To finalise the SL pedagogy within an undergraduate Bachelor of Nursing curriculum, as reflected in the aspects that inform the learning and teaching practices, the typology of CE, and the indicators to manage the quality of the SL elements, based on findings of Objectives 1 and 2.

1.12. Delimitations of study

The SL pedagogy was formulated from the recommendations of the Phase 1 and Phase 2 research findings. The advanced development and dissemination of the pedagogical model was excluded in this current study, and will be explored as post-doctoral work.

1.13. Assumptions

The significance of the research assumptions is to be observed in the meta-theoretical, theoretical, and the methodological assumptions, which provide a framework for this current study. The intention was to explore the undergraduate nursing curriculum, and understand the

meaning that nurse educators attached to their pedagogical practices, as was evident in their learning and teaching methodologies.

1.13.1. Meta-theoretical assumptions

The meta-theoretical assumptions are defined as "non-epistemic statements that are not planned to be tested" (Mouton & Marais, 1994, p. 192). The researcher's opinion about learning is that knowledge generation (power) has the potential (learning) to change (transform) the student, as well as the environment in which the learning occurs (Campbell, Verma, Melville, & Park, 2019; Johnson, 2010, p. 1). Building on these assumptions about learning, the following key concepts, through which learning could be acquired and evaluated, are described, namely power, engagement, identity (social accountability and social justice), and community. Learning, therefore, becomes transformational, when teaching invites both students and teachers (nurse professionals) to discover their full potential as learners, as members of society, and as human beings (Johnson, 2010). This ensures the potential to develop more nurturing human beings, who are better able to perceive the interconnectedness of all human, plant, and animal life (Narve, 2001). The paradigmatic perspective of this current study, therefore, embraces the transformative worldview, through critical theory, as it allows the research to be conducted through a social justice lens, to facilitate change in the current learning and teaching practices of the undergraduate nursing curriculum, and the key role-players.

- *Power* refers to the transmission of knowledge that could be used to transform or redress past injustices. Transmission of knowledge is also a tool to liberate the oppressed, and free them from social injustices, while being regarded as tool to do public good. The assumptions shared by Narve (2001) and Johnson (2010) are upheld, shared, and adopted in this research.

- *Engagement* is the tool used in this current study for the purpose of redress, and to produce socially responsive and socially accountable Bachelor of Nursing graduates.

- *Identity* of a nurse, according to Geyer, Mogotlane, and Young (2010), is the product of assimilating a variety of influences and experiences, as evident in professional values and ethics. It is a process that takes place within practitioners, through contact with other practitioners in the health sector, with

whom they work throughout their careers. Primarily, the identity could develop on professional solidarity, accountability, proficiency, the maintenance of a code of ethics, and the welfare of the public (Geyer et al., 2010, p. 34). Identity, therefore, references a responsive accountable citizen, delivering public good to remediate tensions created by social injustices. A socially accountable citizen is conscious of democratic values as the transformational characteristics.

- *Community* refers to the South African society as a whole, regardless of geographical location, group affiliation, ethnicity, religious belief, gender, age, or sexual orientation (South African Nursing Council [SANC], 2013). *Community*, in this current study, is viewed and considered a societal space, which contains unique opportunities that are socially, culturally, and academically authentic, for students to engage with, thereby linking classroom discussions with services rendered.

1.13.2. Theoretical assumptions

A conceptual framework was formulated to guide the development of the SL pedagogy for undergraduate nursing programme. The conceptual framework consists of two pillars namely, Kotter's (2007) Organisational Change Theory, and the five curriculum design guiding principles of Hansen (1995), which provided the necessary structure for this current study. According to Polit and Beck (2012), the purpose of an explicit theory is to guide the research tradition and methods of the study. Kotter's Organisational Change Theory provided a "one sequence of movement through the eight stages organisational change" (Pollack & Pollack, 2015, p. 61). The distinctive contribution and significance of Kotter's Organisational Change Theory (2007) in this current study, rests solely on the view that change is one cohesive process, or the sum of many coordinated processes (Pollack & Pollack, 2015). Therefore, Kotter's Organisational Change Theory (2007) was adopted as the first pillar of the conceptual framework.

Kotter's Organisational Change Theory rests on three dimensions, which consists of the eight steps that provided the theoretical (epistemic) assumptions, in terms of transforming the educational practices at school level. However, only the first two dimensions (dimension 1 and 2) of the three dimensions was applied to this current study. Each dimension implemented was linked to a specific phase of the study, and the

steps of each dimension, to the objectives of the particular phase. This provide control, in terms of the methodological stance of the research study. Dimension 1, *Creating a climate for change*, provided the opportunity to perform a document analysis (Objective 1), and a curriculum mapping exercise (Objective 2). Dimension 2, *Engaging and enabling the whole organisation*, was activated in the study through the individual interviews with the nurse academics, who were participating on the undergraduate nursing curriculum. The two dimensions of Kotter's Organisational Theory that were applied to this current study, comprised the following:

Dimension 1: Creating a climate for change

1. Creating a sense of urgency:
2. Forming a powerful guiding coalition
3. Developing a vision

Dimension 2: Engaging and enabling the whole organisation,

4. Communicating the vision
5. Empowering others to act on the vision
6. Planning and creating short-term wins

A detailed discussion of the steps relating to Dimension 1: *Creating a climate for change,* and *Dimension 2*: *Engaging and enabling the whole organisation*, that were executed in Phases 1 and 2 is presented in Chapter 2.

The second pillar of the conceptual framework for the development of the SL pedagogy, is the five curriculum design guiding principles (Hansen, 1995). The five principles of curriculum development, proposed by (Hansen, 1995), introduce the foundation for the exploration of curriculum theory within the proposed study. "Curriculum theory, is a complex field of scholarly inquiry within the broad field of education that endeavours to understand curriculum across the school subjects and academic disciplines" (Pinar, 2014, p. 21). In addition, with curriculum theory, the emphasis is on teaching strategies within single teaching fields. It further aspires to understand the overall educational significance of the curriculum, providing access to articulate the curriculum through relationships, the individual, society, and history (Pinar, 2014). Therefore, in this current

study, the five principles of curriculum development provides the limits, in terms of exploring the undergraduate curriculum, in phase 1 and 2. The five principles of curriculum design embrace the following:

1. The essence of the curriculum design;
2. Conceptualisation of attitudes and beliefs about learning;
3. Epistemological rationale;
4. Political realities of curriculum development;
5. Curriculum development planning process.

A detailed discussion on the application of the conceptual framework is provided in Chapter two (2) of this thesis, and outlines how Kotter's Organisation Change Theory and the five curriculum principles guided the study.

1.13.3. Methodological assumptions

The paradigmatic perspective relates to the worldview, evident in the philosophical assumptions, as well as the distinct methods, or procedures applied to a scientific study (Creswell, 2014). The worldview "… enables the readers to judge the relevance of the methodological approach" (Hennink, Hutter, & Bailey, 2011, p. 10). Therefore, in this current study, a multi-method research approach, within a predominant conventional qualitative tradition, was used, because the participants' views were valued. In addition, it allowed the researcher to make interpretations.

A constructivist paradigm was considered and explored; however, this constructivist paradigm was inadequate, in terms of advocating for change (Creswell, 2014), and addressing the issues of marginalisation and social injustices imbedded in this study. According to Kivunja and Kuyini (2017, p. 33), "In this paradigm, theory does not precede research but follows it so that it is grounded on the data generated by the research act". Therefore, the paradigmatic perspective of this current study embraced a transformative perspective, through critical paradigm. Kivunja and Kuyini (2017, p. 35) assert that "Critical paradigm situates its research in social justice issues and seeks to address the political, social and economic issues, which lead to social oppression, conflict, struggle, and power structures at whatever levels these might occur". In this current study, it became essential to view the education of nurses as a means to negotiate

improved healthcare delivery, by advocating for change in the structure of the nursing curricula. This change could produce socially accountable nurses, on completion of the 4-year bachelors of nursing programme.

The current undergraduate nursing curriculum should be reviewed, and a conscious attempt made to transform the curriculum, to adhere to learning and teaching practices, which nurture social accountability, for example, opting for methods and strategies aligned to the SL pedagogy. This could transform the pedagogical practices to demonstrate relevance and services to communities. The learning and teaching practices in the undergraduate nursing curriculum, therefore, would be viewed through a social justice lens. The paradigmatic perspective is elaborated on further in Chapter 3.

1.14. Research methodology

The multi-method research approach that was used in this current study is depicted in the Figure 1.5 below (See Chapter 3 for a detailed discussion).

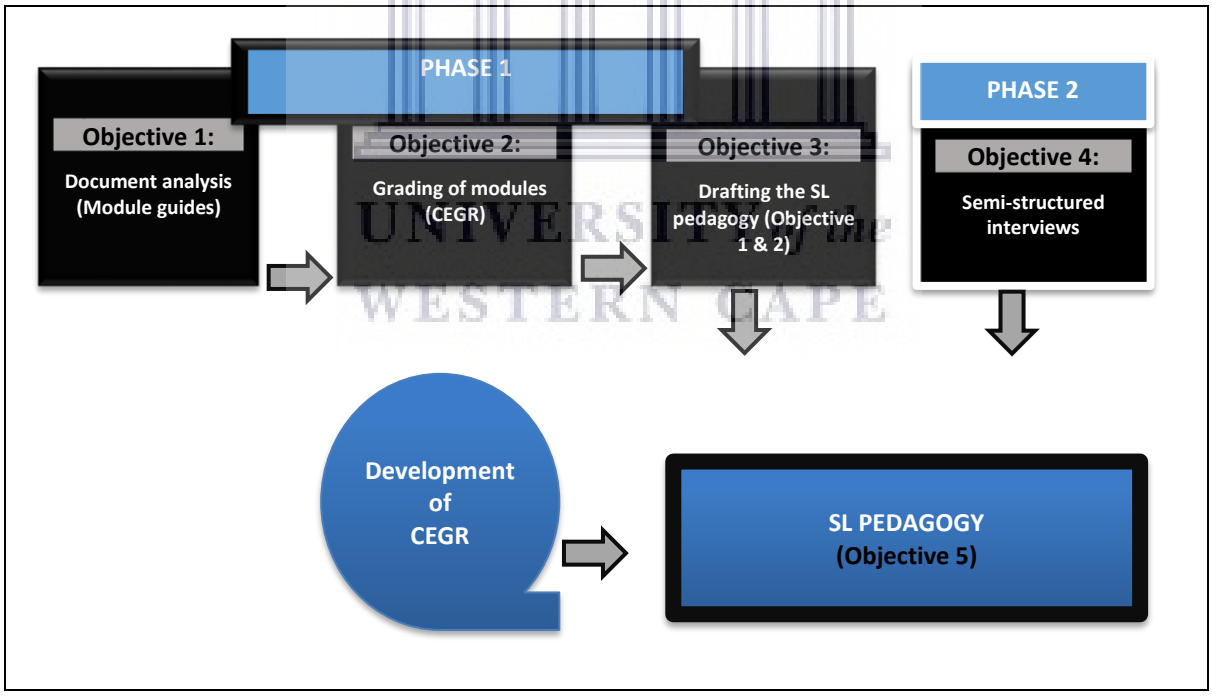

Figure 1.5: Multi-methodology of study

1.15. Significance of the study

This current study makes a significant contribution to nursing education and SL institutionalisation in the following areas:

- Aligning nursing education with national standards and regulations, to respond to the healthcare needs of society through social obligation;
- The SL pedagogy that was developed to institutionalise SL in the undergraduate nursing curriculum, with the aim of aligning SL practices with transformational standards of education;
- Developing an instrument to allow educators to determine the SL potential of modules; and
- Assisting to make the undergraduate curricula more relevant to the current healthcare needs of society.

1.16. Operational definitions

- **Community engagement (CE)**

  This denotes higher education's interactions with external interest groups, aimed at building, and exchanging the knowledge, skills, expertise, and resources, required to develop and sustain society. In this current study, it refers to the activities summarised in Figure 1.1; however, more precisely, it also refers to "initiatives and processes through which the expertise of the institution in the areas of teaching and research are applied to address issues relevant to its community" (Council on Higher Education [CHE], 2012, p. 1). In addition, it refers to the learning and teaching practices that cultivate student learning in community settings, as part of the undergraduate nursing curriculum.

- **Curriculum**

  In nursing, curriculum refers to the course, or the educational programme that students must complete, in order to obtain a qualification. In this current study it refers to the course, or programme in the art and science of nursing, which provides the total learning and teaching experiences that educators must plan for the education of nurse training.

- **Pedagogy**

  Pedagogy refers to the learning and teaching methods used to facilitate the learning outcomes in a curriculum. In addition, SL is regarded as pedagogy in this current study, which consists of authentic scholarly activities, aligned to the academic learning

outcomes of modules, with engagements to develop communities and student learning, through reflective activities.

- **Service learning (SL)**

  Service learning is operationalised as an engaged pedagogical process that requires students to integrate theory with relevant community service, which embeds community engagement. In this current study, it is referred to as a learning and teaching pedagogy, which aims to address community needs, within an equal partnership between the university, community, and service providers that share the same values through authentic learning experiences, and reflective activities (Julie, 2014; Ramasasa, 2018). SL could also be viewed as "Applied learning which is directed at specific community needs and is integrated into an academic programme and curriculum. It could be credit-bearing and assessed, and may or may not take place in a work environment" (HEQC, 2004, p. 26). In this current study, SL is regarded as *engaged pedagogy*, which prescribes that students integrate theory with relevant service provision activities, to address the community needs in equal partnership with the community. SL is also distinguished from other forms of learning for example Work Integrated Learning since it focuses uniquely learning and service goals whereas WIL focus is limited to Learning goals only.

- **Institutionalise**

  A multifaceted construct was defined by the research and goals of several scholars (Bender, 2007; Hall, 2010; Smith-Tolken & Williams, 2011; Julie, 2014; Kruger et al., 2015). It indicates the prioritisation of the SL indicators, to facilitate learning and teaching. In this current study, it implies adopting SL pedagogy and its main indicators (scholarly activities, aligned to learning outcomes, community service, and reflective activities), to facilitate learning and teaching at programme and module level of the Bachelor of Nursing programme.

- **Undergraduate Bachelor of Nursing**

  This is a professional undergraduate curriculum that extends over four years. In this current study, it refers to the undergraduate nursing curriculum that is aligned to meet the criteria of Regulation 425 of the South African Nursing Council (SANC, 2013), which qualifies a recipient to practise as a registered nurse. In this context, it refers to the programme offered at the institution, where this study was conducted, which subscribes to Regulation 425 of the South African Nursing Council (SANC, 2013).

- **Nursing education**

  Nursing education covers an area in the science of nursing, which equips students with the knowledge, affective and psychomotor skills, to practice, effectively, in the nursing sector. In addition, students learn to manage the clinical training through nursing curricula, to apply it in nursing practice, using learning and teaching practices strategies, as well as to master assessment.

- **Community**

  Community refers to the South African society as a whole, regardless of geographical location, group affiliation, ethnicity, religious belief, gender, age, or sexual orientation (SANC, 2013). Additionally, different values, perceptions, levels of knowledge, beliefs, attitudes and practices are integral to communities. In this current study, a community is viewed as, or considered to be, any societal space, which contains rich opportunities for students to collaborate with, in order to bring about change for the benefit of society.

- **Social obligation**
  - Is the act of public good that is expressed on different gradients, in relation to the specificities within the concept of social responsibility, social responsiveness, and social accountability (Boelen et al., 2012, p. 181);
  - Refers to *being committed* to what is intuitively considered the welfare of society (Dharamsi, Ho, Spadafora, & Woollard, 2011). In this current study, it refers to the intention to produce "good practitioners", based on the implicit identification of society's health needs;
  - *Social responsiveness* is responding to society's welfare, by directing its education, research, and service activities, towards explicitly identified health priorities in society (Cruess, Johnston, & Cruess, 2002). In this current study, it reveals the intentions of the school of nursing to produce graduates, who possess specific competencies to address community needs;
  - *Social accountability* is *working, collaboratively,* with government to address the priority health needs of society, by going one step beyond implementing specific actions through its education, research, and service activities (Boelen, Heck, & World Health Organization [WHO], 1995). In this current study, it refers to measure that is in place, to ensure that students meet the required skills,

to assist with societal needs, by addressing real issues, and acting as a change agent.

1.17. Sequence and structure of research report

Chapter 1: This chapter comprises the orientation and introduction to this current study. It includes the background, problem statement, and rationale, significance of the study, methodological scope of the study, the definition of terms, and the sequence and structure of the research report.

Chapter 2: The researcher outlines the conceptual framework that will underpins the study. In this chapter, the literature, pertaining to the study, is explored, under its theoretical context.

Chapter 3: In this chapter, the researcher describes the research methodology applied in the study.

Chapter 4: A discussion of the development of the Community Engagement Grading Rubric is presented, including the development of a Performance Descriptor.

Chapter 5: In this chapter, the data collection, analysis and statement of results of Phase 1 are presented, relating to the first three objectives of the study.

Chapter 6: The researcher presents the data collection, analysis, and statement of results of Phase 2 in this chapter, as they relate to the last two objectives of the study.

Chapter 7: The SL pedagogy is finalised by using a discussion to present the main findings of the research with the support of related literature.

Chapter 8: The key findings of the study, conclusion, limitations, recommendations and suggestions for further studies are outlined, including a self-evaluation section that reports on the quality of the research.

1.18. Summary

In this chapter, the researcher provided an overview of the research by articulating the focus of the study that guided the research. It commences with an introduction of the position and regard for SL and CE in Higher Education. This is followed by an introduction of the existing

typology, which encapsulates CE. Background information on the UWC directives were provided, in relation to its position on CE and SL, at institutional and departmental levels.

The construction of the problem statement highlighted the need for this type of study. The aim and objectives are derived directly from the study, as well as the significance of conducting the study. The meta-paradigmatic approach of this current study was elucidated, which unfolded into the research methodology, followed by the operationalisation of key terminologies that underpin this study. Lastly, the researcher presented an overview of how the research will unfold in the subsequent chapters of this dissertation.

CHAPTER TWO

THEORETICAL FRAMEWORK UNDERPINNING THE STUDY

2.1. Introduction

In the previous chapter, the researcher provided an overview to orientate the reader to the research study, and concluded with a synopsis of the expectations of this current study, as it unfolds. This chapter commences with a discussion on the need of a framework and the rationale for the selection of a specific framework for this current study. This is followed by a discussion, outlining the main features of the framework, and reiterating the importance of the conceptual framework for this current study, before briefly summarising this chapter and introducing the next chapter.

2.2. Frameworks considered for the study

Creswell (2014) asserts that a conceptual framework provides the rationale for the structure of the study, based on an explicit theory (Polit & Beck, 2012). It further allows the integration of observations and accumulated facts, in an orderly manner and structure, to guide a particular understanding of the phenomenon under investigation. The following three realities were considered in the search of a suitable framework for this current study: the actual undergraduate curriculum; the learning and teaching practices (pedagogy); and the organisation of the curriculum, which refers to scaffolding and constructive alignment across the programme, and across all year levels, giving effect to praxis needs, in order to actualize the SL pedagogy. The intention was to design an enabling learning and teaching environment for the undergraduate curriculum that facilitates the development of socially responsive and socially accountable nursing graduates. Since, the focus of this current study falls within the ambit of educational and organisational change, theories related to curriculum development and organisational change were explored.

Several sources of literature (Kraft & Latta, 1972; Kotter, 1996; Mizikaci, 2006; Scott, 2008; Huerta & Zuckerman, 2009) were studied to identify change theories that might be eligible for this study. However, the following three (3) theories were considered most relevant for this current study: Systems Approach to educational organisational change (Kraft & Latta,

1972); Institutional change theory (Huerta & Zuckerman, 2009); and Kotter's Eight (8) Step organisational change model (Kotter, 1996). Each of these theories are discussed briefly, in terms of its relevance and suitability for this current study.

2.2.1. Systems Approach to educational organisational change

The systems approach to educational organisational change has been introduced in the field of education to manage, control, and improve the process and products of education (Kraft & Latta, 1972). This theory refers to the systematic organisation of four interrelated, and interdependent elements that operate in a unique way, namely, input, process, output, and environment. The organisation of these elements, drives all the sub-systems of the educational organisation, namely, the learner, teaching staff, non-teaching staff, employers, accrediting bodies, quality assurers and assessors, as well as the government (Mizikaci, 2006, p. 39).

This theory was not deemed suitable, as the focus of this study was, primarily, the structuring of learning and teaching activities by the nurse educator. Although the elements of input, process, output, and environment were considered in the systematic organisation of learning and teaching practices of the undergraduate curriculum, not all the sub-systems of the educational institution were involved. Subsequently, the systems approach was eliminated, on the basis that the focus was too broad for the purposes of this current study.

2.2.2. Institutional Change Theory

In the 1970s, this theory was developed as a framework, based on the relationship between the school and their cultural environment (Huerta & Zuckerman, 2009). Society's cultural norms shape organisational structure, by encouraging schools to conform to the accepted rules and rituals of an institution. Scott (2008) states that this theory could also refer to the influence that an organisation's cultural environment has on structure and behaviour, and it seeks to understand the ways in which cultural rules from the environment shape, or constrain organisational action.

Key findings of the baseline study that was conducted in this School of Nursing, revealed that the HEI had created an enabling environment for SL institutionalisation (Julie, 2014; UWC, 2015a), and advocates SL as engaged scholarship in its mission

statement (CEU, 2015; UWC, 2016). However, the implementation of SL pedagogy in the undergraduate nursing curriculum was hampered by the institutional culture of this specific SoN (Hendricks, 2018; Julie, Adejumo, & Frantz, 2015). Anecdotal evidence concurs that the implementation of SL in the undergraduate curriculum is inconsistent, and linked to individual personas (Boltman-Binkowski & Julie, 2014).

This theory was also excluded as the primary focus of the investigation was not the culture of the institution *per se*. It also included aspects of behavioural change, in terms of an openness (political will) to embrace the philosophy and pedagogy of SL by nurse educators. A framework was needed that would focus on changing the organisation, while simultaneously, but gradually, transforming those involved in leading the change.

2.2.3. Kotter's eight (8) step Organisational Change Model

Change in higher education is challenging, because of the complexity of the educational environment, impacted by multiple education reforms (Stoltenkamp, 2012). Although, organisational change requires an explicit approach, it may not achieve the desired behavioural outcomes. Julie (2014) concurs with this statement, when reporting the outcome of previous interventions, regarding institutionalising service-learning in this School of Nursing. Therefore, O'Rawe (2015) asserts that change often requires a transformative approach, involving consultation, collaboration, and interconnectedness. This implies that key stakeholders need to be mobilised to ensure that change is effected.

Kotter's (1996) eight-step Organisational Change Model was considered superior to the two previous models discussed, because consultation is imbedded in the eight (8) steps, while it ensures that the change is incremental. This model addresses organisational change management, by increasing the motivation of the change agents (nurse educators) to own and implement the required SL pedagogical changes in their learning and teaching practices. This involves aligning current pedagogical practices of the undergraduate nursing curriculum, by embedding service-learning within the existing curriculum structures.

2.2.4. Application of Kotter's eight-step process

Kotter's eight-step process is designed to alter strategies, re-engineer processes, in order to improve quality, and address barriers, through cultural transformation (Kotter, 1996,

p. 61). It enhances foresight, and acknowledges that barriers, related to change are inevitable, and that complacency and their consequences, common to organisational change, are not (Kotter, 1996, p. 37). The eight-step process of Kotter (1996) is not centred on the management of the process, but on the premise of leadership, which is a crucial component in cultural transformation (Polack & Polack, 2015). Leadership aligns, motivates, and inspires stakeholders, by establishing a common direction, through shared goals (Jooste, 2003). Kotter emphasises that sustainable cultural transformation is the antithesis of a linear process (Kotter, 1996; Bucciarelli, 2015). This implies that change is often cluttered with finding solutions to transform the organisation from one point to another. Kotter further describes the net effect of the cultural transformation process as the working of "wheels within wheels", until ultimately, it becomes the new norm (Kotter, 2012, p. 27). Kotter's (1996) framework, chosen for this current study, consists of three dimensions, divided into further sub-sections that serve as probes to complete each dimension.

2.2.4.1. Dimension 1: Creating a climate for change

Chappell, Pescud, Waterworth, Shilton, Roche, Ledger, Slevin, & Rosenberg (2016) asserts that the first step of Kotter's change process underlines an increasing sense of urgency, and a need to gain cooperation. Kotter's position regarding this dimension is clear, and directed at idealising new perspectives, or approaches, which, in this current study, is the creation of a SL pedagogy (Kotter, 1996). However, this dimension also intends to demonstrate that support from superior structures, such as management, as well as national and institutional directives, is not enough to ensure that intentions are translated and utilised. This contention is corroborated by research conducted in the SoN, which reports that, even though the institution's strategic and operational plans enables SL institutionalisation (UWC, 2016, 2015a), not much has been translated into the undergraduate nursing curriculum. For these reasons, this dimension of Kotter's eight step process for organisational change, was utilized to build on the seminal work done on SL within the institution and SoN. In addition, it was reported that evidence exists, which highlights the conceptual difficulty in the SoN, as well as the fact that SL did not feature in either the training, or the redesigning of the undergraduate nursing curriculum. In this dimension, *Creating a climate for*

change, the status quo of SL in the undergraduate curriculum was identified, by executing the following three sub-dimensions, proposed by Kotter (2007):

***Creating a sense of urgency*:** This is the first sub-dimension of *creating a climate for change*. This sub-dimension relates to seeking the cooperation of others for the intended change, by establishing a sense of urgency. Kotter (2007) describes this as the most challenging task, because it relates to initiating the intended change, through participation. In this current study, this step was achieved by comparing SL pedagogical practices in the undergraduate Bachelor of Nursing curriculum, against the national and institutional SL directives and guidelines. A sense of urgency was achieved when SL pedagogical discrepancies were highlighted in the review of CE practices, imbedded in the undergraduate curriculum.

***Forming a powerful guiding coalition*:** This step was executed to create the necessary structures/coalitions to remedy the identified SL discrepancies in the undergraduate programme. Kotter stresses out that renewal often starts with simply one or two people, and in cases of successful transformation efforts, the leadership coalition multiplies (Kotter 1996, p. 62). This step also required the researcher to confront and unpack issues related to organisational culture, in a non-threatening, but transparent manner. This step was achieved through the development of the Community Engagement Grading Rubric (see Chapter 4 of this dissertation). This tool allowed the researcher to engage with the Year Level Coordinators, regarding their understanding of the position of curricular practices, in terms of the developed rubric. This open discussion between the various Year Level and Discipline Coordinators created a powerful coalition among the nurse educators, in terms of differentiating between SL and other CE pedagogical practices.

***Developing a vision*:** This step involved answering the following questions: "What is the vision for the future?" and "What change is needed to realise our vision?" (Kotter, 1996, p. 63). Vision refers to the desired future, with a description on how to create it, implying that the vision clarifies the direction of the change, and provides the impetus for action. In addition, crafting a vision also facilitates the coordination of the actions of different people (Kotter, 2007).

In this current study, the vision was crafted by developing a draft SL pedagogy, outlining learning and teaching opportunities in the nursing curriculum, amenable to bring about the desired societal and professional transformation through the scaffolding of the community engagement typology developed for SoN. This vision was justified, using international and national perspectives on SL and its promise to academia. Additionally, it was also reviewed against professional and institutional commitments towards achieving societal justice. This draft SL pedagogy was used as a working document to engage the educators of SoN

2.2.4.2. Dimension 2: Engaging and enabling the whole organisation

The following three steps were applied sequentially:

***Communicating the vision*:** This step of Kotter's Change Theory involved the transformational process, aimed at developing the insight of the nurse educators further, as related to the vision, through consultations and discussion (Kotter, 1996, p. 63). Artefacts developed to facilitate this insight included: (1) The draft the SL pedagogy, (2) Curriculum maps, and (3) CE Typology for undergraduate curriculum.

***Empowering others to act on the vision*:** It was important to continue communicating and developing the vision of the SL pedagogy (Kotter, 1996, p. 102). When this step of Kotter's process was implemented, educators were consulted regarding their learning and teaching experiences, which became evident during phase one of this current study. Information that emanated from these consultations were used to refine the draft SL pedagogy.

Planning and creating short-term wins: Kotter (1995, p. 65) states that successful change efforts comprise five key factors, aimed at creating more change, namely: bringing in additional people to help; encouraging senior management to keep up the urgency; urging people, lower in the hierarchy, to lead and manage change projects; and finally, involving managers to eliminate interdependencies. Subsequently, key stakeholders would be consulted to ensure that IOPs are valued and that practices are aligned. The key stakeholders comprised the nurse educators, who participated in interview discussions, as they were the individuals, who would be responsible, primarily, for deciding on what to teach, as well as how to teach it.

2.2.4.3. Dimension 3: Implementation and sustaining change, consolidating improvements and producing more change

This dimension, with its two steps of Kotter's eight-step process, was not included in this current study, but earmarked for post-doctoral work on the SL pedagogy developed in this study. In conclusion, please note that only the first two dimensions of Kotter's eight-step process, were applied to this current study. This organisational change theory was deemed suitable: (1) To facilitate the development of a SL pedagogy for the undergraduate nursing curriculum; and (2) To bring the SoN in alignment with the institutional operational plan, as reflected in the vision and mission regarding SL (UWC, 2016, pp. 35-36).

The eight-step process of Kotter is divided into three main sections, with a sub-divided sections highlighting the key features and components. Table 2.1 guided the data collection, aimed at achieving the objectives of this current study (Kotter, 2007).

Table 2.1: Application of Kotter's Organisational Change Model

Dimension	Step	Description
Creating a climate for change	1. Creating a sense of urgency 2. Forming a powerful coalition 3. Developing a vision	Review and critique current practices. Identify what should be in place to ensure materialisation (developing a CE typology through a Community Engagement Grading Rubric); Demarcation of modules per year level. Draft the SL pedagogy: Curriculum maps, Typology of CE.
Engaging and enabling the whole organisation	4. Communicating the vision 5. Empowering others to act on the vision 6. Planning and creating short-term wins	Interview discussions to create reality. Interviews to validate practices. Finalising the SL pedagogy.
Implementing and sustaining change		

2.3. Guiding principles for curriculum development

Kotter's application in this current study, as previously discussed in this chapter, provided a structure to bring about change; however, the guiding principles of Hansen (1995) provided strategic focus on exactly what should be changed. In this current study, the researcher intended to propose a SL pedagogy for the undergraduate nursing curriculum; therefore, it became imperative to prioritise a position on which the SL pedagogy could thrive. The

position relates to reform, as well as social justice, and develops a new paradigm to benchmark nursing education and training. In order to provide meaning and focus to Kotter's steps that were employed, this study would need to ground and stabilise its intentions and outcomes, with education requirements. Therefore, it was a priority to review approaches to curriculum development. Hansen (1995) proposes the following principles to guide the study further, across all the dimensions of the Kotter's steps, which were adopted in this current study:

2.3.1. Principle 1: Essence of curriculum design and the need for a conceptual underpinning

This principle refers to the *ideology that should accompany the curriculum*. It, therefore, gives reference to the framework, or the standpoint that provides meaning and purpose to the curriculum. Alsubaie (2016) states that the ideology of the curriculum should meet the demands and the needs of the culture, the society, as well as the expectations of the population, being served. The essence of this current study is that social accountability is imbedded, as it translates the significance of this study, as captured in Chapter 1.

In this current research, the researcher adhered to the above mentioned principle, and the views expressed by Boelen, Blouin, Gibbs, and Woollard (2019), which highlight social accountability in health education programmes. These authors propose 12 standards, which prioritise social obligation, according to three gradient levels, namely responsibility, social responsiveness, and on its highest level or form, social accountability. These standards were adopted, as they related to the purpose of this current study, concerning the social obligation mandate that health education curriculums should advance social accountability, through its mission statement, educational curriculums, curricular content, as well as the types and location of educational opportunities and experiences, evidenced by specific outcomes measures. The standards that connect these prescriptions to the graduate attributes of the institution, create a well sustained and organised process.

2.3.2. Principle 2: Conceptualising attitudes and beliefs about learning

This principle is orientated towards the three aspects. Firstly, the *transmission position* relates to the function of the schooling being viewed as transmitting facts, skills, and values to students. It focuses on the fundamental aspects of the schooling journey. In this current study, it is based on aspects that relate to the ethos of care. Secondly, the

transaction position personifies the student with his/her ability to be a rational being, and posits the capacity to solve problems. Lastly, the *transformation position* is attentive to the personal and social change, with attention to ecological interdependence and interrelatedness of phenomena.

These aspects relate to the social contract by the philosopher, Rousseau, which became an important underpinning of democratic governments (Skyrms, 2014). It refers to the nature between different forms of life, which could be viewed as mutually exclusive, in the sense that the one depends on the other one. This defines economic independence, as well as interrelatedness, and provides meaning to this current study, in the way that nursing is to care, and the recipients of care depend on the individual to provide. These three aspects offer insights into the philosophical, psychological, and social context, in which a curriculum is developed. It provides the essence to guide the pedagogy through the elements of SL that are explored and reported in Chapter 4.

2.3.3. Principle 3: An epistemological rationale

This principle draws attention to the philosophy that deals with *the origin, nature, and limitations of knowledge.* It draws the distinction between academic curricula, and utilitarian curricula. The debate is ongoing between these two types of curricula, which negotiates tensions on the aspect that the distinction between the two is viewed as having knowledge (academic), and being able to demonstrate/apply that knowledge (utilitarian). Many researchers support the authenticity of the curriculum that aligns its teaching and learning practices, with learning that is contextualised (Bulte, Westbroek, De Jong, & Pilot 2006; Gulikers, Bastiaens, Kirschner, & Kester, 2008; Vereijken, Van der Rijst, Van Driel, & Dekker, 2020). This refers to the praxis that should be evident in an authentic learning experience, which facilitates learning. *Praxis* can be defined as the ability to apply knowledge to a situation, its characteristics include the following:

Metacognition refers to the level of thinking; regarded as the highest form of thinking, when engaged in an activity (Bruce, Klopper, & Mellish, 2011, p. 91). It also refers to the way the student makes sense of his/her thinking, which involves operations such as planning, monitoring, and assessing the thinking in which the student is engaged.

Schema refers to the units of knowledge that students have, based on previous experiences, as well as what they experienced. Schemata influences the comprehension processes, which could be perceived as theories of reality.

Transfer is regarded as the transfer of existing cognitive structures of pre-recognition, which is imbedded in previous experiences (Bruce et al., 2011, p. 91). Transfer of knowledge can be viewed as previous experiences that contribute to meaningful learning. Therefore, educators should be cognizant of the way they expose students to course material, as they should create a structure for the student, which could develop into the total learning experience.

Self-regulation can be described as the self-directive process, through which students transform their mental abilities, into task-related skills (Zimmerman & Schunk, 2001).

Classical conditioning is a type of learning that is classified when a conditioned stimulus becomes associated with an unrelated unconditioned stimulus, in order to produce a behavioural response known as, *a conditioned response* (Quinn & Hughes, 2007).

Operant conditioning translates as a learning process, in which the strength of a behaviour is modified through reinforcement (negative or positive) or punishment (Quinn & Hughes, 2007).

Zone of proximal development *(ZPD)* is a central concept of the Vygotsky' theory (Shabani, Khatib, & Ebadi, 2010), which refers to the distance between the actual level of development of the student, as is evident in problem solving, and the potential level of development, which could be achieved in collaboration, by guiding the student to problem solving (Bruce et al., 2011). In the context of this current study, it could be perceived that SL provides the student with an authentic experience, which could have implications for the student, who needs to engage with a real life experience, as well as the educator, who needs to facilitate the process for the student to complete the task required.

An important denominator exists within the ZPD, namely *scaffolding,* which refers to the level of guidance that is reduced, gradually, to allow the student to complete a task, while learning. Therefore, it "represents the distance between the student's actual level of development, as seen in independent problem solving, and her potential level of

development, which you, or she in collaboration with more able peers, can determine by guiding her problem solving" (Bruce et al., 2011, p. 91).

2.3.4. Principle 4: Political realities of curriculum development

Curricula are a multifaceted concepts, as they are constructed, negotiated, and re-negotiated, at a variety of levels, and in a variety of arenas (Goodson, 1991). This provides the inclination of authorities, like governments, to guide and direct education and practices in higher education. Education, therefore, needs to be aligned to political reality, in order to promote a larger shared vision.

2.3.5. Principle 5: Curriculum development/planning process

The planning process of the curriculum refers to the blueprint for the development of a curriculum (macro view). It could also refer to the plan that educators adopt to organise learning and teaching activities (micro view). Within this principle, the curriculum should be formulated, based on a combination of constituent needs, including the community, schools, educators, and students, in order to develop meaningful learning and teaching experiences, using a rational process-based objective data.

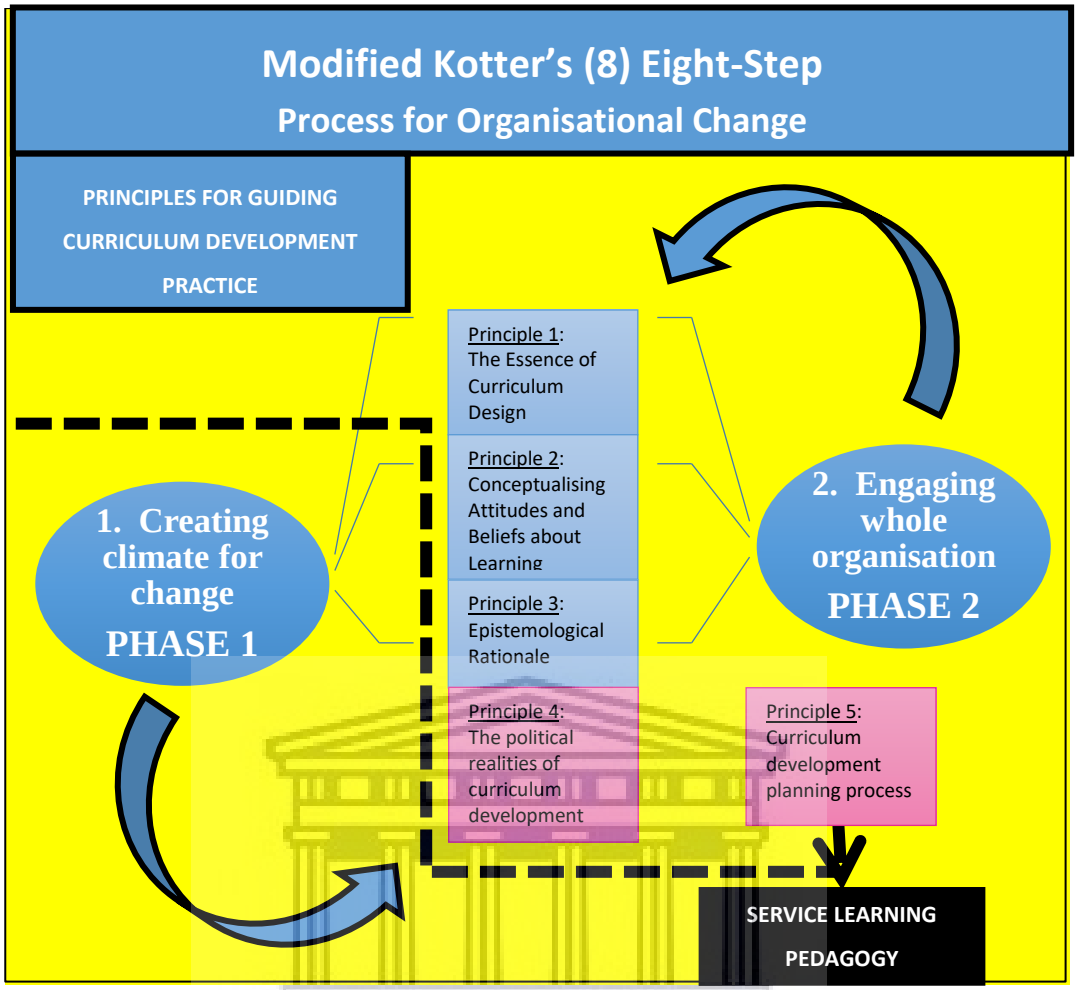

Figure 2.1: Overview of conceptual framework

The principles mentioned would co-facilitate with the steps of Kotter (Figure 2.1) applied in this current study, to achieve the objectives of the study, and to provide a structure, in which the research could ground the findings. Kotter's first two dimensions are applied, sequentially. Further direction would be served, by applying the five guiding principles for curriculum development. It would also aid the analysis and the documenting of the key findings, and main conclusions, as presented visually in Figure 2.1.

It should be noted that no literature review was conducted in this chapter. The literature review was conducted in two phases. The first phase was conducted in Chapter 1, with the aim of developing theoretical sensitivity, in terms of the need to develop the SL pedagogy for the undergraduate nursing curriculum, and was conducted prior to the development of the conceptual framework. The second phase was accomplished during

data collection/analysis, and was aimed at enhancing rigor, with regard to the emerging theory. The literature was also integrated during the discussion of the findings.

2.4. Summary

In this chapter, the researcher provided an overview of the conceptual framework of this current study. It commenced with an introduction, which connected the previous chapter with this current chapter. It continued, by briefly highlighting the main concepts within the significance of the study, which determined the need for a conceptual framework, and identified what would be deemed relevant. An introduction of theories and models, with reference to the specific needs, was presented. Subsequent to the discussion of the three theories, the theories that would fit the purpose of this current study, and provide explicit guidance to the findings of the study, were discussed. A discussion of the conceptual framework for this current study, as well as how it would be applied, followed. The chapter was concluded with a brief introduction to the following chapter. Chapter 3, comprises a discussion and a description of the methodological approach that was employed, when the study was conducted.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1. Introduction

In this chapter, the researcher elaborates on the research design and methodology as introduced and outlined in Chapter 1. The transformative paradigm through critical theory, which was considered appropriate and applied in this study, is discussed. The veracity of the multi-method, as the research approach, is outlined, providing a detailed description, through the three phases, reserved for this current study.

This current research was aimed at developing a SL pedagogy for a Bachelor of Nursing programme, to facilitate social accountability in undergraduate student nurses, on completion of the Bachelor of Nursing programme, at a university in the Western Cape. This SL pedagogy will reveal the essence of the existing learning and teaching practices in the undergraduate nursing curriculum, as well as the experiences of the participants, regarding CE and SL practices. This concept exists in the practice of a human service profession (nursing), and could be placed in the field of professional research (De Vos, Strydom, Fouché, & Delport, 2011, p. 44; Creswell, 2014, p. 185). According to De Vos et al. (2011, p. 46), professional research can be described as scientific inquiry about a professional problem, such as concerns about nurturing social accountability in undergraduate student nurses, which provides an answer, and contributes to the body of knowledge in, for example, Nursing. The conviction for this current study was the development of scientific knowledge, within a professional milieu, to produce socially accountable graduates, on completion of the undergraduate nursing programme. Therefore, the scientific process applied in this current study was built on the epistemology (philosophy of knowing) of inquiry around the current learning and teaching practices in the nursing curriculum, as well as the experiences of nurse educators involved in the programme for undergraduate student nurses.

The overall approach in this current study was qualitative, using multi-methodologies. In this qualitative inquiry, the researcher firstly explores and describes the undergraduate curriculum, by performing a curriculum mapping exercise, to grade and demarcate a module. Secondly, the learning and teaching experiences of educators are described and explored, to facilitate the

elements required for the development of the SL pedagogy, in an undergraduate nursing programme at a higher education institution in the Western Cape. This study was conducted as the main instrument for data collection, analyses and the interpretation of the data, during the qualitative research inquiry. Any personal bias, which could have repressed the research participants from sharing their experiences about the phenomenon under investigation, was avoided. A discussion of the philosophical perspective, as well as a description of the paradigm that situates the study in the qualitative tradition, follows hereafter.

3.2. Philosophical perspective and paradigm

Conducting research within a specific paradigm, relates directly to the way in which the research is viewed, as well as prescribed to a particular characteristic, within which the research will unfold. Du Preez and Roux (2008) aver that, by adhering to these features, the rigor of the research will improve significantly. The selection of a particular paradigm necessitates an understanding of ontological and related epistemological orientations, which are captured in the contemporary and dominant classical research approaches and traditions (Creswell & Creswell, 2018). Guba and Lincoln (1994) suggest that a paradigm defines how individuals view the world, as well as the nature, and the possibilities for its holders, in relation to reality.

A transformative approach, known as Critical Theory (CT), was considered a suitable paradigm for this current research. Multi-method research, linking qualitative, quantitative, as well as statistical tools, was considered relevant, to inform the methodological framework for this current study. CT has an inherent reformative fervour, as it goes beyond the mere recording of observations, and strives to culminate in uplifting reform, for a better world (Creswell & Creswell, 2018).

Some research inquiries have been conducted within an ideological framework, which draws attention to certain social problems, or to the needs of certain groups, to effect change (Polit & Beck, 2004, p. 261). CT is, typically, action orientated, and known for critiquing society, as well as its current practices, with new envisioned possibilities (Polit & Beck, 2013). In this current study, the debate and critique of current practices, regarding the pedagogical practices in an undergraduate nursing curriculum, are pursued. Supporters of CT, embrace values that capture critical theorists, who reject objectivity, and foster subjectivity, while being orientated

towards transformation processes, through enlightening self-knowledge and socio-political action (Creswell & Creswell, 2018). In this current study, the researcher embraces, and acknowledges the fact that education is a tool of power, which has the potential to transform communities, and ensure social justice, while providing students with rich authentic learning and teaching opportunities, towards becoming socially responsive graduates (Creswell & Creswell, 2018).

It is acknowledged that CT fits the purpose of this current study, as it seeks human emancipation, to liberate human beings from the circumstances that enslave them (Ashgar, 2013). Additionally, this paradigm of choice advocates societal balance and democracy. It is centred on issues of power relations in society, education, and other social institutions that contribute to a social system. In this current study, the pedagogy is regarded as the instrument that could redress past social injustices. In addition, it is anticipated that the developed pedagogy would create and instil values of social responsiveness in graduates.

3.3. Multi-method research

A multi-method, qualitative research method was selected. Multi-method research involves some methodological pluralism, referred to as *eclecticism*, which basically means, *to use more than one method* to collect data, or conduct research. Multi-method research accommodates the use of different methodologies, linking qualitative, quantitative and statistical tools (Collier & Elman, 2008).

Scholars promoting this type of research, form part of a diverse community that embraces eclecticism, and thereby gives impetus to a broad range of research methods, which if engaged together, constitute qualitative research. *Eclecticism* results in the increasingly sophisticated use of multiple, complementary methods in composite research designs, based on nesting, or the iterated use of alternative qualitative and quantitative analytic tools and strategies (Collier & Elman, 2008). Scholars refer to this diversity of analytic tools, as appropriate to designate this area of methodology as involving "qualitative and multi-method research" (Collier & Elman, 2008, p. 780).

Multi-method research is common, and was institutionalised in the political sciences. One of its main premises is based on thick descriptions. It is regarded as especially important to

identify the key differentiating characteristics of qualitative research. Qualitative researchers routinely rely on rich, dense information about specific cases (Collier & Elman, 2008). Collier and Elman (2008, 781-782) identify three common methods of multi-methods, namely:

- Multi-method: Diverse approaches within conventional qualitative methods;
- Multi-method: Linking qualitative, quantitative and statistical tools; and
- Multi-method: Conventional qualitative methods vis-à-vis interpretivism and constructivism.

Some of the key traditions of these multi-method approaches could be understood as encompassing the following three different meanings: the heterogeneity of qualitative methods; the interconnections between qualitative and quantitative research procedures; and the relationship with interpretative and constructivist methods. Distinctively they are all anchored in the thick analysis of cases that is distinctively associated with qualitative work (Collier & Elman, 2008).

Addressing Objective 1 (Figure 3.1), a document analysis was conducted, using module guides to formulate the curriculum map of the undergraduate nursing curriculum. It permitted the broad context of the undergraduate nursing curriculum, and in Objective 2, the Community Engagement (CE) typology, currently imbedded in an undergraduate Bachelor of Nursing curriculum, was formulated, which included the management of the SL elements. This navigated the capturing of the specific context of the undergraduate nursing curriculum, in relation to the problem identified in this current study, through curriculum mapping. The community engagement grading rubric (CEGR), therefore, was utilised, to address the specific context of the study. This served to determine the SL potential of each module, as it translates from the typology of CE of the current undergraduate nursing curriculum.

To achieve the first two objectives of this current study, a systemic subjective process was used that built up to Objective 3. Following the initial data collection method, the researcher captured the essence of the two previous objectives. This allowed data to be portrayed in the context of Objective 1 and 2, limiting the manipulation of data to control the context of the research, to, instead, denote the context in its totality (Brink, Van der Walt, & Van Rensburg, 2012).

Objective 4 involved the conducting of semi-structured, individual interviews. The data accrued, provided a detailed view of the learning and teaching practices, making describing, explaining, and analysing possible, within the context of the research. Lastly, achieving Objective 5 required an integration of the findings of the first four objectives as a whole, and reaching consensus, to enable the compilation of the SL pedagogy.

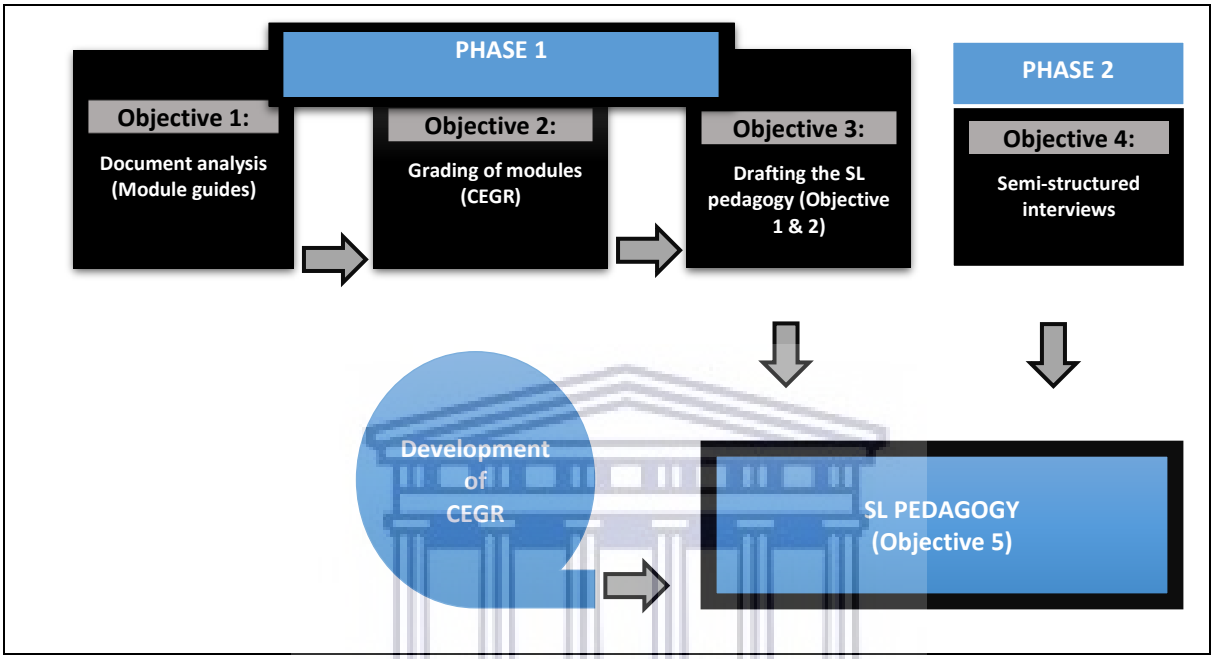

Figure 3.1: Multi-methodology of study

Multi-method research, therefore, allows more than one research methodology and data collection technique, representing methodological pluralism (Collier & Elman, 2008). According to Morse (2003, p. 196), "Multiple methods are used in a research curriculum when a series of projects are interrelated within a broad topic and designed to solve an overall research problem". Distinguishing multi-methods from mixed methods, the significance and superiority of multi-methods for this current research was identified. The undergraduate Bachelor of Nursing curriculum was explored to define the status of the phenomenon under investigation, namely, service-learning pedagogy. Qualitative research, as a scholarly approach, describes life experiences from the perspective of the persons involved (Courtney & McCutcheon, 2010).

The insights gained would not derive from measuring concepts, or establishing causality, but through the comprehension of the phenomenon, as documented within the curriculum guides, and through the interpretation of the understanding and experiences of the nurse educators of

the undergraduate nursing curriculum. This fostered an understanding of service-learning as pedagogy in an undergraduate Bachelor of Nursing curriculum, because it guides and advances the emerging learning and teaching practices in nursing education. The undergraduate nursing curriculum was reviewed and explored via the qualitative research method, being a flexible research methodology, as it uses rigorous and systematic processes that require conceptualisation, inductive reasoning, and elegant expression (Burns & Grove, 2013; Gray, Grove, & Sutherland, 2017).

Table 3.1: Application of Kotter's framework

Dimensions of Kotter	Research Method	Sub-sections of Framework		Objectives
Creating a climate for change	Document analysis	Creating a climate for change	Creating a sense of urgency	To develop a curriculum map at the micro level of the undergraduate Bachelor of Nursing curriculum.
			Forming a powerful guiding coalition	To formulate the CE typology currently imbedded in the undergraduate Bachelor of Nursing curriculum.
	Curriculum mapping		Developing a vision	To develop the draft SL pedagogy (as reflected in the aspects that inform the learning and teaching practices, the typology of CE and the indicators for managing the quality of the SL elements based on findings of Objective 1 and Objective 2).
Engaging and enabling the organisation	Qualitative interviews	Engaging and enabling the whole organisation	Communicating the vision	To explore, analyse and interpret the experiences of the nurse educators regarding their learning and teaching practices.
	Consensus workshop		Empowering others to act on the vision, as well as planning and creating short term wins	To finalise SL pedagogy within the undergraduate Bachelor of Nursing curriculum based on findings of Objective 1 and Objective 2. Presentation of a discussion of the SL pedagogy and its elements.

This study consisted of two phases, and Table 3.1 provides a synopsis of the application of the above conceptual framework, as well as how it communicates with the significance, purpose, and objectives of this current study.

3.4. Research design

A research design is a plan indicating how the research study will be conducted (Babbie, Mouton, Voster, & Prozesky, 2006). It includes the process that was followed in operationalising the study, and therefore, could be described as the logical outflow of the research problem, which directs the choice of the design. A research design is a set of guidelines and instructions that need to be adhered to, when addressing the research problem (Babbie, Mouton, Voster, & Prozesky, 2006).

The purpose for selecting a specific research design was to ensure that the study was conducted with rigor, adding to the trustworthiness of the research, in order to achieve the stated research outcomes of exploratory, descriptive designs (Gray et al., 2017), put differently, to "explore and describe the phenomena in its natural setting with the intention of generating new knowledge about under-researched topics" (Burns & Grove 2009, p. 22). This study design was classified as exploratory, descriptive, and contextual, because developing an SL pedagogy in an undergraduate nursing curriculum, is an under-researched area.

3.4.1. Exploratory research

Exploratory research arises from the lack of information about a phenomenon, or when becoming familiar with a state of affairs is required, in order to articulate a problem (Blaikie, 2000). It is aimed at exploring the natural landscape of the phenomenon and the manner in which it is manifested through its underlying processes (Polit & Beck, 2013). In this current study, an exploratory design was used to gain insight and understanding of the phenomenon under scrutiny (Blaikie, 2000; De Vos et al., 2011).

3.4.2. Descriptive research

The purpose of descriptive research is to provide a total and accurate description of a particular situation, social setting, or relationship. An accurate description of the phenomenon can be achieved by asking questions like 'how' and 'why' (De Vos et al., 2011). Descriptive research provides a depiction of a situation as it occurs naturally (Burns & Grove, 2003; Gray et al., 2017), and was considered appropriate for this current study, because a description and interpretation could be ascribed to the current state of the learning and teaching activities in the nursing curriculum.

3.4.3. Contextual research

Qualitative research is context bound, which implies that it cannot be transferred to another context. A contextual design refers to the critical understanding of the reality of the participants' experiences to a specific context (Creswell & Plano Clark, 2017). Therefore, universal claims cannot be made about the research problem in another context. The specific context of this current study refers to the institutional environment and pedagogical practices of the Bachelor of Nursing programme, and includes the physical, socio-political, and economic influences on the context of the study. To understand the specific context of this current study, the guiding principles for curriculum development was secured, as guided by the conceptual framework of the study.

3.5. Research approach

The qualitative method was utilised, and the discussion for each phase of the study unfolded as follows: objective, method, population, sampling, inclusion and exclusion criteria, instrument development, and data collection. Due to the nature of the Phase 1, each objective is discussed individually, even though the findings of these three objectives emanated from the same source of data. In Phase 1, a curriculum map was created. Subsequently, the findings of the curriculum map were used to formulate the CE typology, currently imbedded in an Undergraduate Bachelor of Nursing curriculum.

3.5.1. PHASE 1: Creating a climate for change – Sub-section 1: Creating a sense of urgency

Objective 1

To develop a curriculum map at the micro level of the undergraduate Bachelor of Nursing curriculum.

3.5.1.1. Method

- ***Document analysis***

  Document analysis studies record human communications, for example, books, policies, and journals (Bowen, 2009, p. 2), which, in its nature, are typical to ethnographic fieldwork (Silverman, 2013). It is a form of

qualitative research, in which documents are examined and interpreted, to give voice and meaning to the topic under review. Documents are social facts that elicit meaning and interpretation. In this current study, the analysis could contribute to the understanding SL pedagogy, and provide rich authentic descriptions, relevant to the research problem (Bowen, 2009).

Document analysis also allows for the triangulation of data, which results in the combination of methodologies, in the study of the same phenomenon (Denzin, 2012). In this current study, the document analysis provided an overview of the existing learning and teaching practices, which generated baseline information for Phase 1. This information was used to extract data that would be evaluated against the rubric, developed in this current study, to classify and grade modules according the CHE typology of community engagement and the SL elements.

- ***Curriculum mapping***

A curriculum map of the undergraduate Bachelor of Nursing curriculum was created, to capture the main findings of the document analysis. Curriculum mapping is a procedure followed to document and visualise student learning, at programme, or curriculum level (Archambault & Masunaga, 2015). Curriculum mapping assisted with the selection, appraising (making sense of), and synthesising of the data, contained in the module guides. In addition, it has been used to identify analytical deficiencies in a curriculum (Freeman, Hancock, Simpson, & Sykes, 2008), as well as test how, and where, learning and teaching technologies are incorporated into a course curriculum, as well as its relevance to the modules (Yorke & Knight, 2006).

Curriculum mapping is also useful to monitor descriptive information of the modules, to determine whether it creates a praxis, through the discourse, reflection, and practice (Biggs & Tang, 2011). In this current study, the main purpose of the curriculum mapping was to understand the

modules, as well as ascertain the potential of each module, regarding the SL criteria and indicators.

3.5.1.2. Population: Nursing modules guides

All undergraduate major nursing module guides (n=23), across all year levels of the B Nursing curriculum, were included.

3.5.1.3. Sample and sample size: Undergraduate nursing module guides

A purposeful, non-random method of sampling was used during Phase 1 to select specific information-rich sources for this current study. Total population sampling was employed, which implies that all the nursing module guides for the undergraduate Bachelor of Nursing curriculum, were included in the study sample.

The inclusion criterion for this objective was that all major nursing modules would be included. A major module is a compulsory one that all students have to pass, before being promoted to the next year level of the curriculum. These modules are mainstreamed in the curriculum towards obtaining the qualification. An exclusion criterion was set for the population, as all the modules of the curriculum were not included. All non-nursing modules were excluded, as these modules are not offered in the school, and are regarded as service modules.

Table 3.2: Bachelor of Nursing curriculum and modules

Bachelor of Nursing level	Modules	Total
B. Nursing Level Foundation	Fundamentals of nursing x 2 Lab clinical module x 2	4
B. Nursing Level Foundation 2	Fundamentals of nursing x 2 Lab clinical module x 1	3
B. Nursing Level 1	Fundamentals of nursing x 2	2
B. Nursing Level 2	General nursing science x 2 Introduction to mental health x 1	3
B. Nursing Level 3	Midwifery x 2 Community health x 1 Unit management x 1 Primary Health Care x 1 Child health x 1	6
B. Nursing Level 4	Psychiatry x 2 Gender-based violence x 1	5

	Professional practice x 1 Research methods x 1	
Total modules of the Bachelor of Nursing curriculum		23

The sample size was 23 of the modules (Table 3.2) of the Bachelor of Nursing curriculum. The size of the population dictates the choice of sampling, which was deemed appropriate and relevant to this current study. The aim of this phase was to learn more about the learning and teaching aspects, which form the central point of this current study (Table 3.1).

3.5.1.4. Inclusion and exclusion criteria: Nursing modules

The *inclusion criteria* refer to all the major undergraduate nursing modules, with a clinical component of the Bachelor of Nursing curriculum, which were incorporated to achieve the objectives of this current study. The *exclusion criteria* refer to the preclusion of non-nursing modules, offered outside the school of the Bachelor of Nursing curriculum.

3.5.1.5. Data collection tool

The context of this current study required the use of unique terminology, as expressed in the course guides. It was regarded as a strategic tool in this phase, and guided the extraction of data, as evident in the module guides (Appendix F) in the undergraduate curriculum. The findings were generated through content analysis and presented in a data extraction table in Microsoft Excel, which served as an instrument to capture information from the module guides, using attributes identified during the document analysis. Codes, categories, and themes were extracted out of the data that presented through the modules guides, which were defined later as the educational attributes to understand the situation of the curriculum, in terms of pedagogical and curricular practices.

3.5.1.6. Data collection

All module guides listed in Table 3.2 were requested from the year level coordinators of the undergraduate Bachelor of Nursing curriculum.

3.5.1.7. Data analysis

Document analysis requires a qualitative data analysis method, such as content analysis. Erlingsson and Brysiewicz (2017) described content analysis as the process, in which raw data are transformed from verbatim transcribed interviews, to form meaning units, and subsequently, codes, categories, and themes. Therefore, it is a process of reducing abstract data into manageable descriptive sections, from literal content to latent meanings. The following six steps, illustrated in Figure 3.2, directed the content analysis performed for this objective.

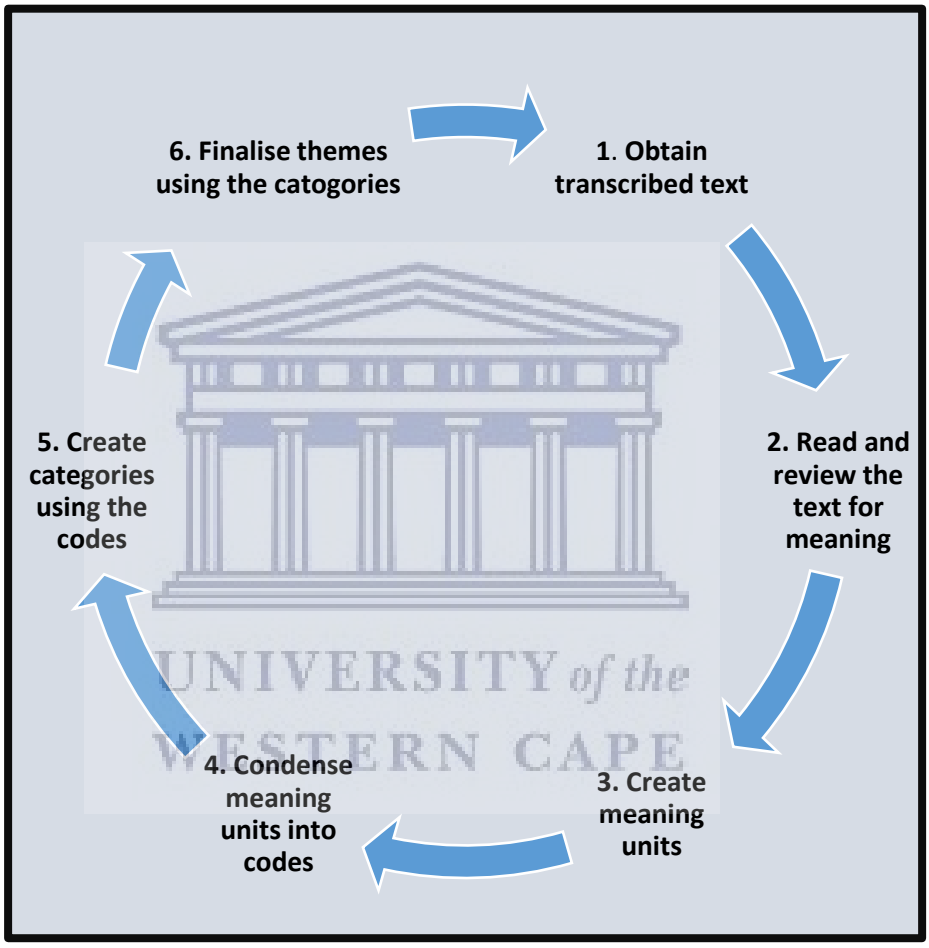

Figure 3.2: Steps to perform content analysis

These steps allowed a systematic and iterative process, through sorting, organising, and interpreting the data collected. It allowed the identification of underlying dimensions and patterns of relationships, which were established during the analysis, and demonstrated in a narrative form, in the chapter that addresses the findings and discussion (Bowen, 2009; Peters & Malaviya, 1998; Polit, Beck, & Hungler, 2001). The content analysis was facilitated by multiple strategies, including manual, as well as computer-assisted strategies, namely Atlas

ti version 8 (Friese, 2019) and CMAP version 6. 01. 01 (Novak & Cañas, 2008). The content analysis resulted in concept maps, matrix tables, and figures, to illustrate the synthesis of data captured on the extraction table (see Chapter 5: Figures).

3.5.1.8. Rigor/Trustworthiness

Rigor applies to the content analysis and the data extraction table. The content analysis provides the structure to conduct the analysis, while the theme was also verified by an independent, nurse educator, with a doctoral qualification in nursing, who was not related to this current study. The data extraction table was planned, using the findings of the first review, which was executed in Atlas ti. This review identified common denominators that existed in each module, per year level, and per curriculum, while the extraction table would allow the modules to be reviewed a second time, as well as the synchronisation of the findings, via synthesis and interpretation of the two reviews, which entailed data triangulation via synthesis and interpretation, while evaluating the same data (Brink et al., 2012).

3.5.2. PHASE 1: Creating a climate for change – Sub-section 2: Forming a powerful guiding coalition

Objective 2

To formulate the CE typology, currently imbedded in an undergraduate Bachelor of Nursing curriculum.

3.5.2.1. Method

A self-assessment exercise was completed using the CEGR on all modules included in Objective 1. The purpose was to grade and classify the CE typology and to determine the management of the SL elements in the curriculum. The CEGR was used as a diagnostic and benchmarking tool, to identify the management of the SL elements, evident in the module guides reviewed.

3.5.2.2. Population: Nursing modules guides

All 23 undergraduate major nursing module guides, across all year levels of the Bachelor of Nursing curriculum, were included.

3.5.2.3. Sample and sample size: Undergraduate Nursing Module Guides

A purposeful, non-random method of sampling was used, as described in Objective 1. The sample size, therefore, resulted in 23 of the modules (Table 3.2) of the Bachelor of Nursing curriculum.

3.5.2.4. Inclusion and exclusion criteria: Nursing modules

The same inclusion and exclusion criteria, used in Objective 2, were applied.

3.5.2.5. Instrument development

The CEGR was developed to determine the CE Typology, as well as the managing of SL elements. The development of the rubric is discussed in further detail, in Chapter 4. A framework, proposed by Walsh and Betz (2001) for the development of the rubric, was adopted to facilitate the process of development. This framework consisted of three (3) phases, namely, the development of the measure instrument, the assessment and testing of the rubric, as well as the assessment of the psychometrics and methodological quality. These phases are discussed, in full detail, in Chapter 4.

3.5.2.6. Data collection

Module guides of the Bachelor of Nursing curriculum were utilised, according to the inclusion and exclusion criteria of Objective 1 (Table 3.2).

3.5.2.7. Data analysis

The CEGR rubric comprised a performance descriptor (PD), which was developed as part of the rubric. Subsequently, this PD was used to score each criterion, as well as calculate the total of each module. Specific scoring categories and scales were created to understand the typology and the SL potential of each module.

3.5.2.8. Rigor/Trustworthiness regarding the CEGR

The rigor of the rubric was enhanced by addressing issues that related to its validity and reliability. *Face validity* was achieved through discussions to reach consensus with various key experts, who included the supervisor of the study, a learning and teaching specialist, and the nurse educators of the School of Nursing.

Subsequently, the grading rubric was proofed for *reliability*, by exposing five (5) nurse educators in the school to a test-retest procedure, using the module guide of the document analysis. This rigor was critical for the purpose of this current study, as it assisted in the determination of cut-off points, for the use of various inferential statistics.

The following measures of reliability were performed namely, internal reliability, inter-rater reliability, and intra-rater reliability. The Cronbach's Alpha coefficient was determined to measure the *internal reliability* among scale items for the rubric, because of its effectiveness in testing a highly "structured quantitative data-collection instrument" (Brink et al., 2008, p. 164).

The *inter-rater reliability,* on occasion referred to as *interclass correlation*, was used to determine the correlation between the scoring of the five nurse educators, who participated in this objective of the study (Polit & Beck, 2012). Various procedures could be applied to determine *inter-rater reliability*, which is categorised on the principles of consensus, consistency, stability, and other measurement approaches (Polit & Hungler, 1999; Polit & Beck, 2012). In this current study the test-retest procedure was used to determine the *inter-rater reliability*, which refers to the degree of agreement among the subjects (Weidle et al., 2019; Noble, Scheinost, & Constable, 2019).

The *intra-rater reliability,* or *intra-class correlation,* refers to the degree of agreement among the repeated administration of a single subject, on two or more separate occasions (Keller, Awwad, Morrison, & Chaudhury, 2019). In this current study the administration occurred one week apart. A full description of the findings is reported in Chapter 4.

3.5.3. PHASE 1: Creating a climate for change – Sub-section 3: Developing a vision

Objective 3

To develop the draft SL pedagogy as reflected in the aspects that inform the learning and teaching practices, the typology of CE, and the indicators to manage the quality of the SL elements based on the findings of Objective 1 and 2.

3.5.3.1. Drafting the SL pedagogy

Deductive and inductive logic was used to create a draft of the pedagogy. Deductive logic is a form of reasoning that moves from general, to more specific Stephens, Dunn, Hayes, & Kalish, 2020). The conceptual framework guided the draft of the SL pedagogy to achieve the desired outcome, as it was imbedded in Objective 1 and 2. In contrast, inductive logic moves from specific observations, to broader generalisations and theories (Stephens et al., 2020).

For Objective 1, inductive reasoning was applied to draft the pedagogy. Initially, a document analysis was performed, based on the module guides of the Bachelor of Nursing curriculum. The findings were expressed in the form of an extraction table to capture the findings. Thereafter, the findings were used to generate the typology of community engagement, as well as the SL potential, as displayed by the management of the SL elements in the modules.

3.5.4. PHASE 2: Engaging and enabling the whole organisation– Sub-section 1: Communicating the vision

Objective 4

To explore, analyse and interpret the experiences of the nurse educators, regarding their learning and teaching practices;

3.5.4.1. Population

The target population were all nurse educators of the undergraduate Bachelor of Nursing curriculum employed in the SoN, during the data collection phase.

3.5.4.2. Sampling

Nurse educators were recruited through purposive sampling. Purposive sampling ensured the identification and selection of information-rich participants, who would add meaning to the sample (Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood, 2015), in terms of representation across all 5-year levels. In this current study, the intention was to include participants across the year levels of the B Nursing programme.

Interviews were conducted with the lowest level nurse educators of the undergraduate Bachelor of Nursing curriculum, and moved up to the highest-level nurse educators, until data saturation was achieved. This cycle was continued until all year levels had been represented (Table 3.3).

Table 3.3: Bachelor of Nursing modules per nurse educators

Bachelor of Nursing level	Modules	Total of Nurse educators
B. Nursing Level Foundation	Fundamentals of nursing x 2 Lab clinical module x 2	4
B. Nursing Level Foundation 2	Fundamentals of nursing x 2 Lab clinical module x 1	3
B. Nursing Level 1	Fundamentals of nursing x 2	2
B. Nursing Level 2	General nursing science x 2 Introduction to mental health x 1	3
B. Nursing Level 3	Midwifery x 2 Community health x 1 Unit management x 1 Primary Health Care x 1 Child health x 1	6
B. Nursing Level 4	Psychiatry x 2 Gender-based violence x 1 Professional practice x 1 Research methods x 1	5
Total modules per Bachelor of Nursing curriculum		23
	Total of M	23

* Some educators taught more than one module, influencing the number of educators involved in the curriculum

3.5.4.3. Inclusion and exclusion criteria

The undergraduate Bachelor of Nursing curriculum is spread across 5 year levels, which are inclusive of a foundation, or the extended curriculum (Table 3.4). In total, 17 nurse educators were responsible for the learning and teaching in the curriculum. The sample of this current study was represented by 9 of the 17 educators. Interviews were scheduled at the convenience of the participants, and no remuneration, or incentives were provided for participation. The inclusion criterion was that all nurse educators were included in this phase of the study. No exclusion criteria were applied.

Table 3.4: Proposed distribution of participants

Level of curriculum	Nurse educators
Foundation	2

First year	1
Second year	2
Third year	2
Fourth year	2

3.5.4.4. Data collection instrument

An interview schedule was developed. The questions that were included ranged from background information about the educators, which modules they were responsible for, their teaching philosophy, which learning and teaching practices educators used to engage students, and which strategies could be implemented to enhance and improve practices (Appendix D: Interview Schedule). During the interviews, notes were taken, to assist with the phrasing of appropriate, probing questions. This ensured that an in-depth understanding was gained, which would facilitate the analysis and interpretation of the findings.

3.5.4.5. Data collection

Semi-structured interviews were conducted to explore, analyse, and interpret the experiences of the nurse educators, regarding their learning and teaching practices. The nurse educators were informed about the study, via email, while the researcher also asked individuals, personally, whether they would be interested in participation in the study. Options of dates and times were sent to the educators, to allow them to choose mutually convenient times. The interviews were scheduled to be conducted during the educators' working hours, and were conducted in their offices, for the sake of privacy. The researcher obtained permission from the participants to audio-tape record the interviews, and also made copious notes during the interviews. The interviews lasted between 45 and 90 minutes.

3.5.4.6. Data analysis: Qualitative data analysis

Flick (2014, p. 5) describes the process of data analysis as "the classification and interpretation of linguistic (or visual) material to make statements about implicit and explicit dimensions and structures of meaning-making in the material and what is represented in it". It requires an active inquiry process, during which conclusions emerge, which allows the researcher to become familiar with the data,

or the intellectual work. An inductive approach was employed; consequently, the data was analysed first, before its relationship to existing knowledge was considered. According to Merriam and Tisdill (2015, p. 17), an "important characteristic of qualitative research is that the process is inductive, that is, researchers gather data to build concepts, hypotheses, or theories rather than deductively testing hypotheses as in positivist research. Qualitative researchers build toward theory from observations and intuitive understandings gleaned from being in the field. Bits and pieces of information from interviews, observations, or documents are combined and ordered into larger themes as the researcher works from the particular to the general". With an inductive approach, or conventional analysis, themes and categories are included, inductively, from the transcripts and/or field notes (raw data). The following steps were used to facilitate the analysis plan (Merriam & Tisdill, 2015).

- ***Plan for the recorded data:*** The qualitative tradition that was adopted for this objective of the study, facilitated a flexible data analysis plan. The researcher selected thematic analysis (TA) that permits a non-specific data analysis plan, different from a phenomenological, or grounded theory study, which requires adherence the specific traditions, as dictated by the research design. In this current study, all data were collected for a specific year level and analysed, before moving on to the next year level.

- ***Data collection, preliminary analysis, managing and organising the data:*** The recruitment of the participants was done personally, by explaining the nature of the study, as well as the requirements necessary to participate. Agreeing to participate required that the participants sign a consent form, confirming their informed consent, which would be on record. These documents were stored away safely, to ensure the anonymity of the participants. During the interviews, notes were taken that could guide the probing for detail not covered during the interview.

  All participants agreed to this, by signing the required consent forms. The interviews were conducted in English, the primary language used by the participants to fulfil their academic responsibilities. The interviews were conducted over a twelve-week (12) period, between August 2018 to

December 2018. This allowed time for the researcher to become immersed in the content of the interviews.

Immediately after the interview, the recorded data were uploaded onto a computer, in a security assisted application, to ensure and maintain the sound ethical practices that relate to the confidentiality of the participants. Once the data were secured, it was reviewed, to ensure and maintain control over the data. Subsequently, the data were transcribed verbatim, and reviewed, against the transcribed document, to ensure that data were captured precisely. The data were not manipulated, when grammatical and spelling errors, which may have resulted during transcribing, were corrected. Following this procedure, the transcribed documents were uploaded onto the computer software programme for the managing of the qualitative data. The "process of making sense out of the data involved consolidating, reducing and interpreting what people said and what the researcher observed and read – it is the process of making meaning" (Merriam & Tisdill, 2015, p. 202). Subsequently, the transcribed documents were grouped into year levels, to increase the possibilities with the data analysis. This advanced the contextual design of the conducted research study.

- ***Reading and writing memos:*** During the interviews, notes were made, which allowed the researcher to keep a record of what was being said. No interruptions were allowed while the interviewee was conversing. The memos assisted the researcher to become fully immersed in the data, by reading and listening to the data recording. This facilitated the identification of segments in the data set that were responsive to the research questions (Merriam & Tisdill, 2015, p. 203)

- ***Generating coding, categories, themes and patterns:*** The researcher became fully immersed in the nurse educators' experiences that were obtained during the interviews. The process that followed involved initial noting of responses, reading through the transcripts, and creating codes of the information that were supported by the recorded voices of the participants. The aim of this process is to break the data down into bits of information and thereafter, assigning "these bits to categories or classes,

which bring these bits together again, if in a novel way" (Merriam & Tisdill, 2015, p. 203). During this process, the researcher begins to discriminate more clearly between the criteria for the allocation of data to one category or another.

Descriptive, linguistic, and conceptual codes were created, using pieces of text in the transcript (Appendix E). *Descriptive* coding was used mostly to provide descriptions of the experiences of the participants. Many *descriptive* codes could be characterised as *in vivo* coding (Howitt, 2019), because they captured the exact words of the participants, during the interviews. *Linguistic* codes, which served to address the specific jargon nurse educators used in the context of their academic requirements, were also created (Wolff, 2003), although minimal. *Conceptual* codes were used where the participants often commented in the form of a question. This allowed the analysis and questioning, in terms of reflecting on what was not said, during the interviews (Linneberg & Korsgaard, 2019).

The first round of coding, of a descriptive nature, was followed by a review of the transcripts, for a refreshed understanding of the data set. This allowed the conceptualisation of the main ideas that would later form a category. Initially, a total of 595 codes were created, followed by refinement that reduced them to 515. These were obtained from the nine interviews that were conducted, as demonstrated in Chapter 6.

Lastly, by developing emergent themes, the categories that were created through the conceptualisation of the codes, were studied for connections, patterns, and interrelationships between the comments made and the transcripts. Therefore, the volume of the data could be reduced, while still maintaining the script of the nurse educators' experiences. Ultimately, these themes would reflect and display the associated interpretation that was attached to the data set, as well as provide descriptions of the experiences of the nurse educators, who participated in the study.

The Atlas ti version 8 permitted the grouping of codes, which formed the categories, and later the smart groups that, in turn, formed the themes of the data set. Merriam and Tisdill (2015, p. 204) refers to this as

"comprehensive classes, each of which could be further subdivided". An independent coder assisted to review the codes created, which subsequently, were grouped and categorised (Polit & Beck, 2012). This maintained the objectivity of the analysis. The themes illustrated the collaboration between the participants' descriptions and the interpretative meanings attached to the descriptions, as expressed in the transcripts.

- ***Testing the emergent understandings:*** During this step of the analysis, the data was reviewed, carefully, in search of negative instances of the patterns. Connections were made within the emergent themes, between codes and categories, with the intention of identifying outliers (Miles & Huberman, 1994; Merriam & Tisdill, 2015). Minimal negative instances were evident and were ruled out in the data set, by providing a rationale for each outlier.
- ***Searching for alternative explanations:*** The nature of this qualitative analysis allowed a search for alternative explanations to the findings from the literature. The purpose of this activity was to contribute towards the achievement of the best possible outcome for this current study.
- ***Representing and visualising the findings:*** A summary of the main findings provide the themes and categories that were developed during the analysis. Further reflection of the data are provided and facilitated by a discussion, which was inductively generated through the data analysis.

To facilitate and conclude the above-mentioned process, a computer software programme for data management, Atlas Ti version 8 software package, was used to assist with the storing and sorting, during the analysis of the data.

3.5.4.7. Rigor/Trustworthiness

The rigor of a study refers to the degree of confidence in the truthfulness, or credibility of the study findings. Ensuring rigor in a qualitative study requires that it be evaluated against a set of criteria, to enhance trustworthiness (Johnson, Adkins, & Chauvin, 2020). Trustworthiness was achieved through "credibility, transferability, confirmability and dependability, as well as authenticity, which was added to the framework at a later stage (Polit & Beck, 2012, p. 484).

Credibility: This aspect deals with the authenticity of the data, by reflecting accurately on the perceptions and experiences of participants (Brink et al., 2012). In this current study, the measures that were taken to ensure authenticity included prolonged engagement, peer debriefing, member checks, and full descriptions (Thomas, 2006; Brink et al., 2012). The interviews were transcribed verbatim, and presented for member checking, while an independent coder validated the findings. Prolonged engagement refers to spending extended time with the respondents in their native culture and everyday world, in order to gain a better understanding, within a certain context (Given, 2008). Peer reviews between the researcher and the supervisor were scheduled, and the interviews were checked by the participants, in order to achieve persistent observation, triangulation, and peer debriefing (reviewing the pedagogy).

Lastly, meaning was attached to the data by exploring the bigger picture of the learning and teaching practices, and converting the raw empirical data into thick descriptions. Thick descriptions give "a rich, thorough and vivid description" of the research context, such as learning and teaching practices in nursing, which aids in the interpretation of the information from the foundation of the theoretical framework of a study (Polit & Beck., 2012, p. 595).

Transferability: Transferability is the equivalent of external validity, and is the extent to which findings from the data could be transferred to other settings, or groups (Polit & Beck, 2012). The findings of this current research is limited to the context and environmental factors of the institution under scrutiny

***Confirmability*:** An audit trail assures quality in qualitative research (Koch, 2006; Jooste, 2017). This is also in line with reflexive methodology. This exercise would indicate that the research was conducted with precision and care. Lincoln and Guba (1985, affirmed by Polit & Beck, 2012) describe six steps to accomplish this audit trail of the research study, namely: raw data; data reduction and analysis notes; data reconstruction and synthesis products; process notes; material related to intentions and dispositions; and preliminary development of information. In this current study, the audit trail is presented as a reflexive report on the implementation of the research methodology. This reflexive report on the audit inquiry is discussed as a self-evaluation in Chapter 8.

***Dependability*:** The dependability of the findings was ensured by keeping an audit trail of the process and procedures (Brink et al., 2012), triangulation, and independent coding. An independent coder was employed to achieve *inter-rater reliability* (Creswell & Creswell, 2018). Triangulation was confirmed through the expert feedback of the independent coder (Creswell & Creswell, 2018). This process is regarded as a reflexive exercise between two people, analysing the same data (researcher and independent coder), which revealed that consistency could be achieved between two people, who were using the same set of data. The measures undertaken in this current study, ensured congruence between the findings, the conclusions, as well as the recommendations (Brink et al., 2012).

3.5.5. PHASE 2: Engaging and enabling the whole organisation – Sub-section 2: Empowering others to act on the vision, as well as planning and creating short term wins

Objective 5

To finalise the SL pedagogy within an undergraduate Bachelor of Nursing curriculum, as reflected in the aspects that inform the learning and teaching practices, the typology of CE, and the indicators to manage the quality of the SL elements, based on findings of Objectives 1 and 2.

3.5.5.1. Validation and consensus

The draft SL pedagogy, developed in Objective 3, reflected aspects that informed the learning and teaching practices, the typology of CE, as well as the indicators to manage the quality of the SL elements, which were updated and refined through the findings of Objective 4, using inductive logic, as explained in Objective 3. Therefore, the main elements of the SL pedagogy were presented to the participants of this Phase 2, sub-section 2, for validation and consensus among the nurse educators. This validation and consensus process was conducted, using the adapted criteria of Chinn and Kramer (2008), namely, clarity, generality, accessibility, and importance of the SL pedagogy.

3.5.5.2. Method

A workshop was arranged to ensure that each participant had an opportunity to respond to exactly the same questions, in the same order. Their opinions were

compared and contrasted with each other, to facilitate the validation of the SL pedagogy, as well as consensus.

3.5.5.3. Population

The population comprised all nine (9) participants, who participated in Phase 2, sub-section 1 of this current study. All the participants were nurse educators, qualified to participate in this segment of the study. Their participation was confirmed by their participation in objective 4 of this current study. The distribution of the nurse educators, across the nursing programme, and across the different year levels of the Bachelor of Nursing, is displayed in Table 3.4.

3.5.5.4. Sample

For this objective, three (3) of the nine (9) participants voluntarily agreed to participate in this segment of this current study.

3.5.5.5. Inclusion and exclusion criteria

The inclusion criterion required participation in Phase 2, sub-section 1. The nurse educators in the SoN, who were not part of this current study, were excluded.

3.5.5.6. Data collection instrument

A workshop was selected as the data collection instrument for this segment of this current study. The aim was for the participants to discuss the draft SL pedagogy, in terms of four main aspects, namely, clarity, generality, accessibility, and importance, according to the adapted criteria of Chinn and Kramer (2008, p. 138).

3.5.5.7. Data collection

A workshop was scheduled with the three (3) participants, who had participated in Phase 2, sub-section 1 of this current study. The researcher presented the key features of the draft SL pedagogy that was developed, for discussion. The workshop lasted approximately 45 to 60 minutes.

3.5.5.8. Data analysis

As in the previous objective of this study, an inductive approach was utilised, in which the data were first analysed before considering its relationship to existing knowledge. According to Merriam & Tisdill (2015, p. 17), “the process is

inductive; that is, researchers gather data to build concepts, hypotheses, or theories rather than deductively testing hypotheses as in positivist research". With an inductive approach, or conventional analysis, themes and categories are included inductively from the transcripts and/or field notes (raw data). Steps proposed by Merriam & Tisdill (2015) were used to facilitate the analysis plan. These steps were previously discussed in this chapter.

The process of this segment facilitated the empowering of others to act on the vision, evidenced the planning, and the outcomes represented the creation of short term wins. Based on the findings of this segment of the study, as well as the contribution thereof towards the validation and consensus of the final SL pedagogy, the nurse educators made recommendations, to facilitate the nurturing of undergraduate student nurses, to develop social accountability, through a responsive curriculum (see Chapter 8).

3.5.5.9. Rigor

When deciding on a method to reach consensus, the rigor of the chosen method needed to be aligned with the general tradition of the research conducted, as well as the objectives and intentions of the research (Humphrey-Murto, Varpio, Gonsalves, & Wood, 2017). The following interventions (Table 3.5) were adhered to ensure trustworthiness.

Table 3.5: **Main interventions undertaken to ensure methodological rigor**

Intervention	Completed
Provide the purpose and objectives of the pedagogy	✓
Describe in detail each step of the process and, if modified, provide explanations.	✓
Describe scientific evidence regarding its selection and preparation	✓
Provide sufficient detail on the process.	✓
Recruit and select participants.	✓
Explain the process and the criteria for terminating.	✓
Describe how validation will be achieved.	✓
Provide a report during each step of the process.	✓

Provide feedback and update the pedagogy as necessary	✓
Describe anonymity and how it was maintained.	✓
Discuss methodological issues.	✓

Conformability: The SL pedagogy developed, was informed by document analysis, semi-structured interviews, and the validation of the pedagogy. This triangulation of methods enhanced the conformability of this current study.

Credibility: The credibility of the research process was enhanced by defining the purpose and objectives of this current study. Clear descriptions of the purpose and objectives of this final segment were provided to ensure that the participants could provide optimal input. They were orientated further, by providing detailed explanations of the process, as well as justifications for the choices made (Table 3.1).

3.6. Ethical considerations

This study used the Declaration of Helsinki as a cornerstone to ensure the ethical soundness of the study (World Medical Association [WMA], 2013). It is widely regarded as the cornerstone document on human research ethics. The proposal was submitted to the Ethics Senate Research Degree's Committee of the University of the Western Cape, for ethical clearance and approval.

Written ***informed consent*** was obtained before participating in the interviews, which is regarded as crucial for ethical research (Burns & Grove, 2003; Thomas & Magilvy, 2011). All prospective participants were provided with an information letter explaining the purpose, the objectives, the basis for inclusion in the study, expectations, ethical considerations, especially the right to withdraw at any stage of the study, contact details of the primary investigator, and the research promoter (Appendix B). Fair treatment was ensured and not exploited, based on the knowledge and understanding of the participants.

Voluntary participation was explained to the participants, as well as that no risks were involved. Additionally, the researcher explained that all the participants had the right of free will to decide whether to participate, or not, and would not be coerced to, against their will.

Confidentiality was assured as only the researcher and the study supervisor had access to the data. The protection of the identities of the participants were facilitated by using fictitious

names, ensuring that no personal information could be connected to any participant in the findings of the study.

Non-maleficence/beneficence was evidenced by conducting the research, using sound, ethical principles, and scientific methods, with no exposure to any physical, or psychological harm, and exploitation (Polit & Beck, 2012. p. 720). Throughout the process of data collection and data analysis the data were treated with sensitivity.

The principle of ***justice*** includes the participant's right to "fair treatment and the right to privacy" (Polit & Beck, 2012, p. 155). In this study the selection of the sample was conducted according to fair inclusion criteria.

3.7. Summary

In this chapter, the researcher introduced the reader to the methodological approach, adhere to, in this current study to, in collaboration with the conceptual framework that was discussed in Chapter 2. The approach was explained, in relation to the research objectives and research design, which included an overview of the main components of the research design (population, sampling methods, inclusion and exclusion criteria, data collection, data analysis, and rigor of the study).

The next chapter will expand on the development of the rubric, used to classify, and grade the typology, as well as determine the SL potential of each module.

CHAPTER FOUR

INSTRUMENT DEVELOPMENT

4.1. Introduction

The focus of this chapter is to provide an overview and a discussion of the activities undertaken to create a sense of urgency among the nurse educators, as advocated in Phase 1–sub-section 1: Creating a climate for change (Kotter, 2007). The assumption was that the empirical evidence related to the current status of CE in the undergraduate nursing programme, would provide the necessary impetus for change among the nurse educators. This entailed the execution of various activities and processes, to develop a draft SL pedagogy for the undergraduate nursing programme. Therefore, the purpose of this current study was to provide this empirical evidence.

However, the researcher had to develop a grading rubric, the Community Engagement Grading Rubric [CEGR], because the existing HEQC instruments in Section C: Managing Quality Component - Managing and Enhancing the quality of a Service Learning Module (HEQC, 2006, pp. 186–187), proved to be insufficient, in terms of differentiating other forms of CE learning and teaching practices from SL. This pedagogical differentiation was crucial for the development and validation of the SL pedagogy. It was primarily absent from the HEQC instrument which were more concerned with the technical aspects of planning the SL activity and it lacked application to SL as a learning and teaching activity. The development of the CEGR was deemed necessary to achieve Objectives 1 and 2, to inform the main finding, in terms of providing strategic direction for the development of the SL pedagogy. It was anticipated that the CEGR would clarify and operationalise the CE typology, as well as the SL criteria, to facilitate the development of the SL pedagogy.

During the development of the rubric, the instrument was piloted against a known SL module in the current Bachelor of Nursing curriculum. Subsequently, the nurse educators were tasked with reviewing the module against the criteria of the CEGR developed for this current study. Additionally, this step was conducted to benchmark the level of knowledge among the nurse educators, against the SL criteria imbedded in the CEGR. The findings of the curriculum mapping and reviewing/grading of the existing SL module, using the CEGR, contributed to

the sense of urgency among the educators in the SoN. This exercise also served the purpose of refining the psychometric criteria of the CEGR.

4.2. Development of the Community Engagement Grading Rubric (CEGR)

Several steps in the construction of instruments and rubrics have been documented to guarantee that instruments are valid and reliable measures of the construct (Walsh & Betz, 2001). Scholars in the field of developing rubrics use three broad categories to guide the development of a rubric, namely, planning, item writing, and the piloting of the initial version of the instrument (Foxcroft & Roodt, 2013). These steps compare well with the steps proposed by Moskal and Leydens (2000). In addition, it forms a framework that is usually interconnected, and outlines three phases of development: "measure development, assessment and testing and assessment of psychometrics and methodological quality" (O'Connor & Casey, 2015, p. 512). In this current study, the six operational steps, proposed by Walsh and Betz (2001), are imbedded in the three phases of the framework, and applied, as expressed under the phases of development. The steps, as outlined in Table 4.1, guided the development process to ensure the rigor of the CEGR.

Table 4.1 Framework for developing CEGR

Phases of development	Six operational steps
Development of measurement instrument	1. Definition and elaboration of the construct to be measured; 2. Choice of measurement method; 3. Selecting and formulating items.
Assessment and testing of the rubric	4. Scoring and rating issues; 5. Review and feedback.
Assessment of psychometrics and methodological quality	6. Pilot study.

The application of each of these phases are discussed next.

4.3. Development of measurement instrument (Phase 1)

Measurement development, the first phase of the adopted framework (Table 4.1), entailed the following three steps:

- Definition and elaboration of construct to be measured;
- Choice of measurement method;
- Selecting and formulating items.

4.3.1. Step 1: Definition and elaboration of the construct to be measured

This step was characterised by the conceptualisation of SL, which involved defining SL and the SL pedagogical variables that were measured, as underpinned by relevant literature (De Vet, Terwee, Mokkink, & Knol, 2011). These authors propose that it is best to develop a multi-item instrument for content domains like SL, which is contested and imbedded in a range of learning theories (De Vet et al., 2011). Therefore, further exploration of the understanding of SL, as a construct, was provided.

4.3.1.1. Understanding the determinants of the construct in the development of the instrument

A contextualised service-learning definition was formulated for the School of Nursing, which contributes to the service-learning operationalisation discourse at the higher education institution (Julie, 2014). This definition was mentioned in Chapter 1 (p. 13), and refined, as well as validated by Ramasasa (2018). A characteristic of the definition, is the criteria of SL that are imbedded within it:

> *"Service-learning is a teaching method that follows reflective learning practice, which is based on real-life experiences and service, through collaborative relationships between the university, the community and service providers, in order to achieve a well-structured community development plan, whilst meeting curriculum outcomes goals and with the purpose of producing socially responsive nursing practitioners." (Ramasasa, 2018, p. 69).*

It provides clear parameters for the determinants of the construct, SL, which were articulated in the CEGR, as a clear understanding of the construct was a prerequisite for the development of a blueprint for the CEGR (De Vellis, 2003). This clarity could be reached with the aid of an appropriate conceptual framework (Moskal & Leydens, 2001). The definition, as expressed in Figure 1.1 (p. 2), provides theoretical clarity, regarding the scope of the construct, and justifies the selection of items that need to be included in the instrument. This definition, the SL criteria (Figure 1.2, p. 4), and the CE typology (HEQC, 2006), informed the instrument.

Instrument development studies use theoretical models to inform the development of domains to be included in the instrument (Zillich, Carter, Doucette & Kreiter, 2005; Van Heerden & Roodt, 2007), while some use it for the domains and the item writing (Bowen, 2009), as well as reducing the number of items (Zelt, Recker, Schmiedel, & Vom Brocke, 2018). Subsequently, operational assessment areas are identified and clearly defined in the blueprint, based on the conceptual framework selected (De Vos et al., 2011). These content domains are thoroughly conceptualised by a process of refinement, and thereafter operationalised. The operationalisation of the construct, includes defining the independent variable, in terms of the procedures that will be performed to facilitate the measuring process. The items are then content validated against these operational definitions (Figure 4.1). The operationalisation of this instrument, therefore, is captured within the typology of CE, as recommended by the CHE (HEQC, 2006; Lazarus, Erasmus, Hendricks, Nduna, & Slamat, 2008; Hall, 2010).

4.3.1.2. Towards a typology of community engagement (CE)

There is a variety of definitions that could be used to describe the various forms of community engagement in higher education. Expressed as a continuum (Figure 1.1), each type of CE articulates with the main criterion used to grade and classify the type of CE. The criteria measure two important variables, namely, the primary *beneficiaries* of the service, which could be the community or student, and the primary *goal* of the service, which could be either to provide a community service, or to enhance student learning (Furco, 2002; CHE & HEQC, 2006). Kliewer (2013, p. 72) contextualises this as "the collaboration between institutions of higher education and their larger communities", alluding to its primary goal, "for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity".

Positioning a learning and teaching activity on the continuum, in relation to these two criteria, could provide meaningful interpretations about the type of CE. Starke, Shenouda, and Smith-Howell (2017), as well as Kolek (2016) categorise two primary challenges, namely, the lack of a consensual definition of community engagement, and difficulties in capturing the multidimensional nature of community engagement. However, these typologies in community engagement

are not necessarily considered discrete, or mutually exclusive, since the boundaries between these typologies are easily blurred, due misinterpretation, which may create disequilibrium, resulting in a shift within the curriculum continuum (Furco, 1994; HEQC, 2004; Bender, Daniels, Lazarus, Naude, & Sattar, 2006; CHE & HEQC, 2006). Examples of the above mentioned are the boundaries between *volunteerism* and *community outreach*; *internships* and *co-operative education*; *community outreach* and *service learning*; and finally, *co-operative education* and *service learning*. Although blurred boundaries are evident among these five different typologies within CE, they all embrace a measure of experiential learning (Furco, 1994; HEQC, 2004, CHE & HEQC, 2006). In this current study, only three of the specified existing typologies (*volunteerism*, *community outreach*, and *service learning*) are applied because of their nature and relevance for the Bachelor of Nursing undergraduate curriculum. Each one of these three types are discussed briefly, and their relevance, as well as applicability, are highlighted. *Internships* and *cooperative education* are not aligned with the undergraduate Bachelor of Nursing curriculum (Figure 4.1), or the curricula at the University of the Western Cape, as they are mostly embraced at Universities of Technology. They are discussed, but not operationalised within this current study, and were excluded from the development of the CEGR.

4.3.1.2.1. Volunteerism

Volunteerism is a type of engagement of students in activities where the primary beneficiary is the recipient *community,* and the primary goal is to provide a *service* (Bender et al., 2006). It provides an indication of the potential to be curriculised, as the service provider (the student) has no tangible educational benefit of engaging in such activities. This reveals that within *volunteerism*, the needs of the community are prioritised over student's learning. This reflect that, as pedagogy, *volunteerism* provides evidence of a low impact pedagogy. However, *volunteerism* is regarded as a type of CE that has gained momentum over time as a form of CE, which is often still utilised, due this altruistic nature (Astin, Sax, & Avalos 1999; Acai, Cowan, Doherty, Sharma, & Thevathasan, 2014). Generally, these activities are relatively small in scale, and have a loose relationship with the HEI. However, students may learn from these activities, as they are

generally not related to, or integrated into the student's field of study. *Volunteerism*, therefore, is essentially extra-curricular activities, which transpire during holidays and outside of tuition time. Students do not necessarily receive academic credit for participation in such activities, and they are generally funded by external donors and/or student fundraising (Berrick & Durst, 2014).

4.3.1.2.2. Community outreach

Community outreach is also an engagement of students in activities, in which the primary beneficiary is the recipient *community*, and the primary goal is to provide a *service* (Bender et al., 2006). However, these activities involve more structure and commitment from students, to a larger extent than in volunteerism. It is generally initiated from within the HEI by a department or a faculty, or as an institution-wide initiative (Bender, 2008). In some cases, recognition is bestowed, either in the form of academic credit, or research publications (Villaluz, Malonjao, Trinidad, & Bojos, 2018). As the service activities become more integrated with the academic coursework of the students, and as the student begins to engage in formal intellectual discourse about service issues, the activities move closer to the centre of the continuum, to become more like *service learning* (Bassi, 2011). *Community outreach* distinguishes itself from *service learning*, as the former tends to be a distinct activity and initiative of the HEIs, whereas the latter is fully integrated into the curriculum. In other words, *service learning* is not perceived as an *outreach activity*, but as an integral and inseparable part of the higher education curriculum, and is located on the other extreme of the continuum (Chapter 1, Figure 1.1).

4.3.1.2.3. Internships and Cooperative education

Internships engage students in activities, in which the primary beneficiary is the *student*, and the primary goal is *student learning* (Bender et al., 2006). *Internships* are intended to provide students with hands-on practical experience that will enhance their understanding of their area of study, achieve their learning outcomes, and provide them with vocational experience (Ramson, 2014). Generally, *internships* are fully integrated with

the student's curriculum (Acai et al., 2014). *Internships* (also referred to as *clinical practice*, in some instances) are used extensively in many professional programmes, such as Social Work, Medicine, Education, and Psychology (Bender et al., 2006; Julie, Daniels, & Khanyile, 2007).

Equally, the primary beneficiary of *co-operative education* activities is the *student,* and the primary goal is *student learning* (Bender et al., 2006). *Co-operative education* provides students with co-curricular opportunities, set within the designated services, which allow the student to provide a service, within designated tasks (Julie et al., 2007). It allows students to learn and relate to it; however, it is not always fully integrated with the curriculum. The primary purpose of *co-operative education* is to enhance the students' understanding of their area of study. The primary differences between *co-operative education* and *service learning* do not necessarily lie in differing methodologies, but in the nature of student placements, and the desired outcomes (Chambers, 2009).

Co-operative student placements are essentially within *industry*, whereas service learning placements are within *service agencies,* or directly in the *community*. As the desired outcome of *co-operative education*, essentially, is student learning, *service learning* includes the additional goal of providing a service to the community. However, in terms of student learning outcomes, both *co-operative education* and *service learning* share the goal of enriching the students' understanding of the course content and discipline.

4.3.1.2.4. Service Learning (SL)

Service learning modules, or courses, engage students in activities, in which both the *community* and the *student* are primary beneficiaries. The primary goals are to provide a *service* to the community, and equally, to enhance student *learning*, through rendering this service (Bender et al., 2006). Reciprocity is a central characteristic of service learning, associated with a primary focus of curricula in this category, and integrating community service with scholarly activity, such as student learning, teaching, and

research (D'Arlach, Sanchez, & Feuer, 2009; Bartleet, Bennett, Marsh, Power, & Sunderland, 2014). This form of community engagement is underpinned by the assumption that service is enriched through scholarly activity, and scholarly activity, particularly student learning, is enriched through service to the community (Groh, Stallwood, & Daniels, 2011; Stallwood & Groh, 2011).

Unlike the other categories of community engagement described above, service learning is entrenched in a discourse that proposes the development and transformation of higher education, in relation to community needs (Pedersen, Meyer, & Hargrave, 2015). Terms often used for this form of community engagement are, *service learning*, *academic service learning*, *academic community service*, and *community-based learning* (Clark, Faircloth, Lasher & McDonald, 2013; Infante et al., 2015; Jones et al., 2016). In this current study, it is the intention of the researcher that SL be identified as the focus of this research, because of its potential to be curriculised. SL also contains its unique typology of activities, which spirals from the original continuum, as presented in Figure 1.1 (Chapter 1).

4.3.1.3. Criteria for service learning

A strong association with experiential learning exists within the typology of community engagement. Some of them (*volunteerism, community outreach*) relate and focus on community service, while others (*internships, co-operative education*) promote student learning. Service learning, however, is deemed superior, in terms of its potential for learning, and is regarded as a high-impact learning and teaching pedagogy that affects a balanced approach for the integration that occurred, by providing a community service, as well as prioritising student learning, and structured reflection (Fink, 2016; Bringle, 2017; Wang & Calvano, 2018).

Alammary, Sheard, and Carbone (2014) state that, when two approaches are blended, it allows differentiation between the following, *Low-impact blend* – adding extra activities to an existing course; *Medium-impact blend* – replacing activities in an existing course; *High-impact blend* – building the blended course

from scratch. Brownell and Swaner (2010) identify the following as high-impact practices: First-year seminars, learning communities, service learning, undergraduate research, and capstone courses and projects. Fink (2016, p. 4) highlights the potential of high impact pedagogies, as the transformation of how students learn. He highlights two concepts, namely, *meta learning*, which means "learning about learning", and *metacognition* that suggests "thinking about thinking". Several definitions of service learning exist in literature, many of which introduce SL as high impact pedagogy, in its potential. *Metacognition* implies that students think about their thinking (Fink, 2016).

The findings of a study, conducted in the United States to examine the effects of an advanced service-learning programme on student learning, revealed that, when students are engaged in SL activities, they become involved in their own learning processes, and achievement, self-efficacy, as well as altruism are enhanced (Terry & Panter, 2010, p. 156), as has been suggested in this current study. In the context of this current study, it would refer to the blending of learning and teaching with service that gives effect to Figure 4.1.

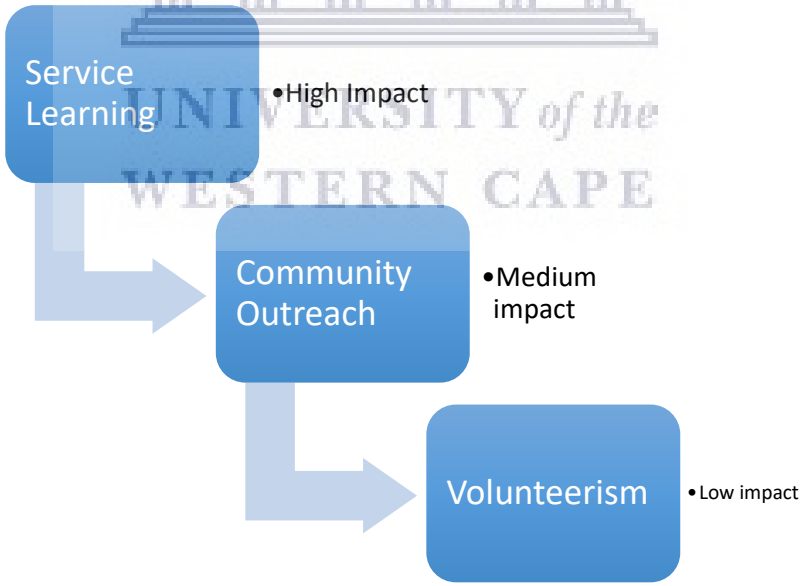

Figure 4.1: CE Typology applied to undergraduate nursing curriculum

SL is known to provide students with meaningful and challenging situations, as well as a reliable structure for reflection on the experience of participation in a service-learning project that puts students into life and working situations, which

are new and different, thereby rendering them capable of experiencing new and valuable kinds of learning (Julie, 2014; Fink, 2016). A SL definition that was developed in a research study, guides and presents clear parameters of how it should be defined and operationalised:

> *"Service Learning is defined as a type CE and regarded as a learning and teaching process, which aims to develop reflective nursing practitioners who address community development needs within equal partnerships between the university, community and service providers, who share the same values."* (Julie, 2014, p. 191)

In the process, students deepen and extend their education in a variety of valuable ways, when engaged in meaningful learning and teaching activities, and are required to use structured ways of reflecting on the experience, following participation in a service-learning project, which places them in life and working situations that are new and different (Fink, 2016, p. 11). In comparison, one of the most commonly cited definitions of SL refers to service learning as a course-based, credit-bearing educational experience, in which students "participate in an organised service activity that meets identified community goals, reflect on the service activity in such a way as to gain further understanding of course content, a broader appreciation of the discipline and an enhanced sense of civic responsibility" (Hatcher, Bringle, & Muthiah, 2004, p. 127).

The similarity that exists between the two definitions informs the key features of the SL criteria, namely, reflection, organised activity, addressing community needs partnerships, reflective practitioners, as well as T&L activity. This is also alluded to in the HEQC's *Criteria for Institutional Audits*, in which service learning is defined as "applied learning which is directed at specific community needs and is integrated into an academic programme and curriculum" (HEQC, 2004, p. 26). It further states that SL could be credit-bearing and relatable to the work environment (HEQC, 2004, p. 26). Evidently, within the context of service learning, *communities* refer to those specific, local, collective interest groups that participate in service learning activities of the institution. Such communities are regarded as partners, who have a full say in the identification of service needs and development challenges. Such communities also participate in defining the service

learning and development outcomes; identifying the relevant assets that they have in place; evaluating the impact; and contributing, substantially, to the mutual search for sustainable solutions to challenge.

In the South African context, generally, the members of such *communities* will be disadvantaged, materially poor inhabitants of under-serviced urban, peri-urban, or rural areas. In many instances, these communities may be accessed, most efficiently, through service sector organisations, such as government or state departments, as well as non-governmental, community-based, or faith-based organisations (Christie & Gordon, 1992).

4.3.1.4. Philosophical underpinning of service learning

The field of experiential learning is the pedagogical foundation of service learning. It is enforced by providing a service that promotes substantive learning (Eyler & Giles, 1999). Service learning connects students' experience to reflection and analysis in the curriculum (Duley, 1981). In nursing education and training, this is mainly the manner in which students acquire skills and competencies, through the provision of services in real life settings that address real problems (Duley, 1981).

Service learning allows students to engage in complex, contemporary social problems, as well as efforts to solve them, as an important element of a complete education (Butin, 2006; Bowen, 2010; Fitzgerald et al., 2012). SL invokes the following learning theories, presented in Table 4.2, providing a description and relevance of the learning theories, in which the SL pedagogy is imbedded.

Table 4.2: Learning theories underpinning service learning (SL)

Theorist	Description and relevance
Dewey (1963)	Connected experiential learning and reflective thought and action, form the core for service learning. Dewey's theory provides a framework in which service learning can operate and function (Pacho, 2015). Service-learning literature positions Dewey's idea that effective learning requires an appropriate and relevant experience. It is also in line with Dewey's view that education, as a social phenomenon, serves to reinforce the aims and methods of society (Hugg & Wurdinger, 2007).
Freire (1970, 1973)	Service learning advocates for social responsiveness and social justice. This finds consolidation within Paulo Freire pedagogy of the oppressed, which focuses on social injustices and oppressive structures (Torre et al., 2017).

Argyris & Schon (1978)	These theorists had innovative thinking around notions, such as *the learning society*, *double-loop learning* and *reflection-in-action* that have become part of the language of education. These notions are rooted in SL pedagogy that cultivates a learning society.
Bandura & Adams (1977)	Social Learning Theory emphasises that the environment offers potential meaning for those to learn from it, and vice versa. This is evident in the reciprocal effect of learning that service learning nurtures and encompasses.
Kolb (1984)	Experiential learning forms the foundation of the cycle of events, as it occurs within service learning

Evidently, based on the above review of literature, experiential learning transforms students, as it helps them to revise and increase their knowledge, as well as modify their practice. In addition, the above review of literature served as a tool towards the understanding of the construct. Service learning has been defined and explained to fit the purpose, rationale, as well as content domain of the instrument, as explained earlier in this chapter, under the Phase 1, Measure development. The construct, as it relates to this current study, is to understand service learning as a pedagogy in an Undergraduate Bachelor of nursing programme. The researcher conducts a document analysis, by reviewing the course guides. Following the review, the module guides are classified, according to the typology of community engagement, as well as the potential of the module to be aligned to the Service Learning Methodology. For the purpose of the task at hand in this chapter, a specific literature review was conducted for instrument development.

4.3.1.5. Typology of community engagement

The literature review revealed that the types of community engagement are a balance between the service provided and the learning that should transpire within the students. This provides latitude for the typology of service learning within the community engagement. According to Sigmon (1997, pp. 3–4), the service learning typology includes:

- Learning goals primary, service outcomes secondary;
- Service outcomes goals primary, learning goals secondary;
- Learning goal service outcomes viewed completely separate; and
- Learning goal service outcomes are equally weighted and contribute, as well as complement each other.

It is essential to view the precise nature of the activities associated with the context of this discussion, for example, in this current study, because it is an academic programme. The nature of the activity needs to be reviewed, according the above-mentioned typology that has been adopted in this current study. This will assist students to clarify the position of the SL pedagogy within the undergraduate Bachelor of Nursing curriculum.

In this current study, it is intended to provide the measure of the activities to transpire that aligns itself to the degree of responsiveness, as contextualised in Chapter 1, by means of the standards created for responsiveness (Boelen et al., 2012). These standards will align with Figure 4.1, which scaffold the impact of the learning and teaching activities, in relation to the CE typology, and will also be transferred to the criteria of SL that will be explored. In addition, to create balance between *service* and *learning*, the abovementioned criteria are pre-ordained and encapsulated into the basic criteria of SL, which form part of the criteria for the CEGR:

- Primary beneficiary of service activities;
- Nature of service activities;
- Primary goal of service activities;
- Reciprocity [main distinguishing element];
- Academic credit;
- Authentic learning and teaching experience;
- Structured reflection;
- Academic discourse;
- Curricular integration;
- Community partnerships;
- Social transformation of students in relation to community needs.

Challenges with the typology of SL has been reported (Furco, 1996). Literature states that engagement activities near the centre of the continuum was listed as challenges, which implies that there are no clear boundaries between the types of

community engagement, its primary goal of the service, and who the primary beneficiary of the service is, to be able to grade the precise engagement type. In this current study, this posed a problem during the development of the CEGR. Boelen et al. (2012) provides three gradient levels, from social responsibility, to social responsiveness, with social accountability, as the highest level. This grading was utilised to scaffold the level of the impact of the learning and teaching activities on the CEGR, as either low, medium, or high impact. However, when determining the cut-off points during the development, often the definition of the type of engagement could not translate easily, without the discretion of the reviewer, or grader. Therefore, the reviewer, or grader, should focus closely on the specified criteria, as defined on the rubric. However, Furco (1996) states that reciprocal learning is one of the main distinguishing features of service learning. This implies that a perfect blend should exist in such criteria, where both student learning and community service are prioritised.

The literature review positioned SL as pedagogy, which is imbedded primarily in experiential learning (EL). EL is a learning process, which occurs naturally through experience (Kolb & Kolb, 2009), and is imbedded, with reflection after engaging in the activity. SL requires opportunities for engagement by the student, with a community. These opportunities, in turn, provide authentic opportunities on which to reflect.

Table 4.3: Outline of components of instrument (CEGR)

Components	Description
Purpose of instrument	The purpose of the instrument is to review a module guide to: 1. To reflect the aspects that inform the learning and teaching practices, the typology of CE, and the indicators for managing the quality of the SL elements, based on the findings of Objective 1 and 2.
Rationale for instrument	1. Formulate the CE typology, evident in the undergraduate curriculum. 2. Classify and grade the SL potential as low, medium or high impact based on the learning and teaching activities utilised in the modules. 3. Contribute to the development of the SL pedagogy for the undergraduate nursing curriculum.
Target population	Screening undergraduate nursing modules.
Content domain	CE types and SL indicators (Furco, 1996; HEQC, 2006)
Instrument and item format	CEGR with performance grading through the development of a performance descriptor.

The development of the instrument phase provides detail on how the overall plan for the instrument was achieved. It will serve as a guide for the rest of the phases in the construction of the instrument (Table 4.3). McIntire and Miller (2007) state that the purpose and rationale for the instrument, the target population, the definition of the content domain, the instrument, and item formats, as well as all other specifications, including the administration and scoring methods, should be stated clearly in the blueprint. Conceivably, it could address test bias during this phase, along with other design issues, as the purpose and rationale would be clearly stated, prior the development (Foxcroft & Roodt, 2013).

4.3.2. Step 2: Choice of measurement method

The intention was to determine the SL potential of each module in Undergraduate Bachelor of Nursing curriculum, as well as identify and define the CE typology that existed within the Undergraduate Bachelor of Nursing curriculum. In the previous step of the instrument development, during the understanding that was built for the construct, two key concepts were identified, namely, the *CE typology* (expressed by determining the primary goal, and the primary beneficiaries of the learning and teaching activities), and the *SL criteria*, which formed the two main items to be measured on the CEGR.

Service learning is clear in its main characteristics, or elements, which are amendable to grading, according to the SL typology (Sigmon, 1994; Bender et al., 2006). The modifiability of these criteria gave impetus to the degree of the impact of the pedagogy (low, medium, and high) as expressed in Figure 4.1. In addition, it provides the measure of the activities to transpire, which align to the degree of responsiveness, as contextualised in Chapter 1, by means of the standards created for responsiveness (Boelen et al., 2012).

SL has the highest form of community engagement impact of the CE typology, because SL, with its well-defined SL criteria, provides the *standard* and *structure* to benchmark other types of CE T&L activities (Sigmon, 1997, Furco, 2002, Bender et al., 2006; Hall, 2010; Julie, 2014). This justifies the following associations about the CE typology, the gradient level of responsiveness (Boelen et al., 2012), and the impact of the learning and teaching activities:

Table 4.4: Associations between CE typology and the impact

CE Typology	Gradient levels	Impact of learning and teaching activities
Volunteerism	Responsiveness	Low impact
Community Engagement	Responsibility	Medium impact
Service Learning	Accountability	High impact

SL is regarded as the balancing of service and learning in its highest form, according to the typology of SL (Julie, 2014). The SL elements were explored against the CE typology, as defined by the South African Council of Higher Education, to serve as key features on this instrument, to grade SL, as well as determine the typology of CE.

4.3.3. Step 3: Selecting and formulating items

The aim was to determine the *CE typology* in the undergraduate Bachelor of Nursing curriculum, and subsequently, grade the typology against the SL indicators, to determine the SL pedagogy potential of the modules. The nature of the instrument was guided by the objectives of the study; however, a grading ability was built into the CEGR. Tierney and Simon (2004) aver that an important feature of grading rubrics is the presence of evaluative criteria, to score the performance of an identified indicator (Panadero & Jonsson, 2013; Dawson, 2017), as depicted in Tables 4.5 and 4.6, respectively.

The complete CEGR, consists of Sections A to E. Section A is entitled the *Orientation of the service activities*, and has three items that address the following: primary beneficiary of the service; nature of the service activity; and primary goal of the service. Section B is entitled the *Description of learning and teaching activities*, which comprises the following eight items: reciprocity; academic credit; authentic learning and teaching experiences; structured reflections; academic discourse; curricular integration; Community partnerships; and social transformation of students in relation to o community needs. Section C to E (see Tables 4.6 and 4.7) are defined as the *performance descriptors* (PD) that will guide the scoring, classification, and grading of the typology of CE, and the SL potential of the reviewed module. Post completion of the first two sections, the scores will be calculated according to the scale used, and subsequently, judged according to the performance descriptors, associated with the HEQC definition of each type of CE, which are discussed later in this chapter.

4.4. Assessment and testing of the rubric (Phase 2)

This is the second phase of the development of the rubric and entailed following steps:

- Scoring and rating issues;
- Review and feedback.

4.4.1. Step 1: Scoring and rating issues

Scoring and rating issues refer to the first step of Phase 2 of the development of the rubric. Scoring and rating are critical factors in the development the rubric, as they contribute towards an increase in the rating consistency of the performances. The variables were categorical; therefore, an ordinal scale was used in this instrument, which is aligned with categorical variables. Using an ordinal scale is appropriate for this rubric, as it needs to classify and grade meaning, to provide a distinguishing response to the question asked. This would be possible as the lowest category would convey the lowest form of engagement, which would minimise potential bias of the person using the CEGR self-assessment rubric.

4.4.1.1. Rating scale

The rating scale used for the CEGR included three levels that were used to grade and classify the level of the criterion assessed (see Table 4.6). Each level was assigned a number to facilitate the calculation of the total score, as follows:

- Low impact L&T activity is equal to one (1);
- Medium impact L&T activity is equal to two (2);
- High impact L&T activity is equal to three (3).

4.4.1.2. Writing performance descriptors (PD)

A PD basically develops a criterion that could be used to benchmark a score, or rating, that has been met and assigned to the criterion. Therefore, a performance descriptor could describe the construct under investigation in a set of areas, which indicates the purpose and performance. In this current study, the PD is used to classify and grade the typology of CE, and determine the SL potential of the module. Table 4.7 depicts the performance descriptor of the CEGR. Two content domains were required to enable the performance descriptors (PD) to be finalised.

The two content domains were SL and CE. Both were required to finalise the PD, as the CEGR was intended to, firstly, determine the CE type, and thereafter, determine the SL potential of the module. This allowed detailing of the typology of CE in the Bachelor Nursing Curriculum, and provided a demarcation of the potential module that could use the pedagogy.

4.4.1.3. Determining cut-off points on performance descriptors

Literature was used to support the development of the rubric, as well as the content domains that should be accessed, using the rubric. Section E allows the user of the rubric to transfer the highest scores, to grade the module. The score needs to be finalised, using the criteria set for each column of this rubric. A score between 1 and 11 would indicate a low-impact pedagogy, a score of 12 to 21 would indicate a medium-impact pedagogy, and a score of 22 to 33 would indicate a high-impact pedagogy. Each of the ranges aligns to a typology of CE. In addition, this rubric would allow the user to classify the CE typology to which the module prescribes.

4.4.2. Step 2: Review and feedback

This is the second step of Phase 2 of the development of the rubric, which assisted with the refinement and testing of the rubric on the sample of educators, who participated in Phase 1 - Objective 1, and Phase 2 - Objective 4 of this current study. The reliability of the rubric was determined, using the Cronbach's alpha coefficient. Cronbach's alpha is useful in determining the reliability and internal consistency of an instrument (Cronbach, 1951). Table 4.8 provides an overview of the reliability testing of the CEGR.

The Cronbach's Alpha is the most generally used statistic to assess reliability, and was applied to the CEGR (Polit & Beck, 2012). Brink et al. (2018) explains that reliability is the degree to which the CEGR could be depended on, to yield consistent results, if used repeatedly over time on the same person, or if used by two researchers. The normal range of values for a Cronbach's Alpha is between .00 and +1.00, while higher values reflect better internal consistency (Brink et al., 2018). The final Cronbach alpha score obtained for the CEGR was 0.7, which indicates an acceptable or satisfactory level. Table 4.5 contains an explanation of the calculations that relate to the Cronbach alpha score determined for the CEGR.

Table 4.5: Cronbach's Alpha for reliability

Items /Questions	11
Sum of Items	3.12
Variance of Total Scores	7.76
Cronbach's Alpha	0.70

Table 4.6: Community Engagement Grading Rubric (CEGR)

MODULE NAME: ……

INSTRUCTIONS

1. Assess your module guide according to the SL criteria listed in sections A and B.
2. Score the 11 SL elements as either low (1), medium (2) or high (3) impact according to the statements in Sections A and B. All stated criteria must be met and only one selection per row is allowed.
4. Add up the total scoring of each column in C1, C2 & C3 to determine CE typology
5. **Calculate SL potential of module:** Identify the column (C1, C2 or C3) with the highest total score.
5. Continue to Section D: Grade the highest scoring total according to D1, D2 or D3. (complete the calculation)
6. Proceed to Section E: To classify the CE typology and grade SL potential of the module in columns (D1/D2/D3).

A. ORIENTATION OF SERVICE ACTIVITIES

No.	SL ELEMENTS	LEARNING AND TEACHING ACTIVITY IMPACT		
		Low	Medium	High
1	**PRIMARY BENEFICIARY OF SERVICE ACTIVITIES** (Description: The person or recipient that benefits from the service activities/learning & teaching activities)	The student is engaged in learning and teaching or service activities where the primary beneficiary is the community.	The student is engaged in learning and teaching activities where the primary beneficiary is the community; however, the student may benefit from such engagement.	The student and community are regarded as equal beneficiaries of the service activities.
2	**NATURE OF SERVICE ACTIVITIES** (Description: The character or qualities of the service activities/learning & teaching activities)	The service activities are entirely altruistic in nature. It is based on a disinterested or selfless concern for the well-being of others.	The service activities are initiated from the student, based on interest and motivation. It is prescriptive as to what services will be offered. It does not necessarily addresses the pressing needs of the community.	The nature of the activities is structured and need commitment from students to engage with the needs of the community. It provides opportunity to learn and to serve the needs of the community whereby students link course outcomes to the needs of the community.
3	**PRIMARY GOAL OF SERVICE ACTIVITIES** (Description: Aim of the service activities/ learning & teaching activities)	The goal of the service is to engage students in service activities to enhance service to the community.	The goal of the service is to provide meaningful service and enhance classroom learning.	The goal of the service is to engage students in service activities to enhance learning and to service the community equally through a meaningful educational discourse that leads to career development and professional preparation.

B. DESCRIPTION OF LEARNING & TEACHING ACTIVITIES (L&TA)				
1	**RECIPROCITY** (Description: - The practice of exchanging things with other for mutual benefit. In the student it will create a praxis between theory and practical requirements)	Learning and teaching activities allows students to provide a service that is in favour of benefitting the community. The service activity is not reciprocal in nature.	Learning and teaching activities allow students to provide a service that is not usually reciprocal to the student and the community. If structured carefully it can accommodate reciprocity between the community and the student. Usually students benefit from these kinds of activities.	Learning and teaching activities to provide service that is reciprocal to the student and the community. It tends to enhance student learning through providing a service to the community. The service activity is therefore reciprocal in nature to the student and the community.
2	**ACADEMIC CREDIT** (Description: The module with learning & teaching activities carries a value towards the completion of the qualification)	Academic credit not attached to service provided. The service activity is not necessarily related or integrated into the nursing curriculum.	Possibility of obtaining academic credit for the service activity exists if learning and teaching activities are structured according to the learning outcomes of the student.	Provides academic credit as the service activities are inseparable from the learning and teaching activities associated with the learning outcomes of the student.
3	**AUTHENTIC LEARNING & TEACHING** (Description: The learning & teaching activities based on real community problems)	The student is engaged in service activities that is altruistic in nature.	Student is engaged in service activities that has the potential to become authentic if identified and organised within the community. It cannot be fully distinguished that community outreach provides opportunities as if it is not imbedded through interaction with the community.	The student is engaged in meaningful activities. Creation of opportunities for authentic learning where students are required to actively apply their knowledge to real world issues, and opportunities are created within the learning experienced.
4	**STRUCTURED REFLECTION** (Description: Reflection that is facilitated through prompts, questions, activities or organised discussions to assist in thinking deeply about an issue)	The service activities are loosely or sometimes not connected to HEI, which does not require structured reflections.	If structured according to the outcomes, structured reflections could form part of service activities. However, these activities are mostly co-curricular and would not require structured reflections.	This form of community engagement is underpinned by the assumption that service is enriched through scholarly activity and that scholarly activity, particularly student learning, is enriched through service to the community.
5	**ACADEMIC DISCOURSE** (Description: Refers to ways of thinking and generating new knowledge through written, spoken and online forums by students)	Does not require an academic discourse as it is extra-curricular and separate from learning outcomes.	Academic discourse could be possible if structured according to module outcomes, meaning that it connects learning outcomes to the service activities.	The learning & teaching activity enriches student understanding of course content, discipline while developing responsiveness and public good in students.
6	**CURRICULAR INTEGRATION** (Description: the relationship between the service activities and the learning & teaching activity)	The service activity is regarded as extra-curricular on the premise that the service activities and the learning & teaching activity do not relate to each other.	The service activity is regarded as co-curricular on the premise that the service activities and the learning & teaching activity complement each other.	The service activity is regarded as curricular on the premise that the service activities and the learning & teaching activity completely relate to each other.

7	**COMMUNITY PARTNERSHIPS** (Description: the influence the external stakeholders and partners have on the development of the learning and teaching goals)	The learning and teaching goals are not influenced by the external stakeholders and partners.	The learning and teaching goals are influenced by the external stakeholders and partners. The context tends to relate to what the student can provide.	The learning and teaching goals are influence by external stakeholders and partners. It creates a perfect context to meet both the learning needs of the student and the service needs of the community.
8	**SOCIAL TRANSFORMATION OF STUDENTS IN RELATION TO COMMUNITY NEEDS** (Description: The change in students when they engage in learning & teaching activities that requires them to serve community needs)	It results in a responsive student to the needs of the community.	It results in a responsible student to the needs of the community.	It results in a accountable student to the needs of the community.
C. TOTAL PER CATEGORY				
		C1_____	**C2_____**	**C3_____**

Table 4.7: Performance descriptor (PD) of CEGR

COMMUNITY ENGAGEMENT GRADING RUBRIC			
MODULE NAME: ……..			
D. PERFORMANCE			
Calculate SL potential of module	**D1**	**D2**	**D3**
C1 multiply total by 1 = D1	_____	_____	_____
C2 multiply total by 2 = D2	_____	_____	_____
C3 multiply total by 3 = D3	_____	_____	_____
E. CLASSIFY TYPE OF CE AND GRADE SL POTENTIAL OF MODULE (Use the highest total only in D1/D2/D3)			
High-Impact Pedagogy	**21-30**	Service Learning	
Medium-Impact Pedagogy	**11-20**	Community Outreach	
Low-Impact Pedagogy	**0-10**	Volunteerism	

In this current study, two content domains were identified, SL and CE typology, which would be used to grade the content (learning and teaching activities) of the module guides of all the nursing modules of the undergraduate Bachelor of Nursing curriculum. The SL elements, which demonstrate a balance between providing a *service* to the community and a *learning* opportunity to the student (see Table 4.6: Section A), were regarded as a priority, as they would indicate a high-impact activity. Consequently, the SL elements, entrenched in the CE typologies, were scaffolded from low to high impact,

as they aligned to the basic principles, and synonymously, to the criteria for SL (see Table 4.7).

Dawson (2017) states that a grading rubric could be presented in a table format, and be used by an individual, who needs to complete a task that requires measurement. In this current study, each SL criterion was delineated as a CEGR section, which prompted the user to grade the module guide. This is based on the view that rubrics could have one dimension, or more, against which the performance of an indicator could be measured. This CEGR was intended for use as a self-evaluation tool, to guide the user to grade and review the construct of SL, and determine the typology of CE. Reddy and Andrade (2010) affirm that rubrics should measure a stated objective, or performance, and employ a range to rate the performance. Besides the criteria, the scale to be used, as well as the definitions of descriptors are also important.

4.5. Assessment of psychometrics and methodological quality (Phase 3)

The third phase of the development of the rubric involves the conducting of a pilot study (see Table 4.1). Firstly, the CEGR was presented to 5 nurse academics to score a SL module. The mean score achieved was 12.73, with a variance of 1.618, standard deviation of 1.272 among the 5 respondents. Their feedback and suggestions were evaluated and, where necessary and relevant, incorporated into the rubric.

4.5.1. Pilot Study

Appropriately, the CEGR was subjected to psychometric testing, in terms of its reliability and validity, as mentioned in Chapter 3. The statistical analysis was performed, using SPSS 25. Initially, a data descriptive analysis was conducted, through descriptive statistics. The data normality was confirmed, using the Shapiro-Wilk test (see Table 4.9). To verify the test-retest for inter- and intra-rater reliability, the Intra-Class Coefficient ($ICC_{2,2}$) was calculated. $ICC_{2,2}$ was based on a 2-way (random effects) repeated-measures analysis of the variance model with consistency agreement. The values found in ICC were classified, according to the literature, as weak (ICC<0.40), moderate (ICC between 0.40 and 0.75), and excellent (ICC>0.75). The level of significance adopted for all tests was 0.05. Table 4.10 below contains a description of the scoring in the test-retest for the CEGR.

Table 4.8: Testing CEGR: Scoring round 1

	Section A: Q 1-3			Section B: Q 1–8								
Participant	A1	A2	A3	B1	B2	B3	B4	B5	B6	B7	B8	**Total**
P1	3.00	2.00	3.00	2.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	28
P2	3.00	3.00	3.00	3.00	1.00	3.00	2.00	3.00	2.00	3.00	3.00	26
P3	2.00	3.00	2.00	3.00	2.00	2.00	2.00	1.00	3.00	3.00	2.00	23
P4	3.00	3.00	1.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	3.00	21
P5	3.00	3.00	3.00	2.00	2.00	3.00	3.00	3.00	3.00	3.00	3.00	28
P Var	0.16	0.16	0.64	0.24	0.40	0.24	0.24	0.64	0.24	0.16	0.16	3.12
Mean	2.36	2.36	2.11	2.04	1.73	2.21	2.04	2.11	2.21	2.36	2.36	
Mode	3.00	3.00	3.00	2.00	2.00	3.00	2.00	3.00	3.00	3.00	3.00	
Median	3.00	3.00	2.55	2.00	2.00	2.60	2.00	2.55	2.60	3.00	3.00	
Standard Deviation	0.90	0.90	0.86	0.75	0.69	0.85	0.75	0.86	0.85	0.90	0.90	

Table 4.9 Tests of Normality (Shapiro-Wilk Test)

Tests of Normality						
	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	df	Sig.
Rater_1_Round_1	.375	55	.000	.693	55	.000
a. Lilliefors Significance Correction						

Table 4.10: Test-Retest Correlation

CORRELATIONS			
		Rater_1_Round_1	**Rater_1_Round_2**
Rater_1_Round_1	Pearson Correlation	1	.898**
	Sig. (2-tailed)		.000
	N	55	55
Rater_1_Round_2	Pearson Correlation	.898**	1
	Sig. (2-tailed)	.000	
	N	55	55
**. Correlation is significant at the 0.01 level (2-tailed).			

4.5.1.1. Inter-rater reliability

For the evaluation of inter-rater reliability, the results obtained by the Intra-Class Correlation (ICC) revealed a weak correlation (ICC= 0.09) between the scoring of 5 Nurse Educators. For more details see Table 4.11.

Table 4.11: Inter-class correlation

Measures	Inter-class correlation	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper Bound	Value	df[1]	df[2]	Significance
Single	0.009[a]	-0.127	0.324	1.044	10	40	0.426
Average	0.042[c]	-1.288	0.706	1.044	10	40	0.426

Two-way mixed effects model where people effects are random and measures effects are fixed.

a. The estimator is the same, whether the interaction effect is present or not.

b. Type C intraclass correlation coefficients using a consistency definition-the between-measure variance is excluded from the denominator variance.

c. This estimate is computed assuming the interaction effect is absent, because it is not estimable otherwise.

4.5.1.2. Intra-rater reliability

For the evaluation of intra-rater reliability, the results obtained by the Intra-Class Correlation (ICC) demonstrated excellent correlation (ICC= 0.9) between the scoring of 5 nurse educators in round 1 and round 2. For more details see Table 4.12.

Table 4.12: Intra-class correlation

Measures	Intra-class correlation	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper Bound	Value	df[1]	df[2]	Significance
Single	0.900	0.835	0.940	18.981	54	55	0.000
Average	0.947	0.910	0.969	18.981	54	55	0.000

One-way random effects model where people effects are random.

4.5.1.3. Validity

Validity was determined on the quality criterion, implying the degree to which inferences made in a study are accurate and well-founded, as well as on measurement, the degree to which the CEGR measures what it is intended to

measure (Polit & Beck, 2012). The types of validity were determined for the CEGR as follows: *Face validity* was determined by submitting the CEGR to the study supervisor, as well as 5 (five) nurse educators, for their expert opinion, to determine whether the CEGR would measure the concepts, which it was intended to measure, in this current study; and *Content validity* was determined through the objective and purpose of the CEGR, as captured in Table 4.3

The findings of the pilot study are discussed in Chapter 7, with the discussion of the findings, as it would contribute to the development of the draft SL pedagogy. In Objective 2, the CEGR, therefore, was used in this current study to classify the typology of community engagement, and the SL potential of each module that was included in the study. The findings of Objective 2 are presented in Chapter 5.

4.6. Summary

In this chapter, the researcher orientated the reader to the instrument that was developed for this current study. This was facilitated through six steps that guided the development. Subsequently, the researcher provided a deep theoretical underpinning, supported by literature, regarding the SL criteria, and the typology of CE, as it is applied in this current study. The CEGR was determined to be reliable by Cronbach's alpha coefficient, and was also subjected to psychometric testing, which indicated that there was a weak correlation between the scores of 5 nurse educators.

In the next chapter, the researcher focuses on the consolidation of the findings of the first phase of this current study, in terms of Dimension 1 of Kotter's organisational change model. *Creating a climate for change* will unfold in three steps, namely, *creating a sense of urgency*, *forming a powerful guiding coalition* and *developing a vision*.

CHAPTER FIVE

PHASE 1: RESULTS AND FINDINGS

5.1. Introduction

In the previous chapter, the CEGR was developed. The aim of this chapter is to state the findings of Phase 1. Creating a sense of urgency in *Objective 1,* the data were extracted from module guides to develop a curriculum map at the micro-level of an Undergraduate Bachelor of Nursing curriculum: *To identify the curriculum development aspects of the curriculum as guided by the conceptual framework of this study. Objective 2* of this phase, with the directive to create powerful coalition, was embarked on: *To formulate the CE typology currently imbedded in an undergraduate Bachelor of Nursing curriculum.* In this objective, the curriculum maps were used to assist in completing the self-assessment rubric that was developed for this current study, to determine the quality of the SL elements. *Objective 3* was aimed at creating a vision: *To develop the draft SL pedagogy as reflected in the aspects that inform the learning and teaching practices, the typology of CE and the indicators for managing the quality of the SL elements based on the findings of Objective 1 and 2*.

Table 5.1: Objectives addressed in Phase 1

Phase 1: Creating a climate for change (Dimension 1 of Kotter)		
Step 1 Create a sense of urgency	**Step 2** Forming a powerful coalition	**Step 3** Developing a vision
Objective 1 To develop a curriculum map at the micro level of an undergraduate Bachelor of Nursing curriculum;	**Objective 2** To formulate the CE typology currently imbedded in an undergraduate Bachelor of Nursing curriculum;	**Objective 3** To develop the draft SL pedagogy as reflected in the aspects that inform the learning and teaching practices, the typology of CE and the indicators for managing the quality of the SL elements based on the findings of Objective 1 and 2.

Table 5.1 provides the scope of Phase 1, in relation to its objectives, as aligned and guided by the conceptual framework that was adopted for this current study. Phase 1 was guided by Kotter's first dimension, set out to create a climate for change. This chapter, therefore, unfolds as guided by Table 5.1.

5.2. Objective 1

Objective 1 of Phase 1 articulates fundamental imbedded aspects on which the curriculum is based. It was anticipated that the fundamental aspects of how the curriculum is operationalised would be revealed, and the current position of the curriculum would be determined to redirect and custom-build the pedagogical practices. This would assist with the identification of obstacles and clarification of complexities, which would convey a sense of urgency to change the current learning-teaching practices that were explored, when the document analysis was conducted.

5.2.1. Document analysis

The *document analysis* performed was described in Chapter 3. Module guides were reviewed, using an inductive approach, which was followed by the extrapolation of data into tables, enabling important aspects of the curriculum to be mapped out. Further codes, categories, and themes were created from the data that were extracted, which were later defined as the educational attributes, to provide a curriculum map, displaying an understanding of the current situation of the curriculum, in terms of the pedagogical and curricular practices.

5.2.2. Curriculum mapping

Applying the themes and categories identified in the conceptual framework, provided the scope for the curriculum mapping, thereby documenting the pertinent information associated with the curriculum, which allowed for further processing of the information into a more acceptable state, to be able to appraise and synthesise the information captured. It offered a measure of objectivity within the data, which were extracted and processed subjectively, based on the interpretation of the researcher**.** This allowed the development of empirical evidence that could be processed through the data extraction table, which would later inform the creation of a vision for the SL pedagogy, through the classification of a CET, as well as the management of the SL elements in curricular practices, by exploring modules, using the CEGR developed in Chapter 4.

All the above actions assisted with the demarcation of SL modules, to facilitate the advancement of the SL pedagogy.

5.3. Modules included in document analysis

According to the FCHS year book (University of the Western Cape [UWC], 2017), the Bachelor of Nursing curriculum includes 31 modules, of which 23 were included, because these 23 modules are offered within the home department, and serve as major nursing modules that students have to pass, in order to promote to the next year level. Table 5.2 contains an overview of the included modules.

Table 5.2: Modules according to document analysis

Topic Module	Module Code	Year	NQF	Credits
Foundations of Nursing 1	NUR 141	1	5	10
Foundations of Nursing 1	NUR 151	1	5	15
Laboratory clinical	NRS 142	1	5	NA
Fundamentals of Nursing 1	NRS 152	1	5	5
Introduction to Philosophy of Care	IPC 124	1	5	5
Health Development & Primary Health Care	HDP 116	1	5	5
Fundamental of Nursing	NUR 111	2	5	15
Fundamental of Nursing	NUR 112	2	5	15
Assessment and Care	CUR 111	2	5	15
General Nursing	NRS 211	3	6	20
General Nursing	NRS 212	3	6	20
Introduction to Mental Health	CUR 214	3	6	10
Child Health Nursing	NRS 313/NRS 324	4	7	15
Primary Care & Skills	CUR 312/CUR 325	4	7	15
High Risk Midwifery	CUR 327	4	7	15
Low Risk Midwifery	CUR 326	4	7	30
Community Health Nursing	CUR 311	4	7	30
Nursing Leadership & Management at Unit Level	CUR 334	4	7	15
Therapeutic Management of Mental Illness	NRS 411	5	8	30
Management and Rehabilitation of Psychiatric Patients	NRS 412	5	8	30
Gender-based violence as public health issue	NRS 401	5	7	20
Professional practice	NRS 421	5	8	20
Research methods	NRS 423	5	8	20
		Total credits		375

NQF = National Qualifications Framework

All these modules, displayed in Table 5.2, were included in the document analysis. They were regarded as main nursing modules, which implies that the other excluded modules, either were not regarded as nursing modules, or alternatively, not offered by the home department, where this current study was conducted. It is noted that 375 credits extend across 23 modules that form part of the nursing modules. The first year level comprises 45 credits, second year level, 55 credits, third year level, 50 credits, fourth year level, 120 credits, and fifth year level, 120 credits. Per year level, the educational complexity of these modules are aligned according to NQF 5–8.

5.4. Attributes of modules

Table 5.3: Educational attributes identified

Attributes	
Time spent on modules	Contact time with lecturer Practical hours Time spent on self-study
Learning and teaching related aspects	Teaching pedagogy Teaching strategies
Need to create a praxis	Practical component Integration of theory and practical Defining of practical requirements and objectives for practical
Profiling of assessments	Formative assessments Summative assessments
Attributes relating to outcomes	Demarcating the relationship between the graduate attributes, specific outcomes and curriculum content

The above attributes were identified, coded, analysed, and documented, using a data extraction table, according to the main characteristics, extant in the module guides. Table 5.3 contains an overview of: the time spent on modules; learning and teaching related aspects; the need to create a praxis, as per the module guides; the profiling of the assessments; and attributes relating to outcomes, per year level of the curriculum. The presentation of the findings is guided by Table 5.3.

5.4.1. Time spent on modules

This attribute explored all time-related aspects of the modules. The following aspects were covered: Contact time with the lecturer, practical hours, and time spent on self-study (Table 5.4).

Table 5.4: Time spent on modules in hours

Module topic	Module code	Contact with lecturer	Practical hours	Time spent on self-study
Foundations of Nursing 1	NUR 141	56	NA	28
Foundations of Nursing 1	NUR 151	112	NA	26
Laboratory clinical	NRS 142	NA	NA	NA
Fundamentals of Nursing 1	NRS 152	112	0	26
Introduction to Philosophy of care	IPC 124	NA	NA	NA
Health Development and Primary Health Care	HDP 116	NA	NA	NA
Fundamental of Nursing	NUR 111	56	NA	NA
Assessment and Care	CUR 111	42	52	14
General Nursing	NRS 211	56	NA	70
General Nursing	NRS 212	56	NA	70
Introduction to Mental Health	CUR 214	24	0	16
Child Health Nursing	NRS 313/NRS 324	28	56	42
Primary Care and Skills	CUR 312/CUR 325	28	NA	42
High Risk Midwifery	CUR 327	28	NA	36
Low Risk Midwifery	CUR 326	28	140	68
Community Health Nursing	CUR 311	56	125	64
Nursing Leadership & Management at Unit Level	CUR 334	28	56	42
Therapeutic Management of Mental Illness	NRS 411	56	154	55
Management and Rehabilitation of Psychiatric Patients	NRS 412	56	154	55
Gender-based Violence as Public Health Issue	NRS 401	28	104	65
Professional Practice	NRS 421	–	–	–
Research Methods	NRS 423	–	–	–

5.4.2. Learning and teaching related aspects

This attribute encapsulates the aspects that relate to the transmission of knowledge. The main parameters that could be identified in the module guides, were those related to the teaching pedagogy, as well as the learning and teaching strategies, employed by the modules, to engage students with the content. Table 5.5 contains an overview of the extraction made.

Table 5.5: Learning and teaching pedagogy and strategies

Module topic	Teaching Pedagogy	Teaching Strategies
Foundations of Nursing 1 NUR 141	Skills laboratory method, self-directed learning	Skills demonstration , skills practice
Foundations of Nursing 1 NUR 151	Not defined	Group work, role play, scenarios, case study presentations, Ikamva (e learning), visiting specialist, theoretical input during presentations
Laboratory clinical NRS 142	–	–
Fundamentals of Nursing 1 NRS 152	Case-based teaching and learning approach.	Group work, role play, scenarios, case study presentations, Ikamva (e learning), visiting specialist, theoretical input during presentations.
Introduction to Philosophy of Care IPC 124	Not defined	Group work, role play, scenarios, case study presentations, Ikamva e learning), visiting specialist, theoretical input during presentations.
Health development & Primary Health Care HDP 116	Not defined	Lectures, group work, role play, scenarios, case study presentations, Ikamva (e learning), visiting specialist, theoretical input during presentations.
Fundamental of Nursing NUR 111	Case-based, Principles of Competency Based Education.	Group work, role play, scenarios, case study presentations, Ikamva (e learning), visiting specialist, theoretical input during presentations.
Assessment and Care CUR 111	Not defined in the module guide	Out of class activities include attending skills lab, watching audio material, attending fundamentals of nursing class, using library, evidence of reflective journaling, using learning contracts, simulation, portfolio of evidence.
General Nursing NRS 211	Case-based, Principles of Competency Based Education.	Group discussions, assignments, self-study utilising multi-media resources, library resources, extra reading & research; peer group teaching, e learning, class room presentations, tutorials, face to face, self-directed and guided clinical practice.
General Nursing NRS 212	Case-based, Principles of Competency Based Education.	Group discussions, assignments, self-study utilising multi-media resources, library resources, extra reading & research; peer group teaching, e learning, class room presentations, tutorials, face to face, self-directed and guided clinical practice.
Introduction to Mental Health CUR 214	Evidence of case-based, not defined	Lectures, group work, case discussions, independent work and consolidatory sessions.
Child Health Nursing NRS 313/324	Case-based, Principles of Competency-Based Education.	Student-centred, self-directed, case-based approach.
Primary Care & Skills CUR 312/325	Not defined in the module guide	Using scenarios.
High Risk Midwifery CUR 327	Case-based learning approach	Solving cases, small group work, group presentation, lecture discussions, self-directed learning and a reflective approach.
High Risk Midwifery CUR 327	Case-based learning approach.	Solving cases, small group work, group presentation, lecture discussions, self-directed learning and a reflective approach.
Low Risk Midwifery CUR 326	Case-based learning approach.	Solving cases, small group work, group presentation, lecture discussions, self-directed learning and a reflective approach.
Community Health Nursing CUR 311/324	Case-based Learning.	Group discussions and case studies in class, online activities using Ikamva (e learning), small group consultations.
Nursing Leadership & Management at Unit Level CUR 334/336	Constructive learning approach with principles of adult learning	Core lectures, active participation in assignments, group discussions, debates, seminars, role playing and other.

Module topic	Teaching Pedagogy	Teaching Strategies
Therapeutic management of Mental Illness NRS 411	Case-based teaching and learning approach.	Group work , role, play, scenarios, case study discussions, blended learning, and theoretical input
Management and Rehabilitation of Psychiatric Patients NRS 412	Case-based teaching and learning approach.	Group work , role, play, scenarios, case study discussions, e-teaching, and theoretical input
Gender-based Violence as Public Health Issue NRS 401	Case-based, augmented with service learning.	Group work, block post case study discussions. project reflections, structured reflections on theory, e-teaching, journal club activities, theory input during presentations
Professional practice NRS 421	–	–
Research methods NRS 423	–	–

5.4.3. The need to create a praxis

The nursing profession combines physical science, social science, nursing theory, as well as nursing practice and technology, when integrating care to individuals. Therefore, it became essential for the researcher to understand the praxis that emanates from the modules offered in the curriculum. The module guides provided a blueprint of the manner in which the module unfolds. Nursing module guides reflect the clinical, as well as theoretical components, in an integrated manner. In Table 5.6, the researcher provides corroboration from the extracted data, to support the evidence of praxis.

Table 5.6: **The need to create a praxis**

Module description	Practical component	Practical & Theory integration	Practical requirement/ objectives for practical
Foundations of Nursing 1 NUR 141	Theory component linked to NUR 151.	Course guide mentions but no integration evident in the course guide.	None
Foundations of Nursing 1 NUR 151	Introduction to case-based teaching and learning, case studies with triggers.	Theory only	None
Laboratory clinical NRS 142	Yes	Not clear	Yes
Fundamentals of Nursing 1 NRS 152	Not part of module linked to 142.	One activity refers to clinical placement.	Not discussed in the guide.
Introduction to Philosophy of Care IPC 124	_	_	Not defined
Health Development & Primary Health Care HDP 116	No	_	No
Fundamental of Nursing NUR 111	No	_	Linked to CUR 111

Fundamental of Nursing NUR 112	No	_	Linked to CUR 111
Assessment and Care CUR 111	Yes	No	Yes
General Nursing NRS 211	Yes	As stated in the course guide but no evidence in the course guide of integration on the week by week schedule.	Yes
General Nursing NRS 212	Yes	As stated in the course guide but no evidence in the course guide of integration on the week by week schedule.	Yes
Introduction to Mental Health CUR 214	No	No	No
Child Health Nursing NRS 313/NRS 324	Yes	Clinical integrated in the module not integrated in the week by week schedule. Clinical objective relate directly to the main content.	The practical objectives relate to the weekly sessions. However, the theory sessions do not refer to the practical objectives met in clinical practice.
Primary Care & Skills CUR 312/CUR 325	Yes	Clinical integrated in the module not integrated in the week-by-week schedule. Clinical objective relate directly to the main content.	Yes
High Risk Midwifery CUR 327	Yes	Clinical integrated through discussions, no skills referenced in the course guide	Yes
Low Risk Midwifery CUR 326	Yes	Clinical integrated through discussions, no skills referenced in the course guide	Yes
Community Health Nursing CUR 311	Yes a community project	The project is integrated with sessions, twice reference is made to the project, and project starts out with an assessment and needs are identified with which students work.	Yes
Nursing Leadership & Management at Unit Level CUR 334	Descriptor identified practical time allocated, no evidence of practical	_	_
Therapeutic Management of Mental Illness NRS 411	Clinical placement	Clinical hours attached, however, no clear link made in course guide between theory and practice.	Yes, clinical requirements, course guide refers to skills, module should be studied in relation to skill work books
Management and Rehabilitation of Psychiatric Patients NRS 412	Practical, outreach project	Clinical hours attached, however, no clear link made in the course guide between theory and practice.	Yes, clinical requirement, outreach project - not defined and no objectives found in module guide
Gender Based Violence as Public Health Issue NRS 401	Yes Service learning Project	Clinical and theory well integrated, plate into each other, theory plated into project, students reflect both ways	The theory objectives are the objective for the projects, and based on the need's assessment conducted
Professional Practice NRS 421	_	_	_
Research Methods NRS 423	_	_	_

5.4.4. Profiling of assessments

Table 5.7 comprises the mapping of the assessments. The nature of the assessments is also displayed, as well as how they are distributed between the formative and summative assessments per module, versus the number of credits of the module. Predominantly, tests are conducted to assess theory, and clinical assessments to assess the clinical. Occasionally, class presentations and case studies are conducted to facilitate the theory.

5.4.5. Attributes relating to outcomes

In Table 5.8, the modules that are orientated towards the community are reflected, as per those highlighted in grey. Generally, the main outcomes were not associated and aligned with community needs.

Table 5.7: Assessment per module

Module code	Credits	FORMATIVE								SUMMATIVE	
		1	2	3	4	5	6	7	8	1	2
NUR 141	10	Clinical 1: Hygiene 20%	Clinical. 2: Mobilisation 20%	Clinical placement report 20%	Portfolio 30%	Clinical Attendance 10%	NA	NA	NA	Theory exam 100%	NA
NUR151	15	Online Test 20%	Assignment 20%	Test 2 20%	Take home 10%	Multiple Choice 20%	Group work 10%	NA	NA	Theory exam 100%	N.A
NRS142	–	–	–	–	–	–	–	–	–	–	–
NRS152	5	Test 1 10%	Test 2 10%	Test 3 20 %	Group assignment 10%	Peer assessment 5%	NA	NA	NA	Theory exam 100%	NA
IPC 124	5	Community visit- group assignment	Individual reflection	Class test	Individual reflective tasks	NA	NA	NA	NA	Theory exam 100%	NA
HDP 116	5	Group presentation	Class test	Group assignment - community profile	Individual assignment	NA	NA	NA	NA	Theory exam 100%	NA
NUR 111	15	–	–	–	–	–	–	–	–	Theory exam 100%	NA
NUR 112	15	–	–	–	–	–	–	–	–	Theory exam 50%	Clinical exam 50%
CUR111	15	Clinical assessm. 1: Hygiene	Clinical assessm. 2: Mobilisation	Clinical assessm. 3: Urine analysis	Clinical assessm.4: Homeostasis	Clinical assessm. 5: Wound Care	Portfolio of evidence	NA	NA	NA	Clinical exam 100%
NRS211	20	Test 1	Test 2	Case study	Clinical skill 1	Clinical skill 2	Progress reports	Clinical learning activities SDL	Quiz	Theory exam 50%	Clinical Exam 50%
NRS212	20	Quiz	Test 1	Test 2	Clinical skill 1	Clinical skill 2	Case study	Progress reports	Clinical learning activities	Theory exam 50%	Clinical exam 50%
CUR 214	10	Online test	Sit down test	Group presentation	NA	NA	NA	NA	NA	Theory Exam 100%	NA

Module code	Credits	FORMATIVE								SUMMATIVE	
		1	2	3	4	5	6	7	8	1	2
NUR 141	10	Clinical 1: Hygiene 20%	Clinical . 2: Mobilisation 20%	Clinical placement report 20%	Portfolio 30%	Clinical Attendance 10%	NA	NA	NA	Theory exam 100%	NA
NUR151	15	Online Test 20%	Assignment 20%	Test 2 20%	Take home 10%	Multiple Choice 20%	Group work 10%	NA	NA	Theory exam 100%	N.A
NRS142	–	–	–	–	–	–	–	–	–	–	–
NRS152	5	Test 1 10%	Test 2 10%	Test 3 20 %	Group assignment 10%	Peer assessment 5%	NA	NA	NA	Theory exam 100%	NA
IPC 124	5	Community visit- group assignment	Individual reflection	Class test	Individual reflective tasks	NA	NA	NA	NA	Theory exam 100%	NA
HDP 116	5	Group presentation	Class test	Group assignment - community profile	Individual assignment	NA	NA	NA	NA	Theory exam 100%	NA
NUR 111	15	–	–	–	–	–	–	–	–	Theory exam 100%	NA
NUR 112	15	–	–	–	–	–	–	–	–	Theory exam 50%	Clinical exam 50%
CUR111	15	Clinical assessm. 1: Hygiene	Clinical assessm. 2: Mobilisation	Clinical assessm. 3: Urine analysis	Clinical assessm.4: Homeostasis	Clinical assessm. 5: Wound Care	Portfolio of evidence	NA	NA	NA	Clinical exam 100%
NRS211	20	Test 1	Test 2	Case study	Clinical skill 1	Clinical skill 2	Progress reports	Clinical learning activities SDL	Quiz	Theory exam 50%	Clinical Exam 50%
NRS212	20	Quiz	Test 1	Test 2	Clinical skill 1	Clinical skill 2	Case study	Progress reports	Clinical learning activities	Theory exam 50%	Clinical exam 50%
CUR 214	10	Online test	Sit down test	Group presentation	NA	NA	NA	NA	NA	Theory Exam 100%	NA
NRS 313/ NRS 324	15	Test 1	Evidence of clinical learning/skill online tut.	Case presentation	Theory Exam	Clinical Exam	NA	NA	NA	Theory exam 50%	Clinical Exam 50%
CUR 312/ CUR 325	15	Test 1	Case based presentation	Clinical skills History taking & physical assessment	Clinical evidence gathered	Online tutorial	NA	NA	NA	Theory exam 50%	Clinical Exam 50%
CUR 327	15	Test 1	Class presentation	Clinical evaluation	NA	NA	NA	NA	NA	Theory exam 50%	Clinical exam 50%
CUR 326	30	Test 1	Class presentation	Quiz x1	Clinical Evaluation	Partograph	NA	NA	NA	Theory exam 50%	Clinical exam 50%
CUR 311	30	Test 1	Community assignment projects at clinical facility for clinical hrs.	Community health promotion day	School health online assignment based on reading assigned	Occupational health online assignment based on reading assigned	NA	NA	NA	Theory exam 100%	NA
CUR 334	20	Test 1	Test 2	Assignment/ clinical evidence	NA	NA	NA	NA	NA	Theory exam 100%	NA

Module code	Credits	FORMATIVE								SUMMATIVE	
		1	2	3	4	5	6	7	8	1	2
NRS 412	30	Test 1	Test 2	Outreach project	Clinical assessment	NA	NA	NA	NA	Theory exam 50%	Clinical Exam 50%
NRS 401	20	Test 1	Reflective practices	Journal Club	Examination project present & file	NA	NA	NA	NA	Theory exam 100%	NA
NRS 421	20	Assignment	Assignment	–	–	–	–	–	–	Portfolio 80%	Assignment 20%
NRS 423	20	Test	Test	–	–	–	–	–	–	–	–

Table 5.8: Curricular outcomes and content

Module code	Module topic	Main outcomes	Main content
		Level 1	
NUR141	Foundations of Nursing 1	Communication, personal hygiene, elimination, activity and stimulation death and dying, infection control.	Communication, personal hygiene, elimination, activity and stimulation death and dying, infection control.
NUR151	Foundations of Nursing 1	Communication for supportive relationships, ethno-socio-cultural care to individuals of all age groups, ethic and legal codes in nursing, apply nursing process to care of basic needs.	Interpersonal communication, basic needs and care, ethics and contextual factors influencing care.
NRS142	Laboratory clinical	NA	NA
NRS152	Fundamentals of Nursing 1	Practice in accordance with ethical and legal codes of nursing and the laws of the country. Demonstrate ability to assess, plan, implement and evaluate care plans to meet activities of daily living needs of individuals and families throughout the life stages including homeostasis, nutrition, well-being, safety and learning. Provide nursing care to a terminally ill patient and support to the family. Share information to promote effective decision making. Demonstrate ability to apply academic, numeracy and computer skills in own learning, as well as ability to work in group and critical analysis of clinical cases.	Nursing ethics, scope of practice and legislation. Needs of individuals and families throughout the life stages. Homeostasis, nutrition, well-being, safety and learning. Terminal care. Interaction with members of the multi-disciplinary and multi-sectoral teams.
IPC 124	Introduction to the Philosophy of Care	Identify and solve problems, teamwork, organisational and management, collect and evaluate information, communication, problem solving, reflect and explore learning strategies, responsible citizenships cultural and ethical sensitivity.	Care, moral concepts, ethics and human rights, ethical and moral dilemmas, professional conduct.
HDP 116	Health Development & Primary Health Care	Identify and solve problems, teamwork, organisation and management, collect and evaluate information, communication, problem solving, reflect and explore learning strategies, responsible citizenships cultural and ethical sensitivity.	Health and determinants, approaches to care, working in communities.
		Level 2	
NUR 111	Fundamental Of Nursing	Communication for supportive relationships, ethno-socio-cultural care to individuals of all age groups, ethic and legal codes in nursing, apply nursing process to care of basic needs.	Interpersonal communication, basic needs and care, ethics and contextual factors influencing care.
CUR111	Assessment and Care	Demonstrate the ability to assess, communicate and take care of basic needs of individuals of all age groups, demonstrate ability to apply principles of infection control in the provision of care, demonstrate competence in communicating effectively with individuals of all age groups during history taking, and demonstrate competence in provision of emergency care to individuals.	Assessment, management and communication of basic needs of individuals of all age groups with regard to comfort (physical, psychological, spiritual, hygiene, nutrition, elimination, internal homeostasis and mobility, rest and sleep, principles of infection control, barrier nursing and wounded, emergency care, terminal care, death and dying).

Level 3			
NRS211	General Nursing	Comprehensive management of illness.	Specialised and systems related health issues.
NRS212	General Nursing	Comprehensive management of illness.	Specialised and systems related health issues.
CUR 214	Introduction to Mental Health	Basic concepts and terminology, primary mental healthcare, preventative and promotive care in mental health, understand mental health and mental illness, screen clients and families.	Basic concepts and terminology, primary mental healthcare, preventative and promotive care in mental health, understand mental health and mental illness and its causes, social problems, screen clients and families, common mental disorders.
Level 4			
NRS313 NRS324	Child Health Nursing	Growth and development, integrated child health illness and child and adolescent services.	Growth monitoring, expanded programme on immunisation and integrated management of childhood illnesses.
CUR312 CUR325	Primary Care & Skills	History taking to various systems of body, physical assessment techniques, management of common conditions, demonstrate understanding of ARVs.	Integrated assessment, diagnostic and management skills with endemic conditions related to all body systems, provincial health plan.
CUR327 CUR332	High-risk Midwifery	Identify and refer complicated pregnancy during intra and postnatal care, obstetrical emergencies, high risk neonate, women of child bearing age.	Safe pregnancy, safe motherhood, common maternal health issue, common neonatal health issues.
CUR326 CUR332	Low Risk Midwifery	Assess and maintain health status of a pregnant woman and developing foetus, prepare mother and family for pregnancy, maintain health status during pregnancy.	Low risk pregnancy, low risk, labor, low risk pueperium, low risk neonate.
CUR311	Community Health Nursing	Prevention of communicable diseases, epidemiology, spirometric screening, audiometric screening, trends in health status, assessments in the community.	Communicable and non-communicable diseases, occupational health screening, population-based health promotion, epidemiological principles.
CUR334	Nursing Leadership & Management at Unit Level	Policies, philosophy of a unit, leadership skills, quality improvement strategies.	Health policy development, resource management, quality assurance.
Level 5			
NRS411	Therapeutic Management of Mental Illness	NA	Mental health act, psychiatric assessment, psychosocial rehabilitation, social versus therapeutic relationships, support groups, family structure and dynamics, communication patterns and developmental tasks, trauma debriefing.
NRS412	Management and Rehabilitation of Psychiatric Patients	Therapeutic and safe environment, implement an evaluate nursing intervention for extreme emotional and behavioural disturbances in mentally ill patients, family centred care , functional assessments, barriers to rehabilitation and developed rehabilitation plans.	Psycho-pharm, psycho-pathology, ethical dilemmas in psychiatric nursing care, physical and psychological intervention, disabilities, theories and models of rehabilitation, de-institutionalised care, community support care.
NRS401	Gender Based Violence (GBV) as Public Health Issue	Magnitude of GBV, theoretical and legal frameworks, intervention strategies.	Manifestations of GBV, epidemiology, models for understanding, legal frameworks, advocacy and empowerment, and general interventions.
NRS421	–	–	–
NRS423	–	–	–

5.4.6. Demarcating graduate attributes and specific outcomes per year level

A number of graduate attributes (GA) are embraced by the University of the Western Cape that are viewed in two tiers. Tier 1 includes a general scope of objectives, as could be expected of an institution of higher education, namely *scholarship* (GA 1), *citizenship and social good* (GA 2), and *lifelong learning* (GA 3). In Tier 2, the graduate attributes (GA 4 to GA 9) are more specific, and could be viewed as outcomes to work towards and to be achieved within, and through the course modules. Therefore, course content and teaching methodology would have been directed toward exposing the

students to learning experiences, to fulfil and meet these outcomes. Table 5.9 has relevance and is presented below.

In year level 2, GA 6 to GA 9 are evident in the course modules, being *autonomous and collaborative* (GA 6), *ethically, environmentally and socially aware and active* (GA 7), *skilled communicators* (GA 8) and *interpersonal flexibility and confidence to engage across difference* (GA 9). By year level 3, these attributes are maintained and developed, while GA 5 (*critically and relevant literate*) is added to the expectations. By year level 4 and 5, GA 4 (*inquiry-focused and knowledge*) becomes evident, along with the rest. It is clear that across the five years of study, there appears to be a logical progression, which, theoretically, makes the outcomes achievable, with the possibility of becoming entrenched.

Table 5.9: Application of University of the Western Cape graduate attributes (GA)

Academic level	TIER 1			TIER 2						Description
	GA 1	GA 2	GA 3	GA 4	GA 5	GA 6	GA 7	GA 8	GA 9	
	Scholarship	Citizenship and social good	Lifelong learning	Inquiry-focused and knowledge	Critically and relevant literate	Autonomous and collaborative	Ethically, environment-ally and socially aware and active	Skilled communi-cators	Interpersonal flexibility and confidence to engage across difference	
Year level 1	_	_	_	_	_	_	_	_	_	No articulation of graduate attributes evident in any of the modules as per F1 and F2.
Year level 2	_	_	_	_	_	x	x	x	x	GA evident, not recent set adopted by university. Only met 4 GA under TIER 2.
Year level 3	_	_	_	_	x	x	x	x	x	GA 5 – GA 9 evident and covered.
Year level 4	x	x	_	x	x	x	x	x	x	GA 4 – GA 9 covered, well aligned with learning and teaching activities.
Year level 5	x	x	_	x	x	x	x	x	x	GA 4 – GA 9 covered, well aligned with learning and teaching activities.

5.5. CE Typology and SL elements

The mapping of the curriculum also provided the opportunity to review the existing CE typology, as well as the existing management of the SL elements in the undergraduate nursing curriculum.

5.5.1. Existing CE typology

The findings of the curriculum map also provided the opportunity to review the module guides for the CE Typology and the SL elements.

Table 5.10: **Bachelor of Nursing programme: Elements of service learning**

Module	Structured reflection	Reciprocal learning	Service provision	Community partnerships	Authentic experiences	Academic discourse	Curricular integration
NUR 141	–	–	x	x	x	–	–
NUR 151	–	–	x	x	x	–	–
NUR 142	–	–	x	x	x	–	–
NUR 152	–	–	x	x	x	–	–
HDP 116	–	–	x	x	x	–	–
NUR 111	–	–	x	x	x	–	–
NUR 112	–	–	x	x	x	–	–
NRS 211	–	–	x	x	x	–	–
NRS 212	–	–	x	x	x	–	–
CUR 214	–	–	–	–	–	–	–
CUR 311/324	x	x	x	x	x	–	x
CUR 312/325	–	–	x	x	x	–	–
NRS 313/324	–	–	x	x	x	–	–
CUR 326/331	–	–	x	x	x	–	–
CUR 327/332	–	–	x	x	x	–	–
CUR 334/336	–	–	–	–	–	–	–
NRS 411	x	x	x	x	x	–	–
NRS 412	x		x	x	x	–	x
NRS 401	x	x	x	x	x	–	x
NRS 423	–	–	–	–	–	–	–
NRS 421	–	–	–	–	–	–	–

5.5.2. SL elements

5.5.2.1. Reflective practices

In Table 5.10, the reflective practices, evident in each year level, are summarised. Predominantly, the modules reviewed use reflection. Reflection, therefore, is a common practice in the Bachelor of Nursing curriculum; however, predominantly, it is unstructured, as no evidence could be retrieved that indicated structured reflection. One module, namely NRS 401, utilised structured reflection methods, through the use of the Gibbs model for reflection (Gibbs, 2013).

5.5.2.2. Reciprocal learning

The majority of modules reviewed, did not demonstrate that reciprocal learning was a priority in the curriculum. No evidence could be established with majority of the module guides. The modules mostly prescribed to a one-way learning dimension, which benefited the student. One module, in its description and overview, clearly reflected that reciprocal learning formed part of the corner stones of the module, which was scheduled to facilitate student learning and community. Most modules advocated student learning, as the purpose.

5.5.2.3. Community partnerships

All modules, except CUR 214, NRS 421 and NRS 423, had partnerships in place, which played a pivotal role in achieving the outcomes associated with the modules, as provided in Table 5.10. These partnerships included those with Department of Health, Non-Governmental Organisations, City of Cape Town, and Communities. Only three modules had partnerships with communities, which were not formalised through the Department of Health.

5.5.3. Nature of service

The following dimensions of the nature of the service were explored, namely, service provision, goal of the service, and beneficiaries of the service.

5.5.3.1. Service provision

All the modules had a clinical component attached. This occurrence automatically provided opportunities to attach service to the activities, where students were required to display competence, as displayed in Table 5.11.

Table 5.11: **Bachelor of Nursing programme: Nature of service**

Module	Service provision	Goal of service	Beneficiary of service
NUR 141	Yes	SL	Student
NUR 151	Yes	SL	Student
NUR 142	Yes	SL	Student
NUR 152	Yes	SL	Student
IPC 142	NA	SL	Student
HDP 116	NA	SL	Student
NUR 111	Yes	SL	Student
NUR 112	Yes	SL	Student
NRS 211	Yes	SL	Student
NRS 212	Yes	SL	Student
CUR 214	NA	NA	NA
CUR 311/324	Yes	SL and CS	Reciprocal learning
CUR 312/325	Yes	SL	Student
NRS 313/324	Yes	SL	Student
CUR 326/331	Yes	SL	Student
CUR 327/332	Yes	SL	Student
CUR 334/336	Yes	SL	Student
NRS 411	Yes	SL	Student
NRS 412	Yes	SL and CS	Student
NRS 401	Yes	SL and CS	Reciprocal learning
NRS 423	No	NA	NA
NRS 421	No	NA	NA

CS=Community Service SL=Student Learning

5.5.3.2. Goal of the service

The modules mainly prescribed to student learning. The activities that related to service were purely for student learning purposes. One module in Level 5 of the curriculum was framed to deliver a service, as well as student learning; therefore, this module adhered to the SL methodology.

5.5.3.3. Beneficiaries of the service

The majority of the modules in the Bachelors of Nursing curriculum advocated for student learning only. Two modules, namely the CUR 311 and NRS 401, had a combination of student learning and community learning, through the promotion of

the outcomes of modules. The module NRS 401 adhered to SL methodology, whereas CUR311 utilised a community outreach project, to facilitate some of the module outcomes.

5.5.4. Responsiveness to community needs

The evidence that these modules addressed societal needs was absent. The majority of the modules addressed clinical learning aspects that consisted of physical skills taught in the skills lab, as per the programme requirements. The activities were distant from graduate attributes and most did not relate to them. One of the main concerns noted, was the level of responsiveness, which was non-existent in the module guides. Three modules provided attempts to address societal needs, namely, CUR311 or CUR324, NRS 412, and NRS 401. The first module (CUR311 or CUR324), offered in Level 4, provided evidence that students were required to assess the needs of community, and address the needs with relevant health promotion. The module articulated this health promotion project, using a community outreach typology to be achieved. The Health promotion project corresponded with module outcomes, and at times, addressed specific learning objectives during lecture sessions. Students were also required to participate in reflection activities. These reflection sessions were scheduled at the end of the module, and could be described as group reflection, personal reflection, and reflection with the community that was served. Academic credits were attached to the outreach project/health promotion project.

Another module, NRS412 in Level 5 of the programme, also included a community outreach project. The objective of this module was not clearly defined, and was loosely linked to outcomes, by meeting the needs of the community, served. It was not directly linked to clinical practical sessions. The brief descriptions that were provided about the project, did not include reflection, and was not structured to coincide with theory, as it did not relate, specifically, to the content of the module. Therefore, the module served no purpose to transform society or higher education.

The last prominent module was NRS401, which prescribed to the SL methodology, and was structured accordingly. This module was framed within psychiatric nursing science, and related to forensic nursing, which could be described as a branch in the field of psychiatric nursing sciences. This module addressed gender-based violence, and the students served vulnerable communities, using their existing knowledge, skills and

values, at this stage of their training. The students were required to complete a needs assessment, and achieve all outcomes, by engaging with the community to address its most pressing needs.

Reflection was structured every second week. This was because students started out by making contact and gaining entry into the community, followed by a class session, every alternate week. During this week, reflection was scheduled to facilitate the session, commencing by reflecting on the theory and consequently, linking it to the project. An extract was noted of the week-by-week schedule of the module, which revealed how this was operationalised (Appendix F). This module integrated blended learning, using the official e-learning platform, to allow small group reflections. Students also reflected in their groups before class contact, and could rely on this to participate in larger group discussions facilitated by the nurse educators. The learning and teaching activities were phrased creatively, to stimulate critical thinking. These activities that were scheduled as class activities, were often required to supplement the activities, which students were required to perform, during community contact. All reflective activities were required to demonstrate evidence of the Gibbs (2013) Model of Reflection.

Table 5.12: **Modules linked to social transformation**

Module	Societal transformation
NUR 141	–-
NUR 151	–-
NUR 142	–-
NUR 152	–-
IPC 142	–-
HDP 116	–-
NUR 111	–-
NUR 112	–-
NRS 211	–-
NRS 212	–-
CUR 214	–-
CUR 311/324	Module prescribes to an outreach project. Students conducts a needs assessment in collaboration with the community and attempt to meet required needs according to course objectives. Reflection takes place however not as frequent as required. Reflective practice contributes to assessments and is imbedded in
CUR 312/325	–-

NRS 313/324	–-
CUR 326/331	–-
CUR 327/332	–-
CUR 334/336	–-
NRS 411	–-
NRS 412	Module prescribes to an outreach project. Students conducts a needs assessment in collaboration with the community and attempt to meet required needs according to course objectives. Reflection takes place however not as frequent as required. Reflective practice contributes to assessments and is imbedded in
NRS 401	Module prescribes to an SL project. Students conducts a needs assessment in collaboration with the community and attempt to meet required needs according to course objectives. Reflection is part and partial assessment and forms an inherent component of determining competence. R
NRS 423	–-
NRS 421	–-

5.6. Objective 2

A grading rubric was used to determine the potential of each module that would contribute to the existing CE typology, as well as the SL potential of the modules. The CEGR was used in a self-assessment for the purpose of Objective 2.

5.6.1 Reliability of CEGR

The pilot study was conducted to subject the CEGR to psychometric testing, as explained in chapter 4. (Objective 2). The testing allowed the nurse academics to assess the module NRS401, using the CEGR. NRS401 was selected to be tested, as it is demonstrated the utilisation of the SL pedagogy, which was blended with the case-based learning method, and was the predominant methodology used in the nursing curriculum. The pilot study, therefore, allowed for psychometric testing of the CEGR.

Psychometric testing was performed on the rubric, using the Cronbach's Alpha coefficient, which was 0.739 for the instrument. The inter-rater reliability was 51.7% for section A, and 55.7% for section B. The intra-rater reliability of 64.2 % was obtained (as explained in Chapter 4). All these provided some measurement of reliability scoring. The I relevant information is provided later, using matrix tables to demonstrate the results of the grading rubric, followed by a brief description, which is used at a later stage, when interpretations and discussions of the objectives are presented.

5.6.2. Findings of the Self-Assessment using CEGR

The following was observed and noted about the self-assessment, as expressed in Table 5.13.

Table 5.13: Self-assessment exercise

Module	Service provision	Goal of service	Beneficiary of service	Structured reflection	Reciprocal learning	Service provision	Community partnerships	Authentic experiences	Academic discourse	Curricular integration	Transform student
NUR 141	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
NUR 151	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
NUR 142	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
NUR 152	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
IPC 124	NA	Low	Low	Low	Low	High	High	High	Low	Low	Low
HDP 116	NA	Low	Low	Low	Low	High	High	High	Low	Low	Low
NUR 111	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
NUR 112	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
HDP116	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
NRS 211	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
NRS 212	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
CUR 214	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low
CUR 311/324	High	High	High	High	High	High	High	High	High	High	High
CUR 312/325	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
NRS 313/324	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
CUR 326/331	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
CUR 327/332	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
CUR 334/336	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
NRS 411	High	Low	Low	Low	Low	High	High	High	Low	Low	Low
NRS412	Med	High	Low	High	–	Low	High	Med	–	High	Med
NRS401	High	High	High	High	High	High	High	High	High	High	High
NRS 423	No	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low
NRS 421	No	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low

In Table 5.13, an overview of how modules scored on the self-assessment exercise is provided. This finding relates to those, yielded in the curriculum mapping exercise in objective 1 (see Table 5.11 & 5.12). For the purpose of this current study, explaining this methodology, using quantitative terminology, was avoided, as the intention was to create more objectivity, through a subjective investigation. The main finding from Table 5.13 indicates that a correlation coherence exists between the scoring of the 5 nurse educators in round 1 and 2, who participated in the pilot study of the CEGR.

Lastly, Objective 3 of this current study was imbedded in Objective 1 and 2, as well as part of Phase 1. The findings of this objective are presented in Chapter 7, under section 7.7. This permitted the voices of the participants (nurse educators) to strengthen the findings with their learning and teaching experiences.

5.7. Summary

A review of the objectives, as well as how they articulated with the conceptual framework, was addressed, followed by the statement of the findings for Phase 1, according to Objective 1 and Objective 2. Accordingly, Objective 1 (document analysis) resulted in attributes being identified that would provide an opportunity to draw on the issues of key interest for this current study. The findings of the Objective 2 were stated, namely, the existing classification of typology of CE, as well as management of the quality of SL element in the undergraduate curriculum. Objective 3 is discussed as part of Chapter 7. The next chapter, Chapter 6, comprises the findings of Phase 2 of this current study.

CHAPTER SIX

PHASE 2: RESULTS & FINDINGS

6.1. Introduction

In this chapter, the researcher focuses on the findings of Phase 2, and commences with Objective 4 of this current study, while, simultaneously, initiating the second dimension of the Kotter Organisational Change Theory. The latter is infused in the study, as part of the conceptual framework, namely, communicating the vision, and empowering others to act on the vision, as well as providing methodological support, as grounding for the findings of Objective 4.

In Phase 2 (Objective 4), a transformational process was followed, during consultations with nurse educators, to further explore the curriculum aspects that relates to the learning and teaching practices. The researcher conducted interviews with educators of each year level of the nursing curriculum. The purpose was to examine the results of the document analysis, which provided the researcher an opportunity to understand the dimensions. This provided more depth, provided clarity and contributed to the rigor of the study.

Following the previous step of Kotter's Organisational Change Theory, the researcher manages this chapter, through a continued effort to communicate the developed vision for SL pedagogy. For the implementation of *empowering others to act on the vision*, consultations with the nurse educators were conducted, to consider their specific learning and teaching experiences, regarding the CE typology and the elements of SL, as explored in Objective 2. A session was conducted with the nurse educators, allowing an opportunity to respond to the learning and teaching practices that were identified and formulated in the CET, regarding the SL potential. Subsequently, these findings are utilised to update the existing SL pedagogy. The findings of this objective are discussed in Chapter 7, in conjunction with other findings, to finalise the SL pedagogy.

6.2. Data analysis

The data analysis was applied according to the data analysis plan, created in Chapter 3. An interview schedule was used to assist in obtaining information from nurse educators. Pseudo names were used to protect the anonymity of the participants who voluntary participated in the interviews. The interview schedule contained questions regarding the learning and teaching practices, to which the participants were required to respond. The questions did not probe for specific SL aspects, but rather focused on the reality of the nurse educators, as they shared the requirements of the module. The themes and the categories emerged as the codes were studied for connections, patterns, and interrelationships between the comments made, against the transcripts and the conceptual framework, as guided by the first four principles of curriculum development. This resulted in a reduction of the data volume, while maintaining the script of the nurse educators' experiences. These themes, ultimately, reflect and display the interpretation attached to the data set, as well as provide descriptions of the experiences of the nurse educators, who participated in this current study. Atlas ti version 8 allowed the grouping of codes, categories, and later, smart groups that formed the themes of the data set. An independent coder was employed to review the codes created, which were grouped and categorised. This allowed objectivity, and limited the voice of the researcher, to that of the participants, as expressed by them. Therefore, the themes illustrate the collaboration between the participants' description and the interpretative meaning that, ultimately, was attached to these descriptions.

6.3. Emergent themes, categories and codes

During the analysis of the data collected during Phase 2 for Objective 4 of this current study, six themes, 29 categories, and numerous codes, relevant to the exploration, were identified. Table 6.1 illustrates the six themes that were generated, and indicates how the findings were grounded in the conceptual framework. Each theme is broadened, by eliciting the main excerpts that were transferred into a category. Each category further encloses codes, which operationalise the meaning of the category, giving effect to the associated theme.

In this chapter, the researcher continues to introduce and develop each theme by means of an introduction to the theme, the category, and the code, as well as a description of the meaning attached to the code.

Table 6.1: Themes and categories based on conceptual framework

Conceptual framework	Themes	Categories
Essence of curriculum design, need for a conceptual underpinning (Ideology)	**Theme 1:** Nature of nursing and nurse training	Ethos and practice of nursing
		Collaboration in care
		Community as a landscape for nursing practice
		Implications for nurse training
Conceptualising attitudes and beliefs about learning	**Theme 2:** Domain/dimensions of learning	Exploring educational altitude
		Progression in learning
Epistemic rationale	**Theme 3.1:** Learning and teaching practices	Teaching traditions, strategies, methods and activities
		Social media and utilisation of technology
		Learning and teaching relating to clinical practicum
		Reflective practices in learning
		Authentic engagements
		Planning educational activities
		Opportunities to integrate research and scholarship
		Feedback practices
		Working in groups
		Assessment practices in learning and teaching
		Content alignment & integration of theory
	Theme 3.2: Student-related aspects	Personal attributes of students
		Student engagement
		Behaviour of students
		Student entrepreneurship
	Theme 3.3: Educator-related aspects	Purpose of the educator
		Lecturer reflection
Political realities	**Theme 4:** Responsive curricula towards sustainable communities and accountable graduates	Environmental relevant content to curriculum
		Involvement and engaging with the community
		Critical citizenship: Being socially responsive
		Engaged institution
		Aligning content with current
		Outcomes aligned to CE practices
		Student engagement

6.3.1. Theme 1: Nature of nursing and nurse training

Theme 1 involves the nature of nursing and nurse training, which addresses what nursing is, how nursing is viewed, what the ideal platform for practising nursing is, how nurses should claim their role in society, and highlights the nurse training institutions, regarding how to structure nurse training, which should be in line with nursing practice. Four categories were identified that operationalise meaning and interpretation through the review and description of the associated codes. The culminating four categories include *ethos and practice of nursing*, *collaboration in care*, *community as a landscape for nursing practice*, and *implication for nurse training*.

6.3.1.1. Theme 1 – Category 1: Ethos and practice of nursing

Ethics is an integral part of the nursing profession, and forms one of its cornerstones. The ethos of nursing in South Africa pays tribute to the role and the responsibilities of nurse practitioners, towards the individuals, their families, and communities. The attributes necessitate nursing practitioners to safeguard, promote, and restore health, as well as prevent illness, or suffering, and preserve life (SANC, 2013). Ethos, therefore, is indigenous to the profession and maintains priority in the practice of nursing.

The following codes emerged from the data analysis under the category, *Ethos and practice of nursing*, namely, *advocacy for clients*; *developing ethical behaviour*; *nursing values*; *passion for caring*; and *universal ethical standards*. These codes reflect the views and practice requirements, relevant to the profession, illustrated and supported by the actual responses of the participants (names used are pseudonyms), which attach meaning to it.

(a) Advocacy for clients

The nurse acts as an advocate for the client, in times when the client is unsure about which decisions to make, or advice to follow. Nurses apply their knowledge of situations, in which the clients are trapped, or with which they have to cope, and ultimately, advocate for their clients, by voicing relevant concerns. Additionally, in the context of nursing, the nurse needs to promote, protect and optimise health, as well as prevent illness and injury. This advocacy role transcends the individual,

to include the family and the community, in which the clients find themselves. The following extracts refer:

> *"We advocate for our patients, if you do not know how things can go wrong with you, you cannot stand up for yourself. So we as nurses need to be leaders at what we do because nursing is a unique field."* **(Izelle)**

> *"It is a caring profession. It is a profession where you can guide, you can support, and you can nurture the client."* **(Daniela)**

> *"I believe that, as a nurse, I should provide the best possible healthcare and it should be comprehensive. In a sense, that I will provide for all the basic needs of the patient, be an advocate for the patient and look at the emotional, spiritual, physical, psychological well-being of the patient."* **(Hezekiel)**

Nursing, therefore, remains true to the existence of the client, who needs care that exceeds the normal expectation, to include making decisions. These could be effected through education and promotion of what is required to make ends meet.

(b) Developing ethical behaviour

Unethical and erroneous behaviour tends to disregard the client, while instilling ethics could be tough and demanding. However, constant attempts need to be made to ensure that nurses become more ethically inclined, to conduct their core function. One participant stated that she prioritises the development of ethical behaviour by sensitising students to ethics and morality, as well as how it impacts practice and the nurse his/herself. The following extract refers:

> *"Ethics is very important to me. So that is something that I will always talk about … ethics, morals; not just for patient care, but definitely for yourself."* **(Bonny)**

(c) Nursing values

Caring in nursing is best demonstrated through the values that are attached to the profession. Some of these include care, respect, and diversity, among others. A participant revealed the following about nursing values:

"They must also know how to respect others and how to respect the patient, and how to, if the patient differs from their opinion, how to respect that outcome of the patient." **(Daniela)**

Another participant stated that nursing is a religion in its own right, referring to the values attached to the profession, as follows:

"We are a religion on our own. We cannot, if you nurse anybody, you cannot have any feelings of negativity whether it is a different race, culture or … because it is within the values of nursing." **(Emily)**

(d) Passion for caring

Passion for caring remains central to the profession of nursing. Nurses spend a great deal of their time working with patients and their families; assisting them to sort out the choices they make regarding their healthcare. Educators need to instil passion in their students, which remains a daunting task. Passion is at the core, and integrated into the values of nursing. The participants acknowledged the priority that passion should receive in the nursing profession. The following extracts refer:

"Because I mean if you look at nursing and nursing care, it is all about care and I feel if we can start off with that …" **(Bonny)**

"I think when you come into the nursing profession, a prerequisite is probably that you need to be passionate about caring for people." **(Hezekiel)**

"What I mean when I say I'm a real nurse is I love people. I love to work with people. I am passionate about my work." **(Jolene)**

"I refer to the heart. We can teach you about it … we can provide you with knowledge. We can offer you skill, but we cannot give you the heart." **(Hezekiel)**

(e) Universal ethical standards

The South African Nursing Council prioritised the codes of ethics in a report published in 2013 (SANC, 2013). Ethics is not fragmented, and should be viewed

universally. What applies to one context, for example in a nursing ward, could be transferred to the community, as well. The following extract refers:

> *"... if you think about ethics, ethics in nursing, ethics in the community – there is a little bit of an overlap. It is basically based on the same understanding and underlying principles that have to do with patients."* **(Ann)**

Ethics is universal in nature. What applies to the context of the client remain in place when the client is in the proximity of his family and ultimately his community. Ethics in nursing is instinctive to the values associated with the profession: care, passion, love and respect. Nurses often advocate on these premises in their practice. However, the platform to instil knowledge and skill and an awareness regarding ethos and practice of nursing remains critical to the profession as expressed by the participants.

6.3.1.2. Theme 1 – Category 2: Collaboration towards care

Literature states that improved healthcare collaboration has been linked to improve patient outcomes. This implies that, if students collaborate, they could better provide the needs of those, whom they serve. A participant expressed the need and opportunities that were deemed relevant for nursing and nurse training.

(a) Teamwork and collaboration towards care

Teamwork provides opportunities to integrate more opportunities, in an attempt to achieve and improve outcomes. The participants expressed the opinion that it was impossible to survive in nursing, without embracing teamwork and collaboration. The following extracts refer:

> *"I talk about care and I feel that when you try and instil teamwork, it is not just a team for nursing."* **(Bonny)**

> *"We work in collaboration unlike any other practitioner."* **(Izelle)**

(b) Opportunities for inter-professional and inter-sectoral collaboration

Further collaboration could transpire on different levels, namely inter-professional, and inter-sectoral. Both approaches have been observed to be utilised as methods to engage nursing students. Inter-professional collaboration extends to those partners providing

health-related services, and includes social workers, physiotherapists, and occupational therapists. Inter-sectoral collaboration goes further and beyond the health-related services, to include other sectors, which could include the municipality, the police, as well as information and communication services. The following extracts refer:

> *"When they do community engagement, all the more they can see what impact they can have at the moment as a student and what it contains and how they must collaborate with the other departments like physio, occupational therapy, natural medicine so they can see their part."* **(Arona)**

> *"They are involved with a NGO (non-governmental organisations) that is working there and they also are involved with the municipality, police and those people they also have to go to, to find out information and request someone to assist them."* **(Arona)**

Collaboration provides opportunities for nurses to improve their services, as they could provide above and beyond what is required. This also commends and ensures a more comprehensive intervention, since each stakeholder could contribute significantly to the health outcomes.

6.3.1.3. Theme 1 – Category 3: Community as a landscape for nursing practice

Opportunities to practise nursing should exceed the doors of a health institution, so that services are not only curative orientated and institutionalised, but imbedded in Universal Health Coverage (UHC). Opportunities to practise nursing should include community-based settings, for example, home visits, outreach projects, among others.

(a) Being aware and synchronising theory with what is happening in the community

Nurses have the accountability to ensure that communities are educated and informed of how conditions in the community influence disease profiles. Community awareness, therefore, is a critical and essential component in ensuring preventative healthcare, as well as continuing and maintaining appropriate care in

curative care. Those responsible for the implementation of national and provincial health initiatives, should seek to realise all the factors that influence health. Similarly, health training institutions need to ensure that students are trained to address both extremes of the continuum of care, by involving the community as platform to develop skills. The following extracts refer:

> *"Also just looking at what is going on in the communities as well. To me that is making them more self-aware and also more self-aware of why they came to study and, with that, what are you expecting from a higher degree education?"* **(Bonny)**

> *"It is part of nursing because where our care is ultimately for the community. The patient, yes, but if you go into the different levels or if you go into paediatrics, it is not only the patient but it is the patient, the parents or the mother and that latches on for the support from the community or whoever is part of the referral as well."* **(Emily)**

> *"It was very useful that we actually go on the ground and actually go out to the houses because you do get people who can't, are not able to go. Even disabled children we found locked up in houses, I mean things like that. So it is important that we come down, for me, to the ground that we actually operate in the community."* **(Arona)**

(b) Societal relevant content to curriculum

This code addresses the issue, which ensures that the content taught is appropriate to the context in which we live, or the context/environment in which the student lives. Some issues are pertinent to a particular context, and should not be excluded in the construction of learning and teaching. This implies that issues, which are relevant to a particular context, should be addressed. The following was extracted from a question that related to how issues, relevant to our society are taught:

> *"... you have particular conditions that exist that are because of the area we are in, for instance, drug abuse and things like that, but you have other things that you really get to see."* **(Izelle)**

"It was very useful to see what is actually taking place on the ground." **(Arona)**

"For instance, an example is, when you look at intellectual disability in South Africa, there are a lot of concepts that have been brought from overseas to be used for people with intellectual disability. While it says you need to put them in mainstream schooling. But if you compare that with what is happening in America, yes they have mainstream schooling, but the number of students in a class is different." **(Izelle)**

This participant shared that she associated teaching with what she could experience first-hand; however, she stated that there were other experiences that she did not encounter.

(c) Importance of community profiling

The outcomes of modules are frequently applicable to a community context. The participants often provided descriptions of how they applied theory to the context of the community.

"I haven't done it myself but we talk in class, I always ask for specific examples maybe in the person's own life or in a community and that becomes a discussion." **(Bonny)**

"Yes, your fundamentals, your basic needs. So those were the things that they cover in the community profile." **(Ann)**

"Yes, we linked to community. We're linked to, especially baby immunisation, linked to family planning, linked to the community. Some of the investigations they do they also do it in the community." **(Jolene)**

"South African perspective in a sense is what you want it to be relevant to the community of South Africa, because things have to be contextualised." **(Izelle)**

The responses in this section provided evidence that community settings offer a viable landscape to practice nursing. It is a platform that provides rich learning and

teaching opportunities, where theory could be explored and applied to the context of the community, to provide valuable opportunities of educational enrichment for students to meet praxis requirements.

6.3.1.4. Theme 1 – Category 4: Implications for nurse training

Restructuring and transforming nurse training curricula is well underway with the implementation of reformed curricula nearing, to be implemented within the next two to five years. Key issues have been reported to make curricula more consistent with knowledge, skills and expertise, which are based on the changing needs of South African society and the economy. In addition, the need exists to create critical thinkers, who would allow graduates to make complex decisions through clinical reasoning.

(a) Recognising need to integrate

Nurse training is always confronted with two features, clinical and theory integration. Often this poses challenges for nurse educators, as the boundaries between the two overlap, requiring an integral connection between the two. The participants were well aware of the need to integrate the two. However, in the current curriculum, at first year level, these two features are separated in two different modules. The following extract refers:

> *"Clinical is a separate module and theory is a separate module but the one can't go without the other."* **(Daniela)**

(b) Uniqueness of reality

The socialisation of nursing students in real life situations remains at the centre of the nurse training curriculum. This provides students, not only with the required skills, but also with experience. However, real life situations pose challenges, which could be unique and rich, if facilitated appropriately. The following extracts refer:

> *"I think they underestimate the project. They think it's a quick fix. So as they move. Because it is a real life experience as they move through the process, they have negative encounters. So some of them don't*

know how to deal with it, because some of them are younger adults with no life experience. But at the end of the day, when they reflect, you will see that … for instance, one student wrote about how they went on knocking from one door to another, but they did not give up. They succeeded." **(Hezekiel)**

"We need to follow up our students while they are at the facilities to guide them and to show them how these things link with each other … to see the link between health promotion, prevention and curative." **(Arona)**

The responses above reveal that students were not prepared to engage in real life situations, as a learning and teaching task. However, the participants expressed their growth, after engaging in real life situations, when they were exposed to reflective practices. Additionally, the need to facilitate the real life situations were expressed to ensure the students growth.

(c) Re-dressing nature of training curriculum

It is clear that, even though the participants across the different year levels provided insight, the need to transform the curriculum, to a more primary orientation, was identified. One participant expressed concern that students, entering the third year experience, find it challenging, when they need to transfer the knowledge and apply it to a primary context. The following extracts refer:

"Mostly, general nursing science would enable our current students to be able to comprehensively understand and manage patients with illness; not only at primary, but secondary or tertiary institutions as well." **(Emily)**

"At the moment, it is actually only when the students hit the third year, I think, that they are being engaged a lot and then they come from secondary level of care. So their whole mind set is actually so secondary orientated. They are just thinking medication and they can't imagine what health education or promotion they can give." **(Arona)**

6.3.2. Theme 2: Domain/Dimensions of learning

Theme 2 involves the *domain/dimensions of learning* and its related categories, namely *exploring educational altitude* and *progression in learning*. The categories provide meaning and interpretation through the review and description of the associated codes. The two categories emerged by means of inductive tradition.

6.3.2.1. Theme 2, Category 1: Exploring educational altitude

Attention should be paid to the altitude of learning, which should occur to achieve the educational goal. In this current study, the altitude of learning refers to the length, or the height at which learning transpires, or simply the extent of such processes. In addition, it could simply refer to the categories, or levels, which exist within learning. Learning has to increase in complexity in the academic environment, as this would ensure that the student achieves higher levels of competence.

Additionally, with a professional degree, such as nursing, the expectation is that the highest form of learning is attainable, especially since nursing is often associated with situations, in which critical and clinical reasoning form the genesis of primary principles, and care is associated with saving lives and advancing health. This category was formed, using the experiences of nurse educators, as they shared their views, opinions, and practices. It highlighted how thinking (cognitive), doing (psychomotor) and feeling (affective) of people evolve within an educational setting, because of experience, as well as how these factors articulate with one another within an educational setting.

(a) Need for conceptual knowledge

Knowledge is the entry level when engaging with learning. It requires the ability to memorise and store information, as well as recall/retrieve it at a later stage, when needed. Measures that allow the laying down of knowledge should be in place, when engaging students in tasks. The following was shared by a participant:

> *"How can you apply if you don't have knowledge and that is why I'm wondering if case based is working in the first year?"* **(Clyde)**

The first year in nursing training is regarded as the phase, in which the students are equipped with the fundamentals of nursing. However, the educator expresses suspicion regarding the adequacy of the teaching methodology, and recognises the need that the foundation laid, be destined for greater, more complex tasks, which should evolve. In addition, this implies that students need to draw information and venture to a more complex state of learning.

(b) More than cognition required

Cognition is the level of learning that relates to the acquisition of knowledge. In addition, it refers to the accumulation of information acquired through learning or experience. One participant in the foundation level of the Bachelor of Nursing curriculum clarified that learning is more than acquiring knowledge, as per the following extract:

> *"It is very important to me that it is not just cognitive. It is more than that as well. The psychological for me is also very important."* **(Bonny)**

In this response, the educator implies focusing on more than one level of learning. The educator refers to psychological, which relates to the affective domain of learning that refers to emotions, as well as dealing with emotions. She comments further:

> *"They [students] experience the sadness of death and the emotions that goes with it."* **(Bonny)**

> *"You will have to understand what the patient is going through and that is why we talk about empathy, which is one of the principles in nursing."* **(Hezekiel)**

Another educator of the 4th year level shared that, during a session, she could observe that the students were affected by the content, which was up for discussion.

> *"We had content in class that we did and students were very emotional and we had a breakdown … we realised that it wasn't just one student but more students were affected. Yes, they were not crying, but you could see they're drained, the silent tears and all of that."* **(Izelle)**

This suggests that learning is multifaceted, and does not relate to knowledge alone. What students do with knowledge, how they relate to knowledge, and how they deal with the knowledge, became apparent.

(c) Emotional growth strategies

Dealing with emotions involves the affective domain and requires a certain amount of emotional growth. In nursing, emotions play a pivotal role, and students could relate to a vast range of emotions in one particular day. Therefore, it is important to guide them through such situations. The following extract refers:

> *"... and also caring for people in hospital like the last attendance that you do, it drains you emotionally, it plays on you. So all of those and if you reflect you see how you can do it differently."* **(Izelle)**

Feelings and nursing practice are synonymous. The above-mentioned segment refers to strategies that ensure smooth transition, which is beneficial in addressing the emotional growth of nursing students.

(d) Fear during transition

Transition refers to growth, and has always been a challenging process. In this context, it refers to the way students adapt, for the ability to deal with the realities they need to face, as student nurses. Various factors influence transition. In the nursing curriculum, students are exposed to various specialities within the nursing field. This results in frequent rotations, often of a rapid nature, due to the SANC requirements and specifications of meeting minimum requirements to practise nursing, after completing the curriculum. The following extract refers:

> *"... because, like in every new environment, it is a transition and with every transition there are challenges ... but the main thing there is fear because you are not sure what is happening."* **(Izelle)**

This response speculates that fear comes from being unsure, not knowing, or not having the fundamental knowledge. This statement reveals the integrative nature of the domains that are being articulated. Knowledge is required to influence other domains in this regard. Knowledge creates a space for students to react to certain situations with more confidence to ensure growth. Further growth implies that an

individual progresses through a certain number of stages, during the learning process.

(e) Levels of growth

As noted previously, growth is a continuous process towards achieving different levels of complexities. These complexities are often measured against predictors that are indicators of the level of progression. In the data set, it became apparent that these indicators are deemed relevant and appropriate for measuring the progression of students. The following extract refers:

> *"So with the novice, for me, it is always that they are novices until they go to the clinical setting. Then you can see how they feel … and they also reflect that they actually now experience what they call a real life situation."* **(Bonny)**

(f) Shaping psychomotor abilities

Psychomotor development refers to the acquisition of physical skills; the actions an individual physically performs. In nursing, this forms a key component because, in addition to the cognitive and affective domains, the psychomotor domain could also be articulated in the progression of learning, in the life of a nursing student. The following extract refers:

> *"In my view is, they are confident when they go out because they can actually repeat all these psychomotor skills as well."* **(Emily)**

This category provided an overview of the knowledge generated regarding the altitude of learning. It demonstrated that the nursing curriculum should be articulated meticulously around the major domains of learning, since the nature of nursing could be aligned as an art, science, as well as a service to human kind.

6.3.2.2. Theme 2, Category 2: Progression in learning

To learn, is to change behaviour, in order to produce a result that would influence an individual's actions and missions positively. It is not a single event, and should be regarded as a process, which demands the continuous engagement of an individual, in the area that needs to be acquired, strengthened, or prioritised. It is

continuous, in a way, similar to growth and development, as new milestones and new complexities that exist, comes to the fore. It can be concluded that learning is a progressive process, and, as stated in the previous category of this theme, it could be observable and rational, or, attitudinal and abstract to comprehend.

(a) Articulating clinical and theoretical learning

The nature of nurse training emerges out of two equally important components, namely, clinical and theory. The current training curriculum of the BNUR curriculum, appears to prioritise the theory component first. A few participants provided the following descriptions:

> *"They are placed two times a week at clinical facilities. I believe that learning really occurs there as well. Although there's a clinical supervisor, a student working eleven (11) hours a day for two consecutive, currently this year for two consecutive days, is a continuation of learning where whatever they have learnt in class should they be placed in a ward where perhaps that topic was covered, they actually can see it, experience it and understand it."* **(Emily)**

> *"What I'll do, I'll ask the students where do you work, what is the setup of the ward, what are you exposed to? Take the content and do an introduction, I'll explain where it relates to nutrition, safety or whether it is vital signs."* **(Ann)**

> *"The clinical supervisor starts with the work that I strengthen in class."* **(Jolene)**

> *"… and obviously the best way to learn for me is in the clinical field."* **(Clyde)**

> *"The scenarios will be clinical directed cases and then also skill integrated the theory which will then be definitely incorporated."* **(Baronese)**

The participants shared various views regarding the integration of theory and clinical learning, as well as which one to prioritise, when initiating learning.

However, a balance between the two should also be maintained, as both components share equal weighting in a nursing qualification.

(b) Protraction of learning through year levels

Nursing remains a unique field, in which various dimensions of the health could be integrated into one. Evidently, the comprehensive management of patients is advocated, according to the definition of health, as provided by the WHO, which stipulates that health is a state of complete physical, mental, and social wellbeing, and not merely the absence of disease, or infirmity. This definition highlights the intention of providing healthcare, and often these components in the definition overlap, or are integrated. In the nursing curriculum, the content of the components often relates to and informs each other, as the boundaries of health is in close proximity to each other. The following extracts refer:

> *"Your first year will have half of the work done and then the other will be done in second year where we include the philosophy of care."* **(Baronese)**

> *"It's like when you learn to write. You first need to learn the skill of writing. Then you can do all the fancy things about writing later on."* **(Clyde)**

> *"It's a bit higher than first year. A bit deeper or more than what they used to know in first year…if we start in the first year they start with first aid. In the second year they do emergency trolley… So it links and it goes a little bit further with emergency care."* **(Emily)**

> *"So that is why I think these modules (NRS411 & 412) are pitched in the fourth year because we have a more mature student that went through three to four years of training."* **(Hezekiel)**

According to the above quotations, the year levels are clearly interlinked, and form a continuation, as students are being developed into professional nurses, qualifying with the Bachelor of Nursing degree. In addition, it is evident that the level of maturity grows, as students are being exposed to the various components of the

degree. Therefore, a high level of maturity is required in the 4th year level of the curriculum, in which more complex tasks features of primary importance.

(c) Learning is a process

In any process, a series of actions or steps are taken, to ensure that a particular outcome is achieved. In nursing, the same principle applies, as learning transpires through exposure to various dimensions, which translates into experiences that usually occur over a period of time. The participants reflected as follows:

> *"Learning is a process. They learn from experience. They learn from constant exposure."* **(Hezekiel)**

> *"Learning does not only occur on the spot but can occur afterwards."* **(Emily)**

> *"So in a sense they have prior knowledge, they have some information but it's always that you just need to put it way past them … I don't know if that is the right terminology to use but it is all about building on …"* **(Izelle)**

The above statements indicate the nature of the learning process, as stated, learning requires time, experience, and constant exposure, to meet its purpose. Some of the participants submitted statements related to the nature of student exposure, as well as the level of exposure, in the following extracts:

> *"Firstly, we put a student through demonstration. Then we have simulation and eventually the student will practice …"* **(Hezekiel)**

> *"If you look at bloom's taxonomy, how can you apply it if you don't have knowledge?"* **(Clyde)**

The above statements describe the learning process, as various methods of exposure are involved in ensuring evidence of the students' growth, as well as that the growth is hierarchical in nature, as it increases in complexity, as the students advance through year levels.

6.3.3. Theme 3.1: Learning and teaching practices

Theme 3.1 comprises the learning and teaching practices that relate to the following categories:

- Teaching traditions, strategies, methods and activities
- Social media and utilisation of technology;
- Learning and teaching relating to clinical practicum;
- Reflective practices in learning;
- Authentic engagements;
- Planning educational activities;
- Opportunities to integrate research and scholarship;
- Feedback practices;
- Working in groups;
- Assessment practices in learning and teaching; and
- Content alignment and integration of theory.

The categories provide meaning and interpretation through the review and description of the associated codes. The above 11 categories were formulated through inductive tradition.

6.3.3.1. Theme 3.1 – Category 1: Teaching traditions, strategies, methods and activities

(a) Approach to learning and teaching

The approach to learning and teaching is the composition of principles being employed to facilitate learning and teaching. Two of the main criteria are, the role of the student, and the role of the lecturer, during the implementation of techniques to facilitate learning. The fulfilment to these criteria, undeniably, would lead to the approach in operation. The data set proved to be rich in providing a description of the experiences of the nurse educators. A variety of descriptions was provided, of which some are cited as follows:

"Having that conversation with the students, waiting for feedback and having participation from them. I feel that stimulates, the reasoning also why they have to do certain things." **(Bonny)**

"I would put another question on the board that was not part of the case but that drew the content into it and I had groups all prepared and all come and write something on the board and they enjoyed it." **(Clyde)**

"But this group presentation works very well because students are involved in their training." **(Jolene)**

"We would start with a debate; something different and then I would tell them, go on your phones and what is the current Act or policy regarding what you're saying …" **(Emily)**

These responses clarify the role of the teacher and the student. In all descriptions the educator exercises a facilitator role, while the student fulfils an active role during teaching sessions, contributing equally to his/her learning opportunity. However, one educator reportedly experienced a challenge, as some students, coming into the curriculum from the secondary level of education, were not familiar with being involved in student-centred activities. The following extract refers:

"… the challenge is that they are used to a different method in school. … It creates chaos at the beginning because the first groups don't know exactly what is expected of them and you end up repeating yourself so many times on how this thing is going to work …" **(Clyde)**

(b) Diverse teaching strategies

Teaching strategies provide structure to the nature of what needs to be done. It contains the methods that are being employed, to help students meet the course requirements, as well as the outcomes associated with the curriculum. Teaching strategies are broader than the teaching methods, and are underpinned by philosophies. In the analysis, it became apparent that multiple and diverse teaching strategies were being employed, across all year levels of the BNUR curriculum.

The following are comments that have been grouped according to the teaching strategies assumed:

Problem-based learning

"The discussions are based on any uncertainties because the students will come up with a lot of questions if they do not understand the discussion or the activity." **(Daniela)**

"I put another question on that board that was not part of the case but that drew the content into it." **(Clyde)**

"… and unpacking word for word so that they can actually reason as to why this specific scenario … I also encourage them that each patient is a case. So whoever the patient is in the ward, they mustn't just see it as a patient, it's a case that they can study and reason on." **(Bonny)**

Simulation-based education

"I feel it is actually very good. I find it positive. I don't think there is much negativity, because when they do go in, they are quite prepared and we do have the luxury of actually exposing them to simulation." **(Bonny)**

"I simulate during lectures … the low fidelity is the mannequins that basically just lay there … you can't do much with it but it is useful. The high fidelity ones are the ones that are basically connected, you can alternate, you can put in vital signs." **(Ann)**

"I draw up lesson plans for simulation. So even though we should understand the skills lab methodology, the simulation methodology, I still do a lesson plan that we draw up as real as it should be in the facilities with all the resources." **(Bonny)**

Skills laboratory methodology

"Students were introduced from first year to the skills lab. So skill lab is also part of the safe environment where they will practise certain skills before they are introduced to real injury in hospital." **(Emily)**

Case-based learning methodology

"There's a case and then there are questions that need to be answered … the students very often complain about the method that we use with this pure case-based thing…" **(Clyde)**

Service learning methodology

"They need to do a whole project and compile the whole project and eventually have a health promotion day where they then reach out to the community to make them aware of that challenges that they found." **(Arona)**

"Yes, one of the goals of one module is, the gender-based violence module is to do service learning where students should be able to respond to particular needs of the community. Therefore, the students should be able to analyse, do a needs assessment … so you go to a community, like Mannenberg, and find out what is happening in that community. Maybe there are a lot delinquents and broken homes. So you have to identify and then respond to it." **(Izelle)**

Discursive teaching methodology

"Having conversations with students and waiting for feedback and having them participate. I feel that stimulates." **(Bonny)**

"I use the whole class to engage in conversation. For instance, I'll pose a question to the class as a whole and then I am expecting individuals to give feedback on what has been asked. What is their own understanding of that? So in that case, everybody in class is in conversation where they speak to each other. Sometimes it is interesting, because with large group discussions you also get students who critique each other and respond to what others are saying. That stimulates more learning." **(Izelle)**

"We have discussions that are based on any uncertainties because the students will come up with a lot of questions if they do not understand the discussion." **(Daniela)**

Cooperative learning

"Firstly, groups need to work together and then I will go from group to group and see how they are involved." **(Clyde)**

"It worked well, because it made the class a little bit more interactive. It made the class more relevant, especially if they have to give feedback and they share the information that they got." **(Ann)**

Integrating technology

"… we can basically do lesson plans via IKAMVA (e-learning platform) but what is interesting is that you can retrieve stuff directly from the internet and then you can make a lesson on IKAMVA and then interact with your students directly." **(Ann)**

"In conducting a lecture, you use different methods, like using PowerPoint presentation, sometimes you can do a video and then you speak about the video just to clarify certain concepts that have been depicted in the video." **(Izelle)**

Blended learning

"Teaching in class would be traditional. However, we would incorporate other modes as well… so we would start with a debate; something different and then I would tell one … go on your phone and go and see what is the current act or policy regarding…" **(Emily)**

(c) Diversity of teaching methods

Teaching methods are the means, utilised by the educator and the students, to achieve outcomes. One major distinguishing factor is the role that both fulfil in the translation of knowledge. Teacher-centred approaches, as well as student-centred approaches could be utilised; however, teacher-centred methods are more accommodative of the traditional views of the educator, as the main authoritarian figure in the teacher-student relationship. With student-centred methods, both parties claim responsibility for the activities that will be undertaken in the session. The data set revealed that the nurse educators used, and advocated for both approaches to be applied, at their discretion, while frequently, they even combined the two, as the following extracts indicate:

"I look what I can do, what teaching strategy I can use during this lecture to make it interactive. My only thing I want is participation and interaction from the students." **(Ann)**

"Not every Monday we will do the same, not every Monday they will write on the board, not every Monday they will do this. So I try "om dit af te wissel" so that it doesn't get boring." **(Clyde)**

The code above reveals that the lecturer aims to be creative, when opting for a specific type of learning and teaching activity. Frequently, the educator even synthesises the two methods, thereby providing a lecture with strong characteristics of using methods that offer autonomy to the students, as well. The following extract refers:

"I would say, how we actually teach our students in class, we do like case presentations … so it is as if there is a patient sitting in front of you that the student needs to treat or know." **(Arona)**

This statement places a strong emphasis on the role that the student has to fulfil, namely, delivering case presentations. It describes, and is indicative of the fact that the student is responsible for the translation of knowledge during the session. Other views that were shared, revealed that the educators moved freely between these two extremes, when clarifying their roles, which created a pattern within the data set, as the following extract reports:

"I'm going to ask them to summarise, most of them had similar and I actually give them feedback and I also had a class discussion." **(Bonny)**

One lecturer, in one of the specialities within the nursing curriculum, provided a strong emphasis on the role of the educator, which contrasts strongly with previous views of this role during sessions, as the following extract informs:

"When I teach, when I take my class, what I believe, is that, when the students walk out of that class, they know exactly what the content is, the content that I put there for them; and that they know the content." **(Jolene)**

Other educators referred to them as a guide, when they engaged with students in learning and teaching practices. The following extracts refer:

> *"We are just facilitating the process because we want students to have a good learning experience…"* **(Hezekiel)**

> *"However, as an educator, I need to guide them to get the correct information … I would obviously introduce the lecture, do that and then conclude with summarising all their ideas and their topics and give them the main outcomes of the lecture."* **(Emily)**

> *"It is my role to mediate that process. Okay, you can respond to? So it is like a facilitator."* **(Izelle)**

> *"That is why in that presentation, it is a short 10-15 minutes and then it is student involvement the rest of and most of the time…"* **(Daniela)**

These statements clearly highlight that the educators really attempted to be creative, when selecting teaching methods. They frequently opted to combine these methods into one strategy for a session, depending on the need, for example, introducing a session, using an introductory lesson that moved the student directly to the front, to take charge.

(d) Exploratory methods

Exploratory learning and teaching methods refer to those activities that are based on experiential learning. Exploratory learning and teaching methods, therefore, offer opportunities to engage students in problems, critically, while moving them through a cycle to solve the problems, by using inquiry and questioning approaches. The following examples were prioritised for this chapter, as generated through descriptions that prevailed in the data set:

> ***Inductive activities***
>
> *"I went with the students to Coca Cola and then I realised we could do much more with the assignments so it was revamped this year. I think it works better … it links to what is happening out in there factory and how does it come to safety and environmental questions. It is what is*

happening in the houses, what are hazards in the houses, what are hazards in the community itself." **(Clyde)**

Discovery activities

"… then they actually have to physically see, how many rooms there are. They have to analyse how many patients are there, maybe age groups as well and they also see the admin stuff for stats." **(Bonny)**

Problem-solving activities

"Then students will go and prepare for the case. In class, we will work on the case and any group will then be randomly selected to present the case…" **(Hezekiel)**

"The case study is usually cases that students need to able to handle … students would do it in hospital or facilities. They would have a patient and they would need a case study based on a topic that we previously covered in the semester … for instance, diabetes and the student needs to go and interview a patient with diabetes, they get the information but do they understand without looking in the books how to refer them.".. **(Emily)**

Project activities

"So what we found is that once these students are engaged in these activities, they can identify, for instance, in certain circumstances, once we are busy with service learning projects, they pick up which people are at risk for high blood pressure, depression and all of that." **(Hezekiel)**

"The need for the whole project and eventually have a health promotion day where they do then reach out to the community." **(Arona)**

"Okay, depending on the goal of the project, for instance, we have one of the projects where it is about creating awareness for a particular topic and in this case it is gender-based violence." **(Izelle)**

Laboratory activities

"Props from the clinical practice are used to show them this is a catheter. So I've been begging and borrowing and I've got boxes of stuff that I need to carry to class. But the moment you do that it is like things became more … or they become clearer." **(Clyde)**

"We can actually do that as well but at the moment we don't … I'm not incorporating … I did it with vital signs. I used high fidelity ones because that is easy to set up. Just to hear … especially with the lungs … the wheezes and lung sounds." **(Ann)**

Inquiry teaching

"… every lecture is exciting because they would … because I would bring in what is current … it was about tax; oh it was about the time when we heard that the tax is now 15% so I brought that into class. And then they had group discussion what do they think about that and the one said not everybody pays tax like prostitutes, they don't pay tax. Some of the groups said but no, wait they shouldn't be paying tax because it's not a business and we were discussing that. And one proposed that it is supposed to be a business and they're supposed to pay tax as well. So it was all about what they know, reflecting about it, what they saw in the hospital, all of the diseases that come in; latching it on and talking about but we were doing HIV and AIDS. That was the lecture we were reflecting on that and the possible, I was going into the statistics about HIV how it was and the most current." **(Emily)**

Reflective teaching activities

"We promote journaling from the beginning of the year where they write every day or once a week their experiences wherever they are. And they also write a self-reflection on paper which is hand written." **(Bonny)**

Cooperative activities

"… but the goal is firstly, we want to see if the students are able to work as a team. We want to see if they are able to manage their time.

We want to see if they are able to delegate. So we want to see leadership qualities in them and also how they plan the whole event. So planning, the presentation skills, so all those aspects become part of evaluation and then the execution itself." **(Izelle)**

6.3.3.2. Theme 3.1 – Category 2: Social media and utilisation of technology

(a) Usefulness of social media and technology

Social Media and Technology offer various opportunities to students and educators. It has become one of the priorities of institutions to invest in, or to create, opportunities for students to be engaged in such activities. A strong pattern featured in the data set, which validates the usefulness of social media and technology in nursing education, as the following extracts endorse:

"Any other resources, maybe like DVD's that we've got or any recording that we can playback, which we should also incorporate." **(Bonny)**

"So you know the drive is for an online learning environment which I think is very useful for students." **(Clyde)**

"So I went for training and they told us that we can basically do lesson plans via IKAMVA … retrieve information from the Internet … and then directly interact with your student." **(Ann)**

"I also like to incorporate the Internet and especially the student needs to learn more advanced information, know how to do online tests." **(Emily)**

"So for me, CMAPS is you've got the main outcomes and to be able to pull maybe a video from YouTube relating to the topic and then maybe have your slides as well." **(Bonny)**

"I also make a lot of use of, what is the thing now, videos that are applicable for that session." **(Daniela)**

One important observation in the data set, in particular, was the extreme of these activities reported in the foundation, 1st and 2nd year of the BNUR curriculum.

(b) Creating a real experience through social media and technology

The participants shared various creative ways of incorporating technology into their lesson plan, in an attempt to complement the content they were covering, as endorsed in the following extracts:

> *"I use PowerPoint presentations. We also show video's for them to strengthen the content."* **(Jolene)**

> *"I can't take an oxygen cylinder there but I can project a picture of an oxygen cylinder and they can have an idea of what I am talking about when I say 'oxygen cylinder'."* **(Clyde)**

6.3.3.3. Theme 3.1 – Category 3: Learning and teaching relating to clinical practicum

Before completing the BNUR curriculum, it is required that students fulfil some mandatory, minimum requirements, to be allowed to register with the South African Nursing Council. Included in these minimum requirements are skills and competencies. Therefore, it becomes essential that students are placed in clinical, as well as other settings, to meet these requirements.

(a) Using clinical exposure to enhance classroom discussion

Discussion often forms a great part of the nurse educator's methods and activities, during their sessions. However, the educators reported that they draw on the clinical experiences of students during their sessions. The following extracts refer:

> *"So what I'll do is I ask the students 'Where do you work? What is the set-up of your ward? What are you exposed to?'"* **(Ann)**

> *"I always draw a little bit of the clinical curriculum into the theory class to link it to see if we talk about a full wash now, then we link it up as well with the hygiene need."* **(Bonny)**

"I allow a half-hour session the following day after placement for the students to, I call it 'vent'; to share their experience and the things that they experienced the previous day." **(Daniela)**

(b) Goal of clinical practicum

Clinical practicum provides the opportunity for student nurses to combine cognitive, psychomotor, affective, and problem-solving skills. It could be graded as a experiential learning opportunity, and is regarded as the fundamental component in the training of nurses. During clinical practicum, student nurses are confronted with reality. Well-structured clinical exposure provides the perfect opportunity, or platform, to integrate theory and the clinical component of the nursing curriculum. The participants expressed superior views of such activities, and frequently used clinical experiences in class, to create opportunities for student to make the connection between theory and clinical practice. The following extracts refer:

"Because currently students are there. They are not part of the work force. They are students at the moment but they need skills." **(Jolene)**

"In the learning and teaching sessions it is seldom that they have real-life situations in class. They are exposed to real-life in the practical." **(Daniela)**

"Well it is to get clinical experience- to learn from nurses that are in the field. So in the clinical placement, you are working with real patients. Remember in class we are working with case-based. We simulate what is happening in the facilities." **(Izelle)**

(c) Using portfolios and practicum reports

Capturing learning and teaching opportunities occur in nursing training, as students' records form an important part of his/her training record. Students have set objectives and outcomes in the clinical curriculum; therefore, portfolios are regarded as useful in capturing clinical experiences. The following extract refers:

"They have a portfolio linked to the clinical portfolio and that has four outcomes what they would have liked to achieve or a learning outcomes for the year." **(Bonny)**

6.3.3.4. Theme 3.1 – Category 4: Reflective practices in learning

(a) Opportunities associated with reflection

Most participants mentioned that they engaged in basic reflection. Some participants regarded reflection as essential, to deal with the real life experiences in the clinical field. The following extracts refer:

"It was the introduction to the reflection to the module. Okay, most of them did an explanation of what HDP was. They did a reflective journal of what HDP is. Let me just and then they did, most of them explain what the module is about. Then they described where they had to tell me about the challenges they experienced working in a group. Their first experiences and then they had to tell me about the challenges that they've experienced working in a group and then what they learnt from the module and what they can apply with that module. Basically it means what they can take from the module to apply one day in their practice?" **(Ann)**

"Where we speak, especially of stuff that is happening in the hospital that might have been traumatic. We can bring it to the classroom and we can discuss it and know if it is too much for the student, where to refer them but they feel safe to express whatever they are feeling." **(Emily)**

"I think in everything you do reflection is critical in terms of you have to evaluate what was done, how it was done because it takes you to the next level because if you are able to reflect it opens room for growth. Because you can see what is happening. How did I do this correctly? Or what was my view or how was it changed? Even in hospital, there was an emergency situation – What did I do? How did I do it? How can

I do it differently? So it is a continuous way to grow, to improve yourself and to make yourself better." **(Izelle)**

"Reflection is actually that they have to reflect on what worked for them, what did not work, and how can they improve on the way forward, and more on to what did they learn and what learning did happen in them and what would they need to improve on and maybe improve the module or how we can go about doing the projects maybe next time." **(Arona)**

(b) Need for criteria for reflection

Reflective practices have been applied widely and acknowledged across all five year levels; however, only a few participants described the nature of reflective practices as follows:

"Yes, we want them to reflect at the end of each module. Then they can compile it into the portfolio so that they can have an idea of what they felt, what worked for them or what was learning for them, and what was now not so learning or what did they not manage to achieve maybe at that facility; maybe the objectives they were not able to reach because maybe there was no TB that was maybe being done there and things like that." **(Arona)**

"Currently, the model that we use is the GIBBS reflection model because it really applies in terms of our field, the nursing field because there are a lot of emotions involved. There's a lot of ... you need to reflect on your practice. So if you have done something you have to describe what actually happened. What was your feeling during the process? What was your take in the process? How can you do it differently? So we use the GIBBS model in the process." **(Izelle)**

"I think reflection is part of learning. I think if reflection is used in a positive manner it can really aid in all phases of learning where you can reflect what was good, what was not good, how can I better it? Or where you can analyse oh, okay this was that way. So I think reflection

if used in a proper or educational way is a method of learning as well." **(Emily)**

"It's supposed to start in the first year already where reflection is part of learning as well. However, in second year, a little bit more because, like I said, reflection is a big part of learning." **(Donny)**

"Students write according to the GIBBS reflection. How did they feel about that? What did they learn? How can they improve? What were the feelings on those specific cases?" **(Hezekiel)**

Based on the above, the following could be concluded. When the curriculum commences, reflective practices should be purposeful and structured as an educational activity, which enhances learning. Therefore, parameters should be employed to structure reflective practices, according to the progression, and the year level requirements of the curriculum. This would ensure that reflection becomes meaningful, and result in appropriate learning experiences.

6.3.3.5. Theme 3.1 – Category 5: Authentic engagements

The learning experiences shape the students' ability, and contribute significantly to the outcomes associated with learning and teaching. Often, reality could be frightening to the student; however, gradual exposure remains a constant, when exposing students to reality. In nursing, clinical practice commences early in the training stages. The participants shared their view of real life, as well as how it contributed towards shaping the graduate's proficiency.

(a) Utilising real-life situations

"We use our cases to demonstrate to the student, and eventually we would make use of real-life situations." **(Hezekiel)**

"We integrate it more in a scenario where they can apply what was now explained to them or what they now worked out in a group presentation, or discussed in a group – this is a type of thing where they apply to the scenario plain, real-life situation then they can say okay, this is where this specific topic fits in and the reality." **(Daniela)**

(b) Advantages of real-life exposure

> *"I don't think it will ever be a hundred per cent because students will reflect and say, ja, we were taught this but now this happened in the wards and so on. So I think sometimes the expectations of the students are quite high and different. Now they come to the healthcare facilities and it's not really happening as they thought it would be."* **(Bonny)**

> *"It is a real experience. It is also part of developing them when they reflect as well they can maybe differentiate the difference between hospital and just doing a quick blood pressure of somebody that's walking past them screaming."* **(Emily)**

> *"The difference between a real-life situation and simulation, simulation is a sort of mimic; where we mimic the reality. They are not faced with reality yet, but we have mannequins and dolls which represent the patient. But real-life situations is where they have to use their critical thinking because real-life situations differ from the simulation situation because the patient, a real patient has emotions, has feelings whereas a mannequin is lying there and not communicating back to them."* **(Daniela)**

> *"It is a real-life situation. It is a real learning opportunity. The feedback that we get from students on reflection is that most of them write about how they enjoyed the activity."* **(Hezekiel)**

These responses all create a connection with the advantages of using real-life exposure, which creates opportunities to participate in reflection, and enhances problem solving, through critical thinking.

6.3.3.6. Theme 3.1 – Category 6: Planning educational activities

To achieve a high impact learning experience, planning is essential in an educational setting. The nurse educator should allow time to engage in planning the module content, the lesson plans, and the final planning of the assessment. Planning is a task that transpires in advance. The following extracts refer:

"What I did this year was I gave them all the due dates. I made a grid and gave them all the due dates of all the assignments and a guide. So they can't say … with the due dates and a guide and I said put that on your wall." **(Ann)**

"So when I prepare I will look at all the prescribed books and also look at obviously, the main outcomes, what it is what I want to achieve." **(Bonny)**

"Then you have to make sure of your logistics and go and find out all your information from maybe the City of Cape Town, the layout of the community and what information they have on the community, where the health facilities are, where the schools are, and how many populations they have." **(Arona)**

This demonstrates that the planning of educational tasks should be a rigorous process, and it is important to consider those being served, in order respond appropriately. The following extracts refer:

"So the thing is, one inherits a module guide when you come on board. It is not that you've been part of the development." **(Clyde)**

"I draw up lesson plans for simulation. So even though we should understand the skills lab methodology, the simulation methodology, I still do a lesson plan which we draw it up as real as it should be in the facilities with all the resources." **(Bonny)**

"What we do is, we basically do an assessment. We do a need assessment and then we will do the planning for this outreach. We will then implement it and evaluate it at the end of the day." **(Hezekiel)**

Determining needs is crucial when providing care, as it creates opportunities, from which to learn, which already engages the student in critical thinking and reasoning exercises, as the following participant explains:

"I think firstly, to be able to have enough time to prepare for teaching. We take teaching for granted. It is a given but it is something that you need to constantly work on, review." **(Izelle)**

Everyone involved, who are responsible and accountable for the learning and teaching activity, carry the responsibility of planning. The data set provided evidence that this was an existing need of all educators, as well as that planning should be prioritised. In the planning process, time and the scheduling of tasks should also be taken into consideration, as it contributes to the success of the learning and teaching tasks.

6.3.3.7. Theme 3.1 – Category 7: Opportunities to integrate research and scholarship

Research aids education, in terms of relevance and best practices. Therefore, the curriculum offered, should be evidence-based, as well as grounded, and its consumers should become engaged through research methods. Gradual exposure ensures that the students start to develop the ability to be research orientated. The main purpose of any curriculum is to translate knowledge into meaningful pieces, to ensure that growth transpires. Opportunities to integrate research and scholarship should be identified, and used positively.

The educators described multiple opportunities that resulted from learning and teaching practices. Learning and teaching practices begin with tasks that search for knowledge, specifically, new knowledge, which provides impetus to commence exposure. The following extracts refer:

"Like I said, they have to go and find out about that community, and the best way is usually to go to the resources that are already there, like for instance the City of Cape Town. They do have information about the layout of that town or that settlement and from there they can move on and also go and plan the thing from there on." **(Arona)**

"I give them books and then obviously, they go on their phones and then they Google the information" **(Ann)**

"We must work within that framework but in order to get all the knowledge that we need for that specific topic. To meet the outcomes of that lesson or presentation we must do further research on the Internet or consult the textbooks." **(Daniela)**

"We sometimes get the media in. It is in the newspaper and then people become aware of these things and they start asking. They ask, but they were never aware that this TB problem was a problem in their community. Since our students started a common intervention, they do the intervention and the community starts becoming aware of what is actually happening in that community." **(Arona)**

The journey to learning commences, and is fully synchronised with some of the main principles of research-related tasks. A student is required to provide the latest dimensions of particular tasks, when demonstrating that they had mastered content. This, in turn, makes them evidence-based practitioners, as they frequently disseminate their findings in constructive ways, when engaged in tasks.

6.3.3.8. Theme 3.1 – Category 8: Feedback practices

Feedback forms an essential part of any education setting. It provides those involved with the opportunity to acknowledge and recognise their potential. It also contributes to building the potential of those involved. For students, it offers assurance of their development. If used reasonably, it could shape and inform practice, especially in a nursing-orientated setting, where advancement is critical, in terms of health and development. The following extracts refer:

"Engagement means that we, not only us, need to also engage with other stakeholders in that community or in our province for that instance to get them on board so that we can walk together into addressing these health challenges." **(Arona)**

"I mark and I actually give it back for them to place in their portfolio. And then I ask them to look at where they're at now, like September/October, and what it was like in February when they started. So they can actually compare whether they have grown and

how they grew. Thinking of realistic goals for the next year also gives them an idea of thinking ahead." **(Bonny)**

Frequent reflection and feedback should be employed to engage the student, as well as the nurse educator. The nurse educator fulfils the role of providing feedback, which is based on the development of the student, while the student reflects on his/her unique journey, as s/he progresses through the curriculum. These kinds of activities should be captured on record, so that the student could track his/her own progress. The following extract refers:

"When it comes to the evaluation, we will evaluate at the end how assess how successful the project was. We will ask feedback from stakeholders." **(Hezekiel)**

The participants provided a variety of views, which contributed to the formation of this theme. They acknowledged that they involved all the stakeholders, including those, to whom they provided feedback. Feedback between the educator and the student should be consistent and regular, as it forms an essential part of the growth that should transpire.

6.3.3.9. Theme 3.1 – Category 9: Working in groups

Working in groups requires students to achieve tasks collaboratively, which extends the working borders beyond the class room. The educators shared their views on group work, as well as how they operationalised group work in their practices.

(a) Regulating group work

The educators reported conflicting situations, regarding group dynamics; however, they had managed to control the situations, as expressed in the following extracts:

"Always the dynamics around group work and that is inevitable that students will complain I don't want to work with this one and that one. But at the end of the day you have control over it." **(Ann)**

"We allow them to set their own group norms. And we allow them to come up with what will be the implications if one group, for instance,

does not participate in the activities of the smaller group. So they have then a rubric where they score participation, et cetera within the smaller group." **(Hezekiel)**

"So they will write for us say, for instance, a student did not submit their part. With how much must we penalise her? When I give the group a mark that student will get minus marks. So we have group norms for students." **(Jolene)**

(b) Facilitation of group work

The educators stated that, in group work, they view their role as the facilitator and mediator of the sessions, as expressed in the following extracts:

"The groups need to work together and then I will go from group to group and see how they are involved." **(Clyde)**

"A large group discussion takes more out of a facilitator. For instance, we give the topic of conversation, in a large group discussion we need to speak in turns. So it is my role to mediate that process. Okay, you can respond to ... what do you think? So, it is like a facilitator in the process." **(Izelle)**

(c) Working through diversity

Group work involves hierarchical relationships, as well as the ability to share power, between roles and responsibilities, which results in the student acquiring a vast amount of skills that could include leadership, and the ability to be led by someone else. The following extracts refer:

"As I said, it is about control, working out their differences and what group work is about, obviously that is many … a challenge for anyone working in a group but it worked well." **(Ann)**

"So what we basically do is that if we have a class of 60 students we will split the group into smaller groups. So every week an activity will run with the children. So the smaller groups are identifying different needs of the children …" **(Hezekiel)**

"Let's say the group is six students and only four take part in the group. They have group norms that they write for us." **(Jolene)**

(d) Benefits of group work

Group work creates opportunities to develop supportive roles and relationships, by working through issues that results from differences and unique opportunities, as expressed in the following extracts:

"But this group's presentations worked very well because the students are involved in their training." **(Jolene)**

"They do very good in that kind of scenario where they sit as a group because they have a combination of everyone and different wards and that is the benefit of group work." **(Ann)**

6.3.3.10. Theme 3.1 – Category 10: Assessment practices in learning and teaching

Assessment practices form an integral part of learning and teaching. It is focused on the end result of conscious activities that were implemented, to guide the outcomes of the student, within the cognitive, behavioural, and affective domains. The educators detailed the following experiences, regarding assessment practices:

(a) Numerous assessments

"Yes there are a lot of assessments one needs to do, but I get mine done." **(Clyde)**

"For assessments of theory, we would have three tasks." **(Emily)**

(b) Assessment methods

"Assessments are just basically done with a tool that we have. So that tool is like a guideline for the assessor." **(Emily)**

"At the end of the term, they did a reflective journal on their experiences to working in a group – that was for the HDP that I did a reflective journal … And we're going to have another reflective journal for the nursing component." **(Ann)**

"Peer assessments, for instance, because we are only facilitating the smaller groups, so once students form the smaller groups, they will assess and what we require as the lecturing team that they need to produce, they need to submit their evidence." **(Hezekiel)**

"I think in everything you do, reflection is critical in terms of what you have to evaluate, what was done, how it was done because it takes you to the next level because if you are able to reflect it makes room for growth." **(Izelle)**

It is part of the CUR [cam mark] to hand in a portfolio of evidence. It is due now at the beginning of the second semester and so they need to put in a lot of their clinical experiences, for instance, what they've done in the wards, their assessments." **(Clyde)**

"For the health education? It's an assessment instrument. At the moment, it is just a competency." **(Bonny)**

6.3.3.11. Theme 3.1 – Category 11: Content alignment and integration of theory

The main purpose of higher education institutions is to achieve a high quality of education. The curriculum forms part of the core method to achieve a high quality of education. In nursing training, this extends further to include a multiple reality, since the curriculum is not only limited to theory, but also includes a strong focus on healthcare provision. To align and integrate these two essential components, requires a coordinating function between the components, which should be planned and executed in an environment that would include educators, students, and stakeholders, in an attempt to achieve the outcomes associated with the curriculum. Content alignment and integration is regarded as the vehicle to achieve the synchronisation of realities associated with higher education. The following categories were coined in the data set of the nurse educators' experiences.

(a) Aligning content with current health practices

"They must bring content from maternal guidelines. Well, the maternal guidelines we use is now 2015. We don't have new ones. So if there's

something new that differs in the practice, they can bring that back to me. Protocols that they come across in the clinical they bring that for me to class and we also do 'wat is die ander ene'?" **(Jolene)**

(b) Alignment of needs with learning and teaching practices

"There are two assignments that link with the community itself. So in the first semester during the April vac period they visit the Coca Cola factory and they get two lectures there. The one is from, we use usually Groote Schuur's infection control Sisters from there and then the City of Cape Town comes and they do a brilliant talk about environmental health. So this whole thing, the assignment is also called environmental health." **(Clyde)**

(c) Integrating project based experiences

"What we found is that once these students are engaged in these activities, they can identify, for instance, in certain circumstances, once we are busy with service learning projects, they can pick up which people are at risk for high blood pressure, depression and all of that." **(Hezekiel)**

"This is very much part of our curriculum in community health because we do expose students to the projects." **(Arona)**

(d) Need to integrate theory and clinical learning

"In the class, the clinical theory is presented to them or discussed with them and in the skills lab the practice." **(Daniela)**

"They need to understand clinically, firstly, how to speak to the patient, how to do an interview with a patient, see that they get all the information and integrate it and they have to understand at the end how to work with all this information, what do we do with the information if you have all the signs and symptoms and the patient is telling you this, where would I have sent the patient for diagnosis? Do I send him for x-rays? Do I send him for a TB test or do I send him for whatever

test? So they have to understand that. And then after that, where do I refer them to, how do I manage them, nursing management plan. If the patient has a cough, what do, I do? It is part of the theory versus linking it with the clinical." **(Emily)**

(e) Aligning activities throughout year levels

"So we would like, as a school, we would also like to be involved and attend to the needs of our community. So we would like to give back to communities. So that is when it comes to our outreach and we try to link it with our module, gender-based violence and the service learning component." **(Hezekiel)**

"But if the need arises that we will need to have more. I have already communicated with my colleagues from first, second and third year and fourth year to be engaged when we do community outreach engagement." **(Arona)**

(f) Alignment of learning and teaching tasks with corresponding assessment practices

"So we are busy with a project but we focus on assessing the students theoretically by a written examination and whatever else there is, class tests, etc." **(Hezekiel)**

6.3.4. Theme 3.2: Student-related aspects

Theme 3.2 involves student-related aspects that contain the designated categories, which provide meaning and interpretation through the review and description of the associated codes. The three categories that were formulated through inductive tradition are as follows:

- Personal attributes of students;
- Student engagement;
- Student entrepreneurship.

6.3.4.1. Theme 3.2 – Category 1: Personal attributes of students

The personal attributes of students relate to those aspects that are centred on the students. It could include character traits, motivation, as well as the experience they had accumulated, to fulfil the task. The selection criteria of students into nursing curricula, requires more rigour, in an attempt to attract compassionate students, who ultimately, would be responsive to the duty call of service. The participants of this current study described the following, which remain central tenets of the students and their personal attributes.

(a) Displayed motives for enrolment

> *"One of the things that I've realised is not all students in your classes necessarily want to be nurses, and I think that is one of our big challenges … Not every student that comes in reality wants to do this course because it has been the third or the second or the fourth choice and I've had some … a few weeks ago I had a student in here. Her performance is dropping. She is not good in the class. She has an influence over the group. She is a very strong person and she told me she doesn't really want to be in nursing."* **(Clyde)**

> *"External motivation is more about … it can be for instance monetary. When you want to become a nurse and you want a salary. Then we have internal because we want to be good nurses. We want to care for patients that are ill. We do nursing because we are caring for other people. You are passionate about caring for people."* **(Hezekiel)**

> *"I love to apply it in my work in the clinical work. And today sometimes you get students, they apply for nursing but they're not in nursing. They're actually just looking for a job."* **(Jolene)**

(b) Nature of students

> *"They must respect the patient's or the person's rights; not only in the hospitals but in the classroom setting. Because in the classroom, they are divided in groups from different nationalities, different cultures and different values."* **(Daniela)**

"We need to change because of the type of modern students we have." **(Emily)**

"You have that difficulty but most of our students are millennials. It is an environment that they like. It is something that you can use to your benefit." **(Clyde)**

(c) Previous experience of students

"I truly also believe they are adult learners, and we can't spoon-feed them and we need to take into account what do they already know." **(Clyde)**

"Many of them come in with … confidence or have been through a few things in life. So for me, it is always good to hear what they're thinking by opening up conversations like that and reflect on how it was." **(Bonny)**

6.3.4.2. Theme 3.2 – Category 2: Student engagement

Student engagement involves engaging/participating in activities. A variety of activities exist, in which students could become engaged. Educators need to utilise methods that stimulate student learning, and demand active participation.

(a) Attitude towards blended learning

The educators were positive in their view about the participation of students, and acknowledged that students responded well to group related activities, as well as when technology was integrated. The following extract refer:

"It keeps them away from the normal just sitting in the class where you have basically an on-line lecture which was interesting … and I said that this is very interesting because it is also a form of interaction. You have a lesson plan and you put it up and your students participate which for me was very interesting." **(Ann)**

(b) Attitude towards group activities

The educators also expressed that students adapt to group work-related activities, and start displaying growth, in terms of how they function within groups.

"They're not scared. They're not anxious because it was instilled in them from the beginning, it took a while but you can see the groups respect one another." **(Emily)**

(c) Interest of the student

One academic shared that, when the attention of the student is not captured, while engaged in a learning and teaching activity, the effort is futile, as expressed in the following extract:

"If you have a student that is really not interested, there is nothing you can do or very little that you can do." **(Clyde)**

Alternatively, when the students deliver the presentations, the benefit is that additional skills are developed, for example, they have to speak in front of their peers and other people. Students need to be actively engaged, as this will ensure that the outcomes and objectives of the curriculum are achieved.

6.3.4.3. Theme 3.2 – Category 3: Student entrepreneurship

Student entrepreneurship refers to the ability of students to use themselves as tools in the learning and teaching environment. Previous educators have expressed that the students carry a vast amount of experience with them, from the beginning, when they start out in the curriculum. In addition, it was reflected that they gain and build experiences as they move through the levels of the curriculum. The following extracts were shared by the participants, which demonstrates student entrepreneurship, as inferred from the voices of the participants:

(a) Self-regulation

Self-regulation refers to the students' ability to regulate themselves, which offers them the opportunity that ensures their development. It requires them to perform and accept responsibility. The following extracts refer:

"On the other hand, if they do the presentations themselves the benefit from there is that you develop other skills like they need to speak in front of other peers and people." **(Clyde)**

"Also, just looking at what is going on in the communities as well. To me that is making them more self-aware and also of why they came to study and with that what are you expecting from a higher degree education." **(Bonny)**

"Yes, students also get an opportunity to discuss what they have learnt in class or what they have encountered over the past week… We allow them to set their own group norms. And we allow them to come up with what will be the implications if one group, for instance, does not participate in the activities of the smaller group. So they have then a rubric where they score participation, etc. within the smaller group." **(Hezekiel)**

"They are also able to come with book skills about sessions where they want to view the videos themselves or self-directed learning." **(Emily)**

(b) Self-awareness

"This is certain, it's talking about the issues that to me I see it as abstract, some things that you can't touch. Things like what are your own morals? What do you believe? What are your own values? So I think that just stimulates that self-awareness." **(Bonny)**

(c) Self-directedness

"However, self-directed learning is specifically where the student see where they have available time, plan when they can do a skill in the skills lab and do it by themselves. So it actually is a learning process where students at the end realise but I actually need to do self-directed learning as well." **(Emily)**

"When it comes to the needs assessment, we don't have a specific tool for a needs assessment. So what the students do, they would go firstly and read up what a needs assessment is. They would get all the theoretical information. They would construct a needs assessment template." **(Hezekiel)**

(d) Self-rewarding

> *"Then the other thing is because they can see the outcome I think that is why they are enjoying it."* **(Hezekiel)**

> *"... because if you are able to speak in class you develop that confidence also in yourself and you learn to interact with each other because you're going to work in a community, so doing that level of engagement with each other."* **(Izelle)**

6.3.5. Theme 3.3: Educator-related aspects

Theme 3.3 comprises the educator-related aspects, along with the associated categories, *purpose of the educator* and *lecturer reflection*. The categories, formulated through inductive reasoning, provided meaning and interpretation through the review and description of the associated codes.

6.3.5.1. Theme 3.3 – Category 1: Purpose of the educator

The educator's role has been viewed as that of facilitator, while other roles, also highlighted in the dataset, relate to the nurse educator being a mediator, a director, a planner of educational activities, as well as a reflective practitioner, to serve the purpose of transmitting and producing knowledge.

(a) Creating a balance in learning and teaching activity

Lecturers often experience challenges with creating a praxis between activities in class session, and what transpires outside of the classroom. One participant shared the following:

> *"But it is not always so easy because you are in this thing that you want them to have the knowledge and you want to control the environment and yet you want them to learn themselves and to merge the two that is sometimes very difficult."* **(Clyde)**

(b) Creating an activity schedule

Lecturers also engage in advanced coordinating activities, to simplify the process of teaching and learning, particularly, for students to create some sort of structure, to assist their progress in the module, as evident in the following extract:

"What I did this year is, I gave them all the due dates. I made a grid and gave them all the due dates of all the assignments and a guide. So they can't say … with the due dates and a guide and I said put that on your wall." **(Ann)**

(c) Balancing and structuring year level appropriate activities

The requirements of the curriculum are of such a nature that each year level has year level appropriate activities, which are more advanced than the previous year level, and should be designed and structured, constructively, to aid the curriculum and its objectives. The following extracts refer:

"It's a bit higher than first year. A bit deeper or more than what they used to know in first year…if we start in the first year they start with first aid. In the second year they do emergency trolley… So it links and it goes a little bit further with emergency care." **(Emily)**

"Obviously, now on a first-year level all those resources, equipment. And then we look that it is structured." **(Bonny)**

(d) Creating simplicity in translating knowledge

Simplicity is a requirement, which relates to all dimensions of the learning and teaching tasks, and includes the use of simple language, as per the following extract:

"I try, especially with my terminology, not to deviate and use plain language." **(Ann)**

6.3.5.2. Theme 3.3 – Category 2: Lecturer reflection

The lecturer has an equal responsibility to participate in honest reflection. These reflective activities form part of the development of the curriculum, to achieve its maximum potential. Specifically, lecturer reflection should mould and shape future learning and teaching practices, as expressed in the following extracts:

"So when I start with something new, I look at what they've done before and I go with that kind of and see so what works and what doesn't work and how could we better it." ***(Clyde)***

"And that came from mistakes that I've made that I also reflect on myself and try to improve on how can I improve in those." ***(Daniela)***

"It gives me also an idea of how we can do things better for the next year on the reflections because there is a question what do you think you could have been told if you were a student before clinical placement." ***(Bonny)***

6.3.6. Theme 4: Responsive curricula towards sustainable communities and accountable graduates

HEIs frequently encourage students to become critical citizens. Critical citizenship requires the student become engaged, as well as develop completely as a person, to achieve more than just knowledge, skills, and values, when engaged in scheduled learning opportunities. Critical reflection starts with self-reflection, to explore emotional experiences, constructed through social interaction activities.

Transmission of knowledge, therefore, is acquired by transforming the nature of the learner, with a more learner-centred approach, as s/he interacts with society, seizes opportunities and improves his/her outcomes, through reflective pedagogies and strategies, which explore growth in a diverse range of the learning domains. Ensuring responsive curricula, towards sustainable communities, and accountable graduates, requires individuals to be socially responsive, changes in the landscape of nursing practice and training, an engaged institution, and the aligning of content with current community engagement.

6.3.6.1. Theme 4 – Category 1: Responsive curricula towards sustainable communities and accountable graduates

(a) Being socially responsive

The participants, in more advanced levels of the curriculum, described how they prioritise the concept of critical citizenship in the modules they teach. They link the institutional graduate attributes, with critical citizenship, as being socially responsive to the needs of the society, as expressed in the following extracts:

"We need to be… our greatest attributes speak about that we need to train social responsive graduates … someone that can look at the needs of society and have an understanding of your contribution…" **(Hezekiel)**

"Also just looking at what is going on in communities as well… to me that is making them more self-aware." **(Bonny)**

"Society actually has an impact…" **(Arona)**

(b) Engaged institution

Higher education institutions, currently, are adopting and embracing community engagement strategies. CE is prioritised in the institutional operational plans at most institutions and plays a pivotal role in transforming, not only communities, but also higher education, as well as learning and teaching pedagogies. The following extract refers:

"We are going to the Genadendal community for the whole day as department and as a faculty … we as a university must be visible and what we preach we must practice." **(Arona)**

Institutionally, the commitment is prioritised to be engaged, setting an example through the participation in activities related to community engagement.

(c) Need to aligned outcomes to community engagement activities

The participants frequently acknowledged the need to integrate community engagement activities. They regarded it as relevant and essential to serve the purpose of the curriculum, in order to make the curriculum relevant to current issues that are challenging to society. The following examples justify the abovementioned:

"What was needed for the theoretical background of healthcare and the structures in the country and where do all the levels fit in and then also all the needs of the community. What they also do is actually look at where the community is, the staff members and the qualifications,

and then the needs of the community and what services, all the services rendered to the community, is it accessible, etc." **(Bonny)**

"Therefore, the students have to be able to analyse, to do a needs assessment to go there and find out what this is about? What is happening? How do we respond to the ... what do we see? It could be like drug abuse. So you go to a community like Mannenberg and find out what is happening in that community – maybe there are a lot of delinquents and broken homes. So you have to identify what is relevant and then respond to it." **(Izelle)**

"The second semester, they do nutrition in the theory and then the assignment is for them to go and visit any facility out in the community, for instance, it could be an old-age home, a crèche; not a hospital. We don't want them in hospitals. They need to find something else." **(Clyde)**

"I actually would like them to partake in community projects. I'm actually sorry that I didn't take them to the one at Fisantekraal." **(Bonny)**

"Students are exposed to the environmental health assignment. In this assignment, if I can make an example, now recently, where this outbreak of listeriosis, the drought in Cape Town, so in this assignment they must now apply what happened outside in the community in relation to theory." **(Ann)**

(d) Involvement and engaging with community

Communities should be involved in their own health, and should share the responsibility of taking matters into their own hands. They should be involved when planning interventions, to address their concerns and health issues.

"If I look at one site where we are involved in the church, the fact that we could get the message of gender-based violence out to so many people, the community became more aware of the implications,

consequences of gender-based violence and they were educated about it." **(Hezekiel)**

"I think it is when they are working in the day hospitals or the clinics, even there in the triage room, when they work there, they can see what type of clients come there and they intervene and talk to the patients and they can make a research-like initiative for that day or just summarise what they saw for that day or for that week and what stands out for them and what are their challenges there." **(Arona)**

(e) Changing landscape of nurse training

With the transformation of the new nursing curriculum in progress, a major shift would influence the way nursing training is offered, and ultimately, how nurses will practice. Currently, nurse training opportunities are curatively driven; however, the vision to manipulate this to a more preventative focus is underway. The participants expressed cognizance of this change in the landscape of nursing, as a profession. The following extracts refer:

"...because the way forward is that our new professional nurses need to be primary health educated. That is where the WHO is placing its money and that is also where the need is to prevent rather than to cure." **(Arona)**

"It can take place in a mall. It can take place anywhere. It depends on the activity that you are doing. We can screen people for diabetes in the mall. We can screen people for hypertension in a club. We can screen people for HIV at a taxi rank. So ja, it shouldn't be that specific area which is the current challenge we have." **(Hezekiel)**

"I think the goal now is - how do we realign the curriculum to speak to what is happening in the community that we see..." **(Izelle)**

6.4. Summary

In this chapter, the researcher stated the findings of Objective 4 of this current study, which was based on the learning and teaching experiences of nurse educators, who teach in the undergraduate Bachelor of Nursing curriculum. The findings of this objective provided a

detailed description of the idea that was revealed in a previous stage of this current study. In the next chapter, the main findings of Phase 1 and Phase 2 of this study are discussed. Subsequently, this leads to the development of the SL pedagogy, into a feasible structure, to be explained later in the dissertation. Important arguments, in terms of key findings and recommendations enables the finalising the SL pedagogy, through validation, as intended for this current study.

CHAPTER SEVEN

DISCUSSION OF MAIN FINDINGS

7.1. Introduction

In this chapter, the researcher provides a discussion of the main findings of this current study. The discussion is focused on the development of the Service Learning (SL) pedagogy for the Bachelor Nursing undergraduate curriculum. The chapter is structured according to the conceptual framework, as discussed in Chapter 1, to illuminate how the different phases, with its objectives, informed the SL pedagogy for the undergraduate nursing curriculum. Research conducted in 2014, at the institution under scrutiny, developed an implementation framework, to institutionalise service learning in a nursing programme, as opposed to the mere module perspective (Julie, 2014).

This current study was conducted in three phases. Phase 1 of the study related to: *Creating a climate for change*, through the execution of a document analysis. The document analysis allowed the development of a curriculum map of the undergraduate Bachelors of nursing curriculum. Subsequently, the mapping allowed the formulation of the CE typology, as reflected in learning and teaching practices, as well as the management of the quality of SL elements, currently in the undergraduate nursing curriculum. Phase 2 of the study focussed on: *Engaging and enabling the organisation*, by conducting qualitative interviews with nurse academics, regarding their learning and teaching practices. The findings of phase 1, together with phase 2, were used to formulate and inform the SL pedagogy.

7.2. Guiding principles related to curriculum development and practices

Five guiding principles were explored in this current study, as documented in Chapter 2. Each one of the guiding principles for the improvement of practice in the curriculum, is clarified to provide a conceptual underpinning for the proposed pedagogy. Even though each principle is managed as a separate entity in this thesis, the emphasis and clarity provides logical connections between and among them, which engender the SL pedagogy. The guiding principles that were explored included: the essence of the curriculum design; the need for a conceptual underpinning (ideology); conceptualisation of the attitudes and belief about

learning; exploration of the epistemic rationale; political realities of curriculum development; and an understanding of the curriculum development/planning process. These provided symbolic meaning related to the pedagogical and curricula practice. In addition, it strengthened the understanding of why SL was needed in the undergraduate curriculum, as well as the need to operationalise SL, meaningfully, for educational practices.

7.2.1. Principle 1: Essence of curriculum design and need for conceptual underpinning (Ideology)

The essence of the curriculum is expressed in terms of its ideology. An ideology represents the important conceptual underpinnings of the curriculum. Accordingly, the conceptual underpinnings of the curriculum are reflected in Figure 7.1, as explored in Phase 1 and Phase 2 of this current study. The main features of the conceptual underpinnings were explored, in terms of the following five ideologies (Boelen et al., 2019):

1. Strategic policies and guidelines;
2. Graduate attributes (GA);
3. Specific outcomes;
4. Curricular content;
5. Types of educational opportunities.

The findings are discussed in terms of the above-mentioned ideologies associated with the curriculum.

7.2.1.1. Strategic policies and guidelines

The implementation of SL in an academic curriculum of colleges and universities is strengthened by strategically planned change (Bringle & Hatcher, 2002). This implies that the alignment and agreement should be evident, strategically, in policies and guidelines that direct learning and teaching practices in Higher Education (HE). The strategic policies and guidelines that direct SL at the institution are imbedded on three levels, which profoundly uphold the curriculum.

This is consistent with recommendations from international standards guiding SL institutionalisation (Bringle et al., 2002).

The first level is the policy of the institution, where the programme is offered. The Institutional Operational Plan (IOP) of the institution schedules their priority through the following statement: *To promote excellence in a learning-focused and research academic environment that facilitates local and global engagement and is responsive to a rapidly changing 21st Century context.* (UWC, 2015a, p. 11).

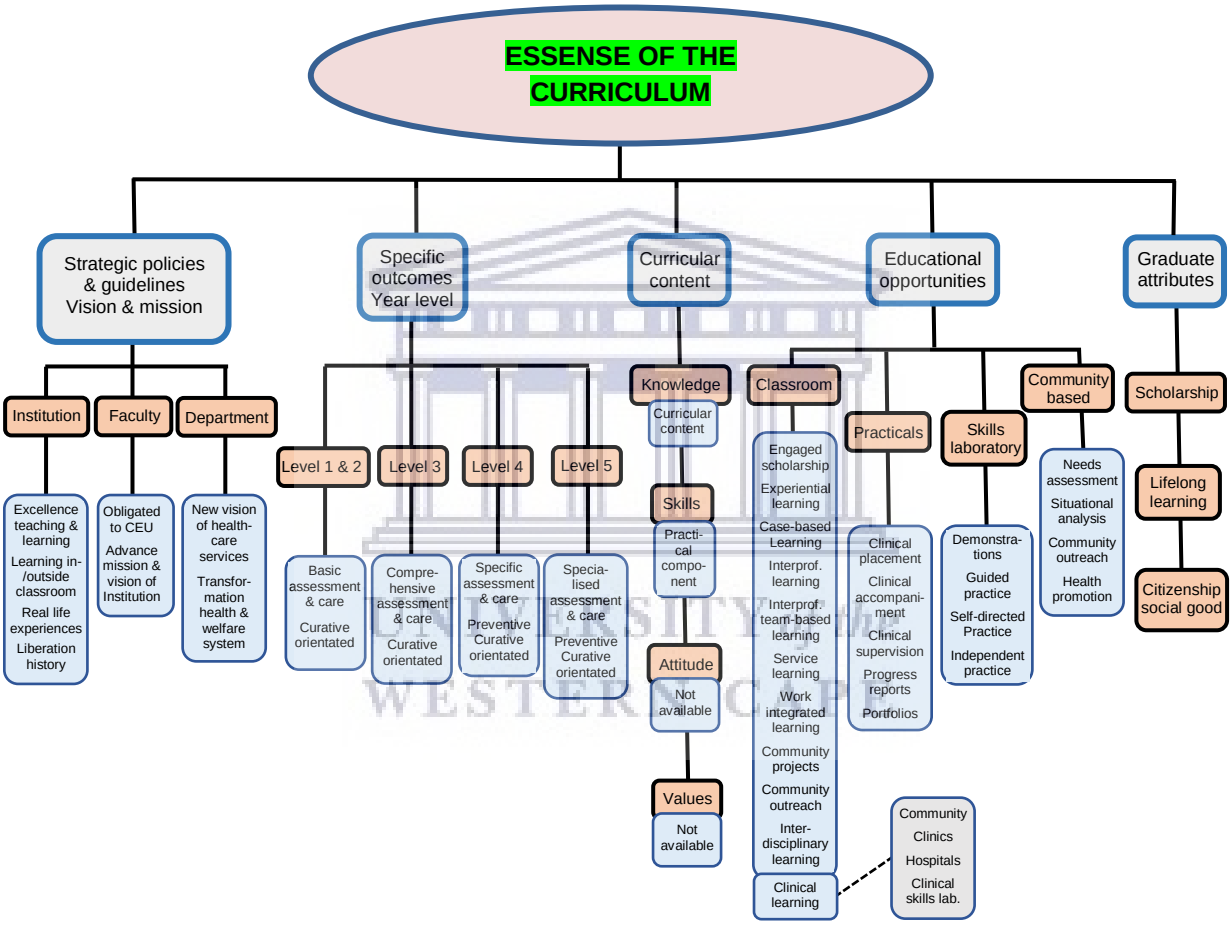

Figure 7.1: The essence of nursing curriculum

The essence of this goal, or priority, provides a description of a prodigy area in the IOP of the institution, where this study was conducted. In addition, the mission of the institution places its goal on excellence in teaching and learning, among its central concerns. The commitment to achieve this goal has been strengthened with strategic positions that were created, namely a directorate for teaching and learning, a director for teaching and learning, as well as teaching and learning specialists in each faculty, to provide leadership and direction, in terms of advancing the institutionalisation of SL at the institution. However, the commitment of the institution should be extended, to specify the relationship and participation that faculties must have with the Centre for Innovative, Educational and Communications Technologies [CIECT], as well as the Community Engagement Unit, in order to activate, plan, deliver, and advance the important tenants of the goal areas, as defined by the IOP.

In this document, the researcher acknowledges that learning should build on the following understanding; learning transpires in various ways, and through a variety of modes, both inside and outside the classroom. Additionally, the researcher mentions the value of real life experiences, which shifts the expectations that each generation brings to the classroom, to nurture a social just society. Specific reference is made to the priorities that were set in the previous IOP (University of the Western Cape [UWC], 2009), which were focused on institutionalising the advancement of Information Communication Technology (ICT), and Community Engagement (CE) in teaching and learning practices at the institution (University of the Western Cape [UWC], 2015a).

The mission statement of the institution acknowledges its proud experience in the liberation struggle, and declares that it is conscious of the distinctive role, played by academia, in helping to build an equitable and dynamic society. In addition, the mission statement further clarifies that the institution aims to design curricular and research programmes, appropriate to its Southern African context. Therefore, this intention provides the opportunity to transform curricular approaches, to more acceptable ones, in order to pursue and combat ills, as well as the disorders that exist in society. This is a clear commitment to the search for meaningful ways to contextualise pedagogical approaches used, which are inclined to deliver healthcare

services to the people in communities. Evidently, this commitment has been sustained, with progression between the previous and the current IOP of the institution.

The Bachelor of Nursing is situated in the Faculty of Community and Health Sciences (FCHS), which is committed to the development of historically disadvantaged communities in South Africa. As a school in the FCHS, nursing also acknowledges in their vision and mission statements that they are committed to the promotion of a new vision for healthcare services, which aim to advance the transformation of existing health and welfare services. Consequently, it is appropriate that the nursing curriculum is undergoing a major paradigm shift, from a curative-based, to a primary-focused, curriculum. Essentially, it necessitates achieving the professed commitment through the redirection of learning and teaching practices, and completely embracing what is required by society.

Through the document analysis, conducted in Phase 1, and the semi-structured interviews in Phase 2, it became clear that learning and teaching practices remain true to the traditional learning and teaching methods, despite the strong case-based learning orientation. Table 5.5 (Chapter 5) demonstrates the strong relationships that remain consistent with the traditional class-based activities within the module. It is also noted that these types of learning and teaching pedagogies and strategies remain consistent, as the student progresses through the curriculum. Progression refers to scaffolding and constructive alignment of outcomes, content, learning and teaching strategies (Bruce et al., 2011). In application and practical implications, it would require the evolvement of the student's ability, from uncertain to self-efficient. Kim and Hannafin (2011, p. 256) refer to this as the "deliberate activities in which students pose to investigate and solve meaningful scientific problems by inquiring through iterative non-sequential phases; problem identification, exploration, reconstruction, presentation and communication, and reflection and negotiation". The mastery of this skill would demonstrate that the student has grown in his/her ability to engage with the tasks at hand.

This is indicative of the pressing need to transform systems, and encourage the move away from the still existing traditional approach, to a more transformative approach in curricular revision, which would foster and embrace community engagement. The

World Health Organization (WHO, 2013) commits to the transformative scaling up of education and training of health professionals, as defined by sustainable expansion and reform, to increase the quantity, quality, and relevance of health professionals, consequently, strengthening the country health systems and improving population health outcomes (Wheeler, Fisher, & Li, 2014). The education and training institutions for health professionals should consider adapting curricula to the evolving healthcare needs of their communities. The emphasis is on achieving the goal, to improve population health outcomes, which should be centred on the immediate needs of society. WHO (2013) recommends the inclusion of a wide range of developments around community-engaged relevant curricula, through to equipping health professionals with the skills to be high quality, competent clinical teachers and academics, contributing to preparing high quality, competent nursing graduates, to practise in societal areas of need.

Ultimately, a greater alignment between educational institutions and the healthcare system is the required ingredient, to bring about transformative change and leadership in preparing future graduates, who have an affinity to work in rural and remote areas, where the challenging issues of health equity and equality exist. According to the National Development Plan (NDP) of South Africa, the intention to transform education, to address the healthcare needs of society, has been invoked. However, it is difficult to act on this, as there are many layers to filter through, down to the intentions. It is evident that, from the document review conducted in this current study, the vision and mission statements of the institution, the faculties, and the departments are aligned to support the transformation agenda. On operational level, however, a missed alignment is evident through the institutionalisation of approaches to education in its learning and teaching practices.

Key features of the vision and mission of FCHS relate to student education that promotes a primary healthcare approach, which is firmly rooted in the community and interdisciplinary teamwork. In addition, the vision of the faculty extends further, to provide responsive models of training and intervention. It is argued that responsive models of training remain elusive and nebulous, as is evident in the majority of learning and teaching practices in the School of Nursing, which remain aligned to the traditional and conventional teaching methods (Chapter 5).

The home department (School of Nursing) of the Bachelor of Nursing professes to produce a competent professional nurse through a community, problem- and competency-based curriculum. Not much is expanded on to activate the acknowledgement of ethos, as well as the underlying values attached to the learning and teaching practices. This reflects a deprived approach to nurture social justice and socially accountable graduates.

Even though the strategic policies are defined at three levels of the institution where the Bachelor of Nursing is offered, the need still exists to promote and strengthen the manner in which social justice is approached, purposefully and meaningfully, through integration into curriculum coursework, so that the knowledge gained from academic experiences, are not isolated experiences, but part of the larger purpose (Rouse & Sapiro, 2007). This would also allow practices to be synchronised with developments in other nursing programmes in South Africa that provide a SL infused approach, starting from the first year, to the fourth year of the undergraduate nursing programme, extending SL into their postgraduate programmes (University of the Free State [UFS], 2016).

One key suggestion by Boelen et al. (2012) promotes the idea that institutions should shift responsibility and responsiveness to accountability. This idea is presented in the form of a social obligation scale that provides elements, which are envisioned to be operationalised and activated in curricula. It lists elements that are graded, using the proposed levels of obligation, which should cut across the purpose, the outcomes, and other important denominators of the curriculum. In addition, Boelen and Woollard (2009) assert that social accountability should include the institution's conceptualisation, production activities, and the usability of graduates. These authors developed the Conceptualisation Production and Usability (CPU) model to assess social accountability, so that teaching and learning organisations could demonstrate the effects of their activities, rather than simplistically describe potential. This would strengthen the call to assist transformation on multiple levels, including HEIs, health systems, and communities. With accountability, institutions commit to work collaboratively with governments, health departments, organisations, and the public, to impact positively on people's health, and be able to demonstrate this by providing evidence that its work is relevant.

In this current study, the main partnership is with the government's Department of Health, at which settings students conduct clinical placements. Additionally, opportunities to actualise community partnership with the Faculty of Community and Health Sciences exist with a major community, which they use as field experience to engender community engagement. Social accountability is the capacity to respond to society's priority health needs, and health system challenges, to yield the most relevant outcomes, and the highest impact on people's health.

7.2.1.2. Graduate attributes (GA)

GA could be described as the generic skills of graduates; their qualities, outcomes, or core capabilities. It has also been labelled as the hierarchy of terms that develop specific knowledge, skills, and values in higher education (Hill, Walkington, & France, 2016). The GA are inclusive of various skills and values, which are mandatory institutionally wide, forming part of all academic programmes offered at the institution. While reviewing the module guides, it was evident that the GA have a consensual role to play between the specific outcomes and curricular content (Chapter 5). GA relate to citizenship and social good, with an emphasis on social awareness, and should articulate the values and morals that institutions intentionally instil in their graduates. The attributes should be aligned with specific intentions of the prescribed curriculum, to operationalise the vision and mission statements of the institution, coherently.

Boelen and Woollard (2009) propose that the values associated with GA should make explicit reference to quality, equity, relevance, and effectiveness. This would instil values in graduates that would foster change agents, with the capacity to work on the health determinants, as well as contribute to adapting the health system to be more relevant to the needs of the society (Boelen et al., 2012). GA should also inform other curricula design aspects, such as learning and teaching practices, and assessment. Spronken-Smith et al. (2015) view GA as skills, knowledge, attitudes, and values. These are distinguished from the disciplinary expertise associated, more traditionally, with higher education, but which contributes towards the profession. A general balance, therefore, should be created among all the aspects that are evident from learning and teaching practices, specific outcomes, and the curricular content of undergraduate training and education.

GA are broader and more encompassing than *employability*, helping to develop academic, citizenship, and career competencies (Hill et al., 2016). These authors further state that the intention of GA is to feed the national prosperity in the emerging knowledge economy. Therefore, it becomes important to consider how GA enhance generic graduate capabilities, as well as disciplinary expertise to undergraduate students. This would avoid deferring market forces and the consequences of commodities in learning and teaching practices (Cribb & Gewirtz, 2013). A propensity of Australian HEIs is the increasing use of GA to inform curriculum design, as well as engagement with teaching and learning experiences at universities around the world (Barrie, 2012). This implies that movement in global trends exists, to activate graduate attributes through curricular activities.

The institution, at which this current study was conducted, has a fully developed set of GA that guides faculties to the core skill set, which each graduate of the institution should possess on completion of a programme at the institution. These GA are developed in two tier sets, which are depicted in Chapter 5. Under Tier One, (1) *citizenship and social good* is acknowledged, while under Tier Two, (2) it recognises that a graduate should be *ethically, environmentally and socially aware and active*. The GA listed under the two tiers form an orientating framework of educational outcomes, which HEIs commit to entrust to graduates, on successful completion of their studies (Hill et al., 2016). In the Bachelor of Nursing curriculum, commitment was evident in the module guides, with the inclusion of graduate attributes. However, it did not reveal how the graduate formed part of the primary goal of educational opportunities that was employed to convey disciplinary knowledge. It is important, therefore, to find structured and meaningful processes of designating and implementing GA, within, across, and beyond curricula. Consequently, conscious decisions are required regarding the way to approach curriculum content and co-curricular activities, pedagogies, as well as the nature and use of learning spaces, to bring GA closer, and more appropriate to serve its purpose.

Another dimension towards activating the GA to reach their full potential is the requirement of strong leadership from senior management and educational structures, which should be active, to ensure that GA and disciplinary content are balanced. This requires substantial support from the educational institution (Ramasubramaniam &

Grace, 2015). Institutional directives, initiatives, and policies should be prescriptive, in terms of its expectation on the manner in which GA should articulate within curricula. It was observed that GA were tabled in all module guides, linking them with curricular content and outcomes; however, when studying the associated learning and teaching activities, it was unclear how GA were dealt with at the basic level of instruction in the curriculum.

The role of the educators remains critical, when executing and implementing their tasks, which require them to infuse disciplinary knowledge with GA, to ensure that GA are achieved. They should take time out to ensure that learning and teaching activities are contextualised to provide opportunities, which demonstrate the balance between GA and disciplinary content (Hill et al., 2016). Nursing education programmes are "obligated to challenge long-held traditions and design evidence-based curricula that are flexible, learner-responsive, inter-collaborative, provide a diverse experience, and use current technology" (Ramasubramaniam & Grace, 2015, p. 77). They further state that:

> *"Instructional reforms should: adopt competency-driven approaches to instructional design; adapt these competencies to rapidly changing local conditions drawing on global resources; promote inter-professional and trans-professional education that breaks down professional silos while enhancing collaborative and non-hierarchical relationships in effective teams; exploit the power of information technology for learning; strengthen educational resources, with special emphasis on faculty development; and promote a new professionalism that uses competencies as objective criteria for classification of health professionals and that develops a common set of values around social accountability."* (Ramasubramaniam & Grace, 2015, p. 77)

The proposed SL pedagogy proposes to meet the required standard, to transform curriculum practices and advance the agenda required by South African authorities, as expressed in the DoE Programme for Higher Education Transformation (RSA, DoE, 1997). Simultaneously, it offers an opportunity to operationalise the graduate attributes, related to social awareness and social good (UWC, 2015a). Osman and

Petersen (2013) assert that SL challenges educators to reconceptualise their curriculum and disciplinary training, as well as their role as educators, when their praxis is interrogated through the lenses of critical social and transformative learning theories. Praxis is accommodating of the application of knowledge, or knowing how to apply what was learned, which signifies the essence of experiential learning. In the next section, the researcher discusses the evidence extracted under the specific outcomes, firstly, and secondly, the curricular content of the Bachelor of Nursing curriculum.

7.2.1.3. Specific outcomes

Guided by the GA, and specific outcomes, the students could learn during the course of the module (Hill et al., 2016). It would reflect the interaction between knowledge, skills, and attitudes that should be transferred to the student. During the document analysis, it was challenging to compare and contrast the specific outcomes with one another. However, an intricate relationship of the specific outcomes of the modules, interact with the GA (Chapter 5). It was clear that specific outcomes were linked, and grouped per year level of the Bachelor of Nursing curriculum. In Chapter 5, the researcher explained how the curriculum was structured, as well as how the NQF level increases as the student progresses through the curriculum. The amount of credits also increases, as the student, who is committed to the nursing module, progresses. This provides ample opportunity for creativity, because of the way learning and teaching activities are structured, according to the prescribed vision expressed in the IOP (UWC, 2016), as well as the graduate attributes, which is indicative that, in the core dimensions of the curriculum, scaffolding and constructive alignment is evident. However, not much evidence was found, which indicates that these two elements were evident in other dimensions of the curriculum.

The specific outcomes relate to a large portion of knowledge, which ranges from basic or fundamental aspects, to specialised disciplinary knowledge, often failing to connect the outcome to the need of the community. In the curriculum, the aspect that carries substantial weight, is the skills that students are expected to acquire. Due to the nature of nursing, and the module guides, it was difficult to note the individual skills associated with each module. Evidence of core values that were associated, is broad, and limited to those mentioned in Figure 7.1, which are applied vaguely to the GA of the institution. A lack of evidence, relating to the values and attitudes that students

need to acquire through the specific outcomes, concerning social obligation, was observed. Ultimately, it is important that the GA connect to specific outcomes, paving the way to the curricular content, creating congruence in the purpose of the curriculum.

An apparent deficiency was identified in the structuring of the specific outcomes of all the modules in this current study, as there was limited, or a lack of information scheduled, regarding the activation of social obligation values, as expressed by social responsibility, responsiveness, or accountability (Boelen et al., 2012). The failure to instil values that engender accountability in the curricular content, has a detrimental effect on the ability of graduates, in their professional capacity, after completing the nursing degree. This influences the standard of graduates negatively, as social accountability is the capacity to respond to society's priority health needs and health system challenges, to meet such needs, and yield the most relevant outcomes, significantly impacting people's health. In order to engender accessible and better-quality healthcare, it is important to recognise the value, as well as the complexity of social accountability interventions, and operate accordingly in the course outcomes (Boydell, McMullen, Cordero, Steyn, & Kiare, 2019).

Curricular content and specific outcomes should be broad, and should accommodate unpredictable implementation processes, by moving towards co-design and horizontal approaches with the community (Boydell et al., 2019). Involvement of the community, when developing specific outcomes, ensures that the pressing needs of communities are met. One participant shared the following:

> *"How do we respond to ... what we see? It could be like drug abuse. So you go to a community like Mannenberg and find out what is happening in that community – maybe there's a lot of delinquents and broken homes. So you have to identify what is relevant and then respond to it."* (Izelle)

The educators explained how relevancy was established between the needs of the community and what they were taught in the classroom. Therefore, it is imperative to persist in strengthening the curricular outcomes, through the GA, which would provide direct and significant leadership towards institutionalising SL, making curricular practices relevant to societal needs that exist.

Specific outcomes provide an opportunity to define competencies for graduates, who follow a degree programme. Competence is understood to be a basic standard, scheduled through two dimensions, namely, the potential abilities that may work effectively under certain circumstances, and the motivation to display usefulness, using those abilities (Fukada, 2018; Salem, Aboshaiqah, Mubaraki, & Pandaan, 2018). Nursing programmes have been subjected to challenges to clearly define the structures for nursing competence, competency levels required for nursing professionals, and training methods (Fukada, 2018), especially, in a rapidly changing environment, where nurses are required to provide comprehensive care that meets complex and diverse societal needs. The participants in this current study suggested that it is essential to change the nature of nursing care, by acknowledging the changing landscape of nursing.

Nurses have the social obligation to ensure that communities are educated and aware of the way conditions in the community influence disease profiles, and contribute to the burden of disease (RSA, DoH, 2012). Community awareness and engagement are critical and essential components that ensure preventive healthcare, or even the continuing maintenance of appropriate care in curative care, as they provide the means of establishing contact with the community.

Those, who are responsible for the implementation of national and provincial health initiatives, should seek to acknowledge *all* the factors that influence health. Fukuda (2018) asserts that nurses are continually challenged regarding their contribution to society, as professionals. The reason behind this fact could be that the nursing curricula in low- and middle-income countries, such as South Africa, are based on earlier models of nursing education; for example, the adoption of apprenticeship, hospital-based, and task-based models, which do not meet the current healthcare demands. This implies that, the competencies set for the current programme, may be insufficient in preparation for the transformed role, which the nurse has to fulfil, with the proposed changes in the healthcare system. Arguably, these practices require restructuring, to imitate the fast changing demographic landscape and healthcare needs (Ma, Fouly, Li, & D'Antonio, 2012).

7.2.1.4. Curricular content

Curricular content refers to the totality of what is to be taught in the curriculum. In simple terms, it refers to the facts, principles, and concepts to be taught in the curriculum. Observations were made about the curricular content applied to the dimensions of knowledge, skills, attitudes, and values in curricular practices. The document review yielded inconsistencies regarding curricular content and societal needs, as illustrated in Chapter 5. Evidently, the current curriculum does not provide acceptable integration of outcomes that relate to societal issues, which is absent in the way curricular practices are structured in learning and teaching activities. In line with South African literature, the findings of this current study highlight the reality that, in South Africa, challenges and inconsistencies have been reported, to include the following: a mismatch between professional competencies and patient/population health priorities; poor teamwork; and insufficient emphasis on primary healthcare (Armstrong & Rispel, 2015, p. 1). One participant revealed:

> *"At the moment, it is actually only when the students hit the third year, I think, that they are being engaged a lot and then they come from secondary level of care. So their whole mind set is actually so secondary orientated. They just thinking medication and they can't think what health education or promotion they can give."* **(Arona)**

This is a direct link to the problem statement developed for this current study. This participant explained how she struggled to change the conviction of the students, regarding their perception of healthcare delivery. She stated that their mind-set was secondary orientated, implying that they were inclined to deliver services that were curative orientated. This poses a major challenge and could confuse the students, as the modus of the programme changes in the third year, when they engage with the CUR311/324 modules. A further challenge is the achievement of merits and standards, attached to the meaning of community-based interventions, which highlights the difficulty for students to switch from a curative-orientated to a primary-orientated healthcare system.

The participant continued by acknowledging the vision of the WHO's Universal Health Coverage (UHC):

"…because the way forward is that our new professional nurses need to be primary health educated. That is where the WHO is placing its money and that is also where the need is to prevent rather than to cure." **(Arona)**

UHC in South Africa is scheduled to be implemented in South Africa, imminently. The bill has been accepted, and fortunately, coincides with the transformation of the nursing curricula that is transpiring. The political motivation could be rationalised, for such a move to coincide with transformation in the nursing profession, as nurses were always regarded as the back bone of the healthcare system, in terms of service provision. This creates a further urgency to truly transform the perception and engagement of students in the curriculum, regarding the values that are transferred, as well as the skill set with which graduates leave the institution. Evidence of associated core values is broad, and limited to those mentioned in Figure 7.1. Not much evidence, relating to the values and attitudes that students need to acquire, currently exists. In addition, it is important that the role of the GA, connects the specific outcomes with the curricular content.

7.2.1.5. Types of educational opportunities

The educational opportunities that exist in the Bachelor of Nursing curriculum, expresses the various opportunities scheduled through the following formats, namely, classroom, skills laboratory, and community-based settings. The classroom setting remains the predominant setting for the transmission of knowledge. Opportunities, which were extracted from the module review in Objective 1 of this current study, revealed that community-based activities are limited to year Level 4 and Level 5.

Level 1, 2 & 3: Integrates discipline-based knowledge and skills through learning and teaching activities, scheduled in class, skills laboratory, and clinical practical sessions.

Level 4 & 5: Integrates discipline-based knowledge and skills, characterised by community-based interventions and reflective practices, through personal, group- and community-based reflections and feedback.

Specifically, only one module, NRS401, utilised SL in the module, combining the case-based method that the curriculum prescribes, and blended learning, through

online blogs and discussion forms. This module displays the well-integrated nature of the latest trends for the curriculum content.

Portfolios have been identified as the most common assessment method alongside tests. Two modules, CUR311/324 and NRS401, demonstrated the nature of the portfolio, in which the students were required to display competence in providing community services and outreach, service learning projects through authentic experiences, reciprocal learning, as well as reflective practice between themselves and the community they service. Portfolios have been described as essential for the development of complex competencies, such as those identified in the GA and outcomes (Frantz & Rhoda, 2007). Portfolios, therefore, provide opportunities to entrench community-based interventions, such as SL, as well as community outreach in assessment practices, where students can demonstrate a multitude of skills and competencies. If structured appropriately, with standardised criteria of focus areas, it has the potential to capture infinite learning and teaching activities, as displayed in the modules, CUR311/324 and NRS401.

During the semi structured interviews, the participants revealed a variety of learning and teaching methods that they used, which constituted the theme 3.1, Category 1, Teaching traditions, strategies, methods and activities. Not much information is provided on these in the module guides, and therefore, they should be revised, to offer guidance to those, who need to operationalise it. This would give meaning and serve to orientate the student to the methodology utilised. Pre-pedagogical training, which serves as orientation to the teaching methodology for the students, is regarded as important to maintain a sustainable professional interest (Sadovaya, Luchinina, & Reznikov, 2016). Referring to *Chapter 6, Theme 3.1, Category 1: Teaching traditions, strategies, methods and activities, codes b and d, an overview of exploratory methods,* these methods of the silent traditions, strategies, methods, and activities, should be stated and operationalised in module guides, to orientate the students towards activities. Most of the strategies are not defined and provide limited information on how to use and facilitate learning and teaching

The educational opportunities identified in the majority of the modules during the review, were not a reflection of attempts to nurture social change. It is often neglected,

or they failed to address social change for greater social good. A study conducted in South Africa revealed that less than half of the institutions display how social obligation is integrated in module guides (Frantz & Rhoda, 2007). Social obligation, therefore, needs to be prioritised, through suitable learning and teaching methods that provide an opportunity to engage with communities, using set ways. The educational opportunities would later appraise the Typology of CE and SL.

However, no fixed methodology exists when dealing with educational opportunities. In Table 5.7 (Chapter 5), the attributes of the curriculum, which point to the required praxis in the curriculum, are illustrated. Only three of the 23 modules did not have an active clinical component attached to the module. These three modules serve a greater purpose, as they are pre-requisite modules for other modules, which implies that they relate to the practical component. These clinical components are often not clearly integrated into the module guides. Challenges were encountered to grade these activities, which are addressed later in this discussion.

The Higher Education Quality Committee (HEQC) propose five SL approaches within a curriculum model, as discussed in Chapter 1. This offers educators the potential to balance different approaches with the structure of the nursing curriculum, as it caters for discipline needs, problem-based learning, and capstone modules (HEQC, 2006). By arguing that these potentially hold promise to develop a typology, based purely on the SL, as part of the CE typology, is encouraging towards redressing imbalances in the design of the nursing curriculum. It could also be reasoned that these exemplars, proposed by HEQC, meet the current trends, not with the progression of the programme, as the first two levels of the programme adhere to addressing foundational disciplinary knowledge. The 3rd and 4th year levels are more problem-based, orientated within the field, and Level 5 of the programme intends to create a generalist view of the curriculum, in terms of skills and values. The educational opportunities and possibilities would later appraise the Typology of CE and SL.

7.2.2. Principle 2: Conceptualisation of attitudes and beliefs about learning

The context of this current study focused on being able to determine the specific attitudes and beliefs about learning, through the following three aspects in Table 7.1.

Table 7.1: Educational position and view of Bachelor of Nursing year levels

Year Level	Outcomes and Objectives	Teaching pedagogies and strategies	Assessment and evaluation Methods	Identifying educational position
Level 1 Level 2	Referring to the main outcomes and main content of the modules listed in this year level it is evident that these modules deals with mastery of basic skills and adopting of certain values as it primarily deals with the fundamental aspects of nursing practice. Practical outcomes are poorly defined and not directly related to theory outcomes	• Problem based • Case based • Self-directed methods	Theory: • Online tests, • Tests • MCQ tests • Peer assessments • Group assignments • Individual assignment Clinical or Practical • Clinical assessments • Portfolio • Progress reports • Community profile	Even though some characteristics responds primarily to transmission and transaction orientations towards learning. Limited evidence exists in the module guides that prescribes to transformative views of learning
Level 3	The outcomes of this year level are narrowly and in a general way described. It does not articulate the nature of nursing which needs to contribute to the greater good of health.	• Case based • Principles of competency-based education • Teaching strategies include group discussions, face to face and tutorials	Theory & Clinical • Tests • Case study • Quiz • Progress reports • Clinical learning activities • Clinical Skills	Primarily view of learning embrace transmission and transaction positions. Transmission is absent. The pedagogy and teaching strategies is more shifted between transmission and transaction.
Level 4	The level deals with a more intimate nature of care. The outcomes are specific to the context of the modules. It does not relate to the broader community and is orientated towards curative interventions. One module CUR311/324 integrates a health promotion project in one semester which adopts elements of SL e.g. providing a service and reflection	• Case based learning • Constructivist learning approach • Principles of competency-based education • Teaching strategies: solving cases, group work, role plays, E-teaching and theoretical input.	• Tests • Assignments • Class presentations • Evidence of clinical learning • Clinical skills • Health promotion activity	An element of transformative position of knowledge transmission is evident, however, it is not equally balanced with transactional and transmission positions of knowledge transmission.
Level 5	The outcomes of this year level are fixed around clients, their families and communities. It involves preventative strategies, promotion of health and rehabilitative services	• Case based • Service Learning • Teaching Strategies: group work, role plays, case studies and theoretical input	• Tests • Group assignment • Clinical assessment • Outreach project • Reflective practices • Journal club activities • Outreach project • SL project	The year level has a strong orientation to the transformative view of learning. The learning outcomes, the teaching pedagogy and strategies as well as the assessment and evaluation methods are securely imbedded into the constructivists approaches to learning.

Set ways in the format of summative assessment methods, which pre-empt a theory examination and clinical examination for all year levels

(a) Transmission position: The act of transmitting knowledge implies that knowledge is transferred from one individual to another, usually in a teacher-centred environment;

(b) Transaction position: This implies interaction, in order to construct knowledge; and

(c) Transformation position: Refers to the ability to create conditions that have the potential to transform the learner. This last aspect relates to the transformative world view, which requires the student to be conscious of situations that lead to a greater understanding of, and care for self, others, and the environment.

7.2.3. Principle 3: Epistemic rationale

The epistemic rationale refers to epistemology, which is a branch of philosophy that deals with the origin, the nature, and the limitations of knowledge. Therefore, it is conveyed and expressed through the philosophical orientation (Table 7.1), in which the curriculum is imbedded. It draws a distinction between academic curricula and utilitarian curricula. The debate is ongoing between these two types of curricula, which negotiate tensions on the aspect that the distinction between the two is viewed as having knowledge (academic), and being able to demonstrate or apply that knowledge (utilitarian).

The basic principle of creating a praxis comes to the fore, in this regard. Praxis refers to the point where knowledge meets practical. This mainly introduces a political element into the discourse, as Service Learning has been linked to the creation of a praxis in the transfer of knowledge, and prioritises the service needs of society with classroom learning. This has been identified as the major contribution of Freire's theory, providing insights that education is always political. By its very nature, it never is, nor could it be neutral, instead, it always serves the interests of some, and impedes others. The core responsibility of the nurse is to care, which captures the essence of the profession, and nurtures the following assumptions about human beings (clients and society), as well as the purpose of nursing, the values and the norms of the profession, health, society, and learning and teaching (Bruce et al., 2011). This could lead to views, which foster the belief that nurses should have an obligation towards societal needs, or that nurse educators should be the sole transmitters of knowledge. Responses to these views should challenge the personal philosophy of nursing, as it extends the boundaries of current nursing practice and training, within the context of this current study.

The National Health Bill was passed in 2019 and the key features of this national policy (RSA, DoH, 2019) acknowledges the following:

- Socio-economic injustices, imbalances, and inequities of the past;
- Need to heal the divisions of the past, and to establish a society, based on democratic values, social justice, and fundamental human rights; and
- Need to improve the quality of life of all citizens, and to free the potential of each person.

This document further specifies the following, regarding its definition of Primary Health Care (PHC). It comprises the addressing of the main health problems in the community, by providing promotive, preventive, curative, as well as rehabilitative services. In addition, it is the first level of contact with the national health system for individuals, the family, and community, which brings healthcare as close as possible to where people live and work, and constitutes the first element of a continuing healthcare process.

Consequently, it could be argued that this position of the nature of nursing to serve society, should be considered, especially if the intention of the vision is to prioritise health in South Africa, as Universal Health Coverage (UHC) for all, by re-engineering PHC through prevention. The South African Nursing Council prioritises codes of ethics in a report published in 2013 (SANC, 2013). Ethics is not fragmented and should be viewed universally. What applies to one context, for example a nursing ward, should be transferable to the community as well. During the interviews, the participants revealed the following about the nature of nursing and their responsibilities towards communities:

> *"... because if you think about ethics, ethics in nursing, ethics in the community- there is little bit of an overlap. It is basically based on the same understanding principles that have to do with patients."* **(Ann)**

Another participant shared the following:

> *"It is a caring profession. It is a profession where you can guide, you can support, and you can nurture the client."* **(Daniela)**

Embracing SL as pedagogy will challenge the boundaries of care, in the context of the nurse, as well as how s/he views the role of providing healthcare in the community. However, it is crucial, if the need is to prioritise Universal Health Care for all, which essentially places greater emphasis on population-based health and outcomes, by providing community-based services. This type of healthcare system will require the healthcare workers to be consistent, accepting responsibility for the healthcare of the population, through prevention, health promotion, and outreach into communities, as well as greater interaction with communities (Bheekie & Bradley, 2016; Khuzwayo & Moshabela, 2017; Moosa, Derese, & Peersman, 2017; RSA, DoH, 2019). Therefore, the revision, or the transformation that is currently scheduled to transpire in nursing education, should set its intentions on achieving UHC for all, as well as all the requirements for such a transformed healthcare system. On reviewing

the national policies that guide the intended transformation, as corroborated by various South African scholars (Bheekie & Bradley, 2016; Khuzawayo & Moshabela, 2017; Moosa, Derese, & Peersman, 2017; RSA, DoH, 2019), it becomes clear that the healthcare professionals, especially the professional nurses, would require a unique skill set, which is unfamiliar to the current standards set out by existing nursing programmes, including the nursing curriculum under scrutiny.

SL is defined as an experiential learning activity, which revolves around a concrete experience, observations and reflections, formation of abstract concepts and generalisations, and lastly, testing the implications of concepts in new situations (Kolb, 1984). It is further corroborated that:

> *"Service-learning should be based on an equal partnership with intersectoral involvement linking theory and practice through in-service training and service to others and is based on an educational exchange through reflective activities and reciprocal learning. It should also have a credit-bearing component and demands resources (financial and human) and is a learning activity that should receive appropriate academic recognition."* (Daniels & Adonis, 2003, p. 2).

The definitions for SL have been aligned with criteria, prioritised by the HEQC to differentiate between the types of CE, providing distinction in SL as a type of CE, based on research by the JET on SL in South Africa, and international literature, by highlighting the following (HEQC, 2006, p. 25):

- Relevant and meaningful service provided with, and not for, the community;
- Academic learning should connect the module objectives and service activities, clearly;
- Structured reflection opportunities, with intention to transform, clarify, reinforce, and expand the concrete service experiences of students into knowledge; and
- SL activities should be designed to cultivate a sense of civic responsibility in students.

Consequently, Julie et al. (2015, p. 191) developed a SL definition for the undergraduate curriculum, as part of the implementation framework that was streamlined, according to the HEQC criteria for SL, as follows:

> *"SL is defined as a type of community engagement and regarded as a teaching and learning process, which aims to develop reflective practitioners who address community development needs within an equal partnership with the university, the community and the service partners who share the same values*."

A focal point to note in the mentioned prescriptions, regarding the definitions of SL, is the prioritisation of the needs of the community, experiential learning, and reflective practice, fostered through service provision. It should also accumulate academic credit, as it alludes to academic learning that occurs as a result of reflection on the community service (Bender et al., 2006). Additionally, according to Osman and Petersen (2013, p. 7), SL is a philosophy with a guiding pedagogy, intended to develop critical citizenship in students. SL has always been contested as a pedagogy, due to challenges that were reported about its academic rigour (Butin, 2006; Bruce et al., 2011). The investigations that relate to the embedding of SL in higher education, relate to the pedagogical potential of SL. Therefore, it also becomes crucial in this discussion to clarify the educational position regarding academic rigor (Table 7.2).

Firstly, SL has the potential to develop the praxis needs of the nursing curriculum. In education, Paolo Freire's, *Pedagogy of the Oppressed,* refers to praxis as the vehicle, through which the student evaluates his/her own position in the world (Bruce et al., 2011). This facilitates the transformation of, not only material conditions, but also his/her consciousness. Aliakbari and Faraji (2011) refer to this as a process that tries to humanise and empower the student. It acknowledges that through "problem posing education and questioning the problematic issues in learners' lives, students learn to think critically and develop a critical consciousness which help them to improve their life conditions and to take necessary actions to build a more just and equitable society" (Aliakbari & Faraji, 2011, p. 77). This indicates the relevance of the need to ensure that praxis is created to facilitate learning, as well as transform society. Praxis resonates with change, which is deeply imbedded in reflective practices that become a repeated process, leading to a re-evaluation of theory, and a reconsideration of the actions that grow from theory. Change for the common good could occur, and it resonates well with lifelong learning (Torres & Mercado, 2004).

In the document review, it was evident that the curriculum negotiates its way through two equally important components, namely, theoretical and clinical components. Educators in the programme are often confronted with situations in classroom settings, during which they

try to create reality, in order to stimulate the student. The following participants shared their creative ways of incorporating technology, as well as other means into their lesson plans, in attempts to complement the content they were covering:

> *"I use PowerPoint presentations. We also show video for them to strengthen the content."* **(Jolene)**

> *"I can't take an oxygen cylinder there, but I can project a picture of an oxygen cylinder and they can get an idea of what I am talking about when I say, oxygen cylinder."* **(Clyde)**

This highlights the need for praxis of the curriculum. SL pedagogical practices shape social change in communities, which aims to produce accountable graduates. Praxis, therefore, becomes a means for developing a critical consciousness, while it has been concluded that SL challenges educators to reconceptualise their curriculum and disciplinary training, as well as their role as educators, when their praxis is examined through the lenses of critical, social, and transformative learning theories (Osman & Petersen, 2013). This would require them to guide students to the outcomes of the module, by setting realistic expectations for students, to control their learning environment. A learning environment could be described as a real-life situational opportunity, as presented. The student, therefore, becomes an active participant when creating the learning opportunity, as guided by the module outcomes.

Table 7.2: Philosophical orientation for nursing curriculum

Aspects	Philosophical orientation
Emphasis of curriculum	Community and population-based services and skills extend the normal orientation of healthcare service, through a curative lens. A transformative and radical approach is adopted in the curriculum, linking academic course work with community-based service. Critical inquiry has the potential for transformative learning and engagement in the classroom and community settings. This attracts "transformative change in higher education, in the ways in which students engage in learning and critical inquiry through reflection and praxis, in communities, and in political, social and economic problems" (Levkoe, Brazil, & Daniere, 2014, p. 71).
Nature of learner	The nature of the learner acknowledges the uniqueness and complexity of the student, and encourages, utilises, as well as rewards the complexity, as an integral part of the learning process (Kimmons & Veletsianos, 2015). The learners, therefore, would reflect on their unique knowledge, allowing them to recognise the ability to interact with the learning environment, which could be consumed in the classroom, or the community setting.
Nature of the educator	The educator, viewed as a facilitator, provides hands-on support, and helps students to understand. Educators encourage self-confidence in students, and create opportunities for engagement.
Knowledge transmission	Knowledge transmission is imbedded in the social constructionist views, and places the emphasis on skill-set practice and reflectivity, social good and critical citizenships, as well as social justice activism. Deep student learning is promoted that is fostered through critical thinking about the experiences, which is just as important and part of the implementation of a pedagogy (Levkoe et al., 2014).
Orientation of content	Content articulates the professional values, skills and competencies of nursing. In addition, it should demonstrate a clear linkage with values that promote societal needs.

Additionally, the philosophy of the curriculum was previously described as a process that relates to praxis. Praxis was defined as the ability to apply knowledge to a situation, and putting theory into practice. Additionally, imbedded in praxis are the following features: the metaphysical competencies of metacognition, schema, transfer, self-efficiency, self-regulation, and the zone of proximal development (Aliakbari & Faraji, 2011; Halamish, 2018; Lemons, Carberry, Swan, & Jarvin, 2011; Levkoe et al., 2014; Slabbert, 2015). In Table 7.3, the metaphysical competencies of the undergraduate curriculum are summarised, through specific features of the epistemic rationale.

Table 7.3: Metaphysical competencies of curriculum

Metaphysical competencies	Description of evidence
Metacognition	The need to demonstrate awareness of knowledge, knowledge-building strategies, self-regulation, strategic planning skills, task analysis, as well as discriminate between useful and less useful information. The degree of reflective opportunities are personal and group reflections.
Self-regulation	The data set delivered a theme called, *student entrepreneurship*, which embraces the codes, *self-regulation*, *self-awareness*, *self-directed learning* and *self-rewarding*. These demonstrate the abilities and potential associated with the reality of SL encounters in the current programme. Slabbert (2015) stated that SL has been associated with a positive impact on a sense of self and practice ability.
Constructive alignment	Refers to the developmental ability of the student.
Zone of proximal development	Refers to the desirable difficulty, which aids students to develop metacognitive competencies. It explicitly refers to the ability of the student to achieve outcomes ranging from, *with the help of the educator*, to *no help from the educator*. This could demonstrate how knowledge is transferred to students, using proper structured learning and teaching activities.

The features relate to the following metaphysical aspects of the undergraduate curriculum, which could be strengthened by utilising the SL pedagogy. In order to yield the full potential of the engagement between the students and the community, the theories studied and used in the classroom are applied thoughtfully, through reflection. Reflection and praxis are two necessary elements that comprise the potential to transform community-based field experiences, from simple volunteer activities to deeper learning. To become engaged citizens, students need the ability to conceptualise and solve problems that entail abstraction (meta-cognition) through the manipulation of thoughts and patterns referring to schemata's, systems thinking (interrelated thinking), experimentation (self-regulation, self-efficiency), and collaboration (Aliakbari & Faraji, 2011; Lemons, Carberry, Swan & Jarvin, 2011; Levkoe et al., 2014; Slabbert, 2015; Halamish, 2018). Reflection is a key element in developing these abilities.

In order to stimulate learning, educators need to structure learning and teaching activities effectively, using metacognitive knowledge-stimulating strategies. SL proves valuable in the following metaphysical competencies that were explored in this current study. Understanding the metaphysical competencies is important before an effective pedagogy could be implemented. These metaphysical competencies would allow students to display good metacognitive skills that are needed to equip graduates with skills to solve complex health problems within the community.

In Chapter 6 *(Theme 2, Category 1: Exploring educational altitude*), an overview of what was generated, regarding the altitude of the learning was provided, which has been extracted in Figure 7.2 to ground the discussion. It demonstrated that the nursing curriculum is well articulated around the major domains of learning, since the nature of nursing can be aligned as an art, science, and a service to human kind. Cognition is the level of learning that relates to acquiring knowledge. It also refers to the accumulation of information acquired through learning or experience. One participant in the foundation level of the Bachelor of Nursing curriculum clarified that learning is more than acquiring knowledge. Other participants similarly referred to the acquisition of knowledge, which were all congruent with each other.

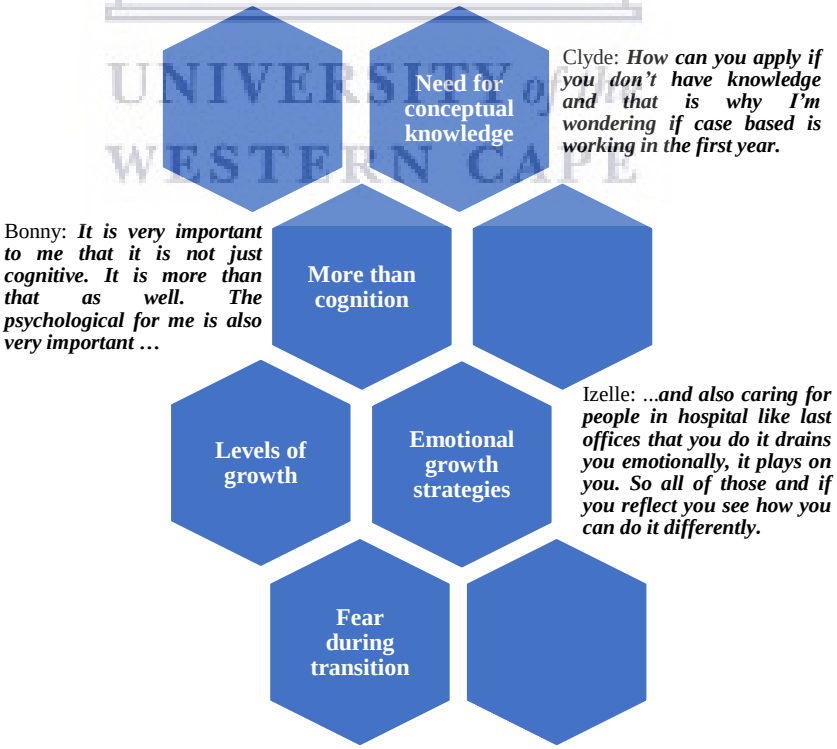

Figure 7.2: Educational altitude

In Figure 7.2, some of the aspects of *Theme 2, Category 1: Exploring educational altitude* are presented, which demonstrates the boundaries of the attitudes and belief about learning. Hansen (1995) postulates three types of positions regarding learning, namely, transmission, transactional and transformational. Each is helpful in understanding the context of the curriculum. The majority of the learning and teaching activities of the Bachelor of Nursing derives from a transactional and transmission position of knowledge between educator and student. This is evident in Table 7.1. However, it suggests that these three views should balance one another in order to understand the philosophical, psychological and social context of the curriculum. It is notable that the transformational view of the attitudes and beliefs of learning relates to the conception of social change, as a movement toward harmony with the environment, rather than an effort to exert control over it (Hansen, 1995). This provides the flexibility to construct knowledge within the environment or social context. It also re-affirms the values associated with social construction of learning, which is fully imbedded in the principle that human development (learning) is constructed through interaction with others. In Table 7.3, information is presented that highlights the three positions on teaching to the context of the nursing curriculum under inquiry.

7.2.4. Principle 4: Political realities

The study of social accountability is a political one, as it is explicitly concerned with changing the power relationship between the citizen and the healthcare providers, within the context of this current study (Boydell et al., 2019). It is important for nurse educators to understand the significance of the 4th guiding principle, political reality in education. Nurse educators need to understand how interest groups compete to establish their vision of a particular area of the curriculum. This indicates the political dynamics in education, which further adds to the multifaceted concept that is constructed, negotiated, and re-negotiated at a variety of levels in education (Goodson, 1991). Social constructionist perspectives in education demand that a social phenomenon is understood, and also recognises the value of the social context. Social constructionism, typically, requires that the interactions in society are valued. This sociology of knowledge was described by Berger and Luckmann (1966). These authors assert that, as people within social systems interact, they create mutual understandings and expectations of each other's actions.

In this current study, a theme was developed that created a pivotal argument towards the need and importance of the SL pedagogy. Strong indications were created in the views of

the participants, which related to a responsive curricula towards socially accountable graduates. This theme had four categories that prompted graduates towards being socially responsive. Some participants referred to following:

> *Someone that can look at the needs of society and have an understanding of your contribution …* **(Hezekiel)**

> *Society actually has an impact …* **(Arona)**

> *Also, just looking at what is going on in communities as well… to me that is making them more self-aware.* **(Bonny)**

They responded to a probing question about what qualities were required by graduates for social good to be instilled. This revealed that nurse educators acknowledged the importance of constructing reality within the community, as well as it contributed towards the quality of the graduates. Boelen et al. (2012, p. 184) conclude that "social accountability spans a series of interwoven events from identifications of societies health needs and challenges to verification that planned interventions will and do have anticipated effects on health". This highlighted the nurse educators' acknowledgement that they did not know what was required to produce more responsive curricula. Boelen et al. (2012) further state that schools need to be aware of those, who require special attention.

The participants acknowledged that the landscape of nursing practice and training is changing. They reported that healthcare should expand the boundaries of the hospital to include taxi ranks, churches, old age homes, shopping malls, and other community settings, among others. Often, developing curricula, as well as the associated practices, are highly politicised, when transforming the curriculum to be more accountable. Currently in nursing, major revisions are being implemented, transforming the curriculum into a primary healthcare focused curriculum, to prepare nursing for the uncertain changes, to be implemented through the NHI. Following the assumptions of the NHI, all clients will enter the health system at a primary healthcare (PHC) level, and be referred, appropriately, for primary care (PC). Great confusion emerges with the understanding of the two concepts, which are used interchangeably in healthcare practices, even though both denote unique concepts. The former, PHC is broad, and fully imbedded in the principles, stipulated by

WHO, regarding an approach to health policy and service provision (Muldoon, Hogg, & Levitt, 2006). This differentiation has a major implication on the purpose, structure, and delivery of such a curriculum. It literally cuts across all aspects of the curriculum and should be regarded as urgent.

Prior to 1994, the apartheid government healthcare regime was characterised by radical, racial, and social inequalities (Maillacheruvu & McDuff, 2014). One of the main ideologies of this healthcare regime caused the progression of healthcare to reverse, until the dawn of the liberation of South Africa in 1990. Healthcare was seen as a political tool in the previous government, and similarly now in democratic South Africa. The following was emphasised about the health and politics:

> *"Health is political because, like any other resource or commodity under a neo-liberal economic system, some social groups have more of it than others. Health is political because its social determinants are amenable to political interventions and are thereby dependent on political action (or more usually, inaction). Health is political because the right to 'a standard of living adequate for health and wellbeing' (United Nations, 1948) is, or should be, an aspect of citizenship and a human right."* (Bambra, Fox, & Scott-Samuel, 2005, p. 187)

This clearly indicates how health could create a divide, and be used to oppress, if not evenly spread, to ensure the basic right to healthcare. Characteristically, the previous healthcare system of South Africa was orientated towards a curative approach, where healthcare was often required, and limited to hospital-based services that had a direct implication on nurse training. Therefore, healthcare should be redirected, to ensure UHC, as well as instil a level of social obligation on healthcare workers, which is consistent to taking responsibility for the healthcare needs of the population, through prevention, health promotion, outreach into communities, and greater interaction with communities (Bheekie & Bradley, 2016; Khuzwayo & Moshabela, 2017; Mofolo, Heunis, & Kigozi, 2019; Moosa, Derese & Peersman, 2017; RSA, DoH, 2019).

Previously in this chapter, the findings of Objective 1, Objective 2, and Objective 4 were specified, according to the corresponding steps of the conceptual framework of this current study. As mentioned at the end of Chapter 5, Objective 2 of this current study was the focus

of Chapter 7, with the intention of stating and updating existing Community Engagement Typology, as well as determining the quality of the SL elements of the undergraduate Bachelor of Nursing curriculum. With the proposed changes, which would advance the longstanding transformation agenda of the South African healthcare system, certain needs descended upon the nursing curriculum, with urgent calls to align curricular practices with current practices, which would foster social accountability that requires engagement with communities.

7.2.5. Principle 5: Curriculum development/planning process

Curriculum development processes are described as a puzzling experience for educators. The process is often referred to as a blueprint for the development, or restructuring of a curriculum. However, it is also defined as the plan for educators, to organise subjects across the curriculum, as well as the learning and teaching activities, which have relevance and meaning to the curriculum. At the core of this current study was the need to develop a SL pedagogy, which was set in terms of its development and usability in academic programmes. The criteria were clear on how to implement such pedagogy, through national guidelines, as well as the criteria of the HEQC, which guide these types of practices. In this current study, the typology of community revealed insufficient evidence that CE was horizontally aligned across the programme, as demonstrated in Table 7.4.

7.3. CEGR

7.3.1. Typology of Community Engagement

From the evidence generated in objective 1, under the mapping of the curriculum, the existing typology of Community Engagement and SL indicators have been compiled. In Table 7.4, the nature of the CET is reflected, as well as the SL indicators, imbedded in the nursing curriculum.

Table 7.4: Existing CET: Typology of community engagement

Components	Level 1	Level 2	Level 3	Level 4 CHN	Level 4 MID	Level 5
Service learning	–	–	–	–	–	x
Community outreach	–	–	–	x	–	x
Volunteerism	–	–	–	–	–	–

Table 7.4 reflects what was indicated in the problem statement created for this current study. It represents the existing CE typology, which is directly based on the Furco's (1996) typology of CE. Such distinction made to demonstrate the typology, was in sufficient to grade and classify the typology, imbedded in the nursing curriculum. Due to the nature of the nursing curriculum, it became essential to search for deeper meaning, to encapsulate all the theory and clinical related components of the programme, essential to grade the typology.

7.3.2. Findings of the pilot study

In Chapter 4, the CEGR was developed, allowing each module to be graded against the HEQC criteria for good practice. According to the results of this self-assessment, only three of the 23 modules prescribed to a form of CE. However, it should be noted that all the modules had practical considerations, which, spontaneously, allowed them to prescribe to the SL pedagogy. Structured reflection was poorly defined in the modules, with evidence of only three indicating the use of a methodology, to facilitate structured reflection.

All the nursing modules, included in the document review, had the potential to be considered for the use of the SL pedagogy. However, a challenge was encountered, only identified when difficulty was experienced with the classification of learning and teaching tasks, especially the learning and teaching activities in the modules that related to the clinical component. In Chapter 5, during the document analysis, a variety of learning and teaching activities related to the typology, but could not be graded under the typology of CE. The envisioned typology was only beneficial to qualify the main types that were obviously connected to community engagement, and were known. However, the challenge existed in the grading of other types of activities, where services had been offered. The quality indicators of SL were useful in providing clarity on those learning and teaching activities, which were not covered, unequivocally, under the CE typology, as identified previously under section 7.7.

7.3.3. Quality of SL indicators

Table 7.5: Quality of SL indicators

SL indicators	Level 1	Level 2	Level 3	Level 4 CHN	Level 4 MID	Level 5
Beneficiary of service	Students	Students	Students	Students	Students	Community & Students
Goal of service	Student learning	Student learning	Student learning	Community service/ Student learning	Student learning	Community service/ Student learning

Service delivery	YES	YES	YES	YES	YES	YES
Community partnerships	YES	YES	YES	YES	YES	YES
Reflective practices	Unstructured	Unstructured	Unstructured	Structured	Unstructured	Structured
Reciprocal learning	NO	NO	NO	NO	NO	YES

Community engagement takes on many forms, as depicted in Figure 1.1 (Chapter 1) within the context of higher education. The HEQC stipulates that CE should be "woven into the fabric of the institution" (HEQC, 2006, p. 12). This could be internalised, to create an organised arrangement between the types of CE within a curriculum. In Table 7.5 a synopsis is provides of the findings that will facilitate the discussion on SL indicators, as explored in this current study.

In the nursing curriculum, five-year levels are evident, which includes a foundation year level. It was identified that all year levels had modules with a service component, which increased the potential to institutionalise SL in the programme. The HEQC stipulates that CE engagement could occur in many forms and shapes within the context of higher education; however, it is not explicit to cover some of the types of engagements present in the nursing curriculum, which justifies practice in nurse training.

In addition, when examining the SL elements, it was explored to provide some meaning to attach to all the learning and teaching activities. The HEQC considers it vital to link education with experience. In the nursing curriculum, abundant opportunities were identified that entailed some sort of service rendered. Frequently, these activities stand loose, and not well connected to the literature on CE typology. It would be essential to attempt to link these activities to some type or form of CE, to strengthen the purpose of education. It could be contested that some indications exist, requiring the expansion of the typology, to embrace all engagements in academic programmes.

The self-assessment exercise performed, provided valuable insights into the grading of these activities, according to the typology, in terms of the nature of the service provided. It was noted that all modules had a clinical practical component that required students to develop skills and values. They were engaged in these activities throughout all year levels. A major

challenge emerged from this kind of engagement, as the CE typology does not have the substance to grade these activities. These activities were often captured with in portfolios, in which students had to prove their competence of the skills and values, they had mastered during each academic year level. It was observed that these opportunities had a strong altruistic obligation, which set the tone for a philanthropic approach.

When others elements of SL were reviewed, in relation to its nature, the following could be viewed as an internship, which engaged students in activities, in which the primary beneficiary was the *student*, and the primary goal was *student learning*. The HEQC specifies that internships are intended to provide students with hands-on, practical experience that would enhance their understanding of their area of study, help them to achieve their learning outcomes, and provide them with vocational experience. These activities are fully integrated with the student's curriculum. The HEQC subtly connects internships to *clinical practice*, which are used extensively in many professional programmes that concern healthcare training.

While internships are graded, exclusively, as a type of experiential learning, under the typology of community engagement, some (i.e. volunteerism; community outreach) emphasise community service, while others (i.e. internships; co-operative education) emphasise student learning. Service-learning represents a balanced approach to, and an integration of, community service and student learning (HEQC, 2006). SL, in its core practice, is comprehensive and dynamic in opportunities, to ensure that these comply with the following four essential criteria for service-learning (Heffernan, 2001; Howard, 2001; Stacey, Rice, & Langer, 2001).

- Relevant and meaningful service with the community;
- Enhanced academic learning;
- Purposeful civic learning (social responsibility); and
- Structured opportunities for reflection

Adhering to these elements would bring these opportunities closer to educational objectives, which would give voice to graduate attributes, curricular objectives (curricular outcomes and educational opportunities), and accordingly, create a balance between disciplinary knowledge and the universal accepted attributes that graduates need to function where

pressing needs exist in society. These elements communicate and increase the level of social obligation, which transforms practice along the parameters that range from responsibility to accountability. Boelen et al. (2012) report that accountability refers to social needs that are anticipative, institutional objectives that are defined with society, and educational programmes that are contextualised, to create health system change agents. One could conclude that the sentiments shared by authors (Heffernan, 2001; Howard, 2001; Stacey, Rice, & Langer, 2001) host some meaningful criteria and standards to make curricula more accountable. This has been a longstanding challenge to develop standards within these kinds of practices (World Health Organization [WHO], 1986; Boelen *et al.*, 2012; Boydell et al., 2019).

SL and its possibilities include service internships that are associated with traditional internships, but differ in terms of intensity, with students working as many as 10 to 20 hours a week in a community setting. As in traditional internships, students are generally charged with producing a body of work that is of value to the community or site. However, service internships have regular and on-going opportunities for reflection, which help students to analyse their new experiences, using discipline-based theories. "These reflective opportunities can be done with small groups of peers, with one-on-one meetings with academic staff advisors, or even electronically with an academic staff member providing feedback" (HEQC, 2006, p. 40). Service internships are further distinguished from traditional internships by their focus on reciprocity, which implies that both the student and the community benefit from activities performed.

How these elements articulate and transform to establish accountability was explored to understand the intentions communicated. When explored in terms of the benevolence and goal of the service that was delivered, the following could be deduced from the nursing curriculum: From Level 1 to Level 4, all activities are for the benefit of the students, implying that learning and teaching/service activities are streamed to accommodate student learning. This corroborates with a previous discussion that students are not trained according to the values that are designated as per graduate attributes, which indicates that inconsistencies exist in the programme, to meet requirements, as guided by the international and national standards as expressed by WHO, the Act on Higher Education and HEQC documents. Saltmarsh (1996, p. 19, as cited in HEQC, 2006) further expresses the view that schools play a role in the production of social change.

In order to effect social change, the outcomes of the nursing curriculum needs to be redressed, in order to accommodate that the benefits of the learning and teaching activities need to serve both the students and the community at large, in a reciprocal manner. However, it could be questioned how concrete experiences are formulated and integrated in the nursing curriculum. Engaging in a concrete experience activates views and notions of "knowledge by acquaintance" (HEQC, 2006, p. 18). This type of knowledge acquired, stimulates higher order thinking that grows out of real-life experiences, which are imbedded into concrete experiences, through learning and teaching activities, linked to service activities in the community. SL provides the opportunity for nurse educators to structure their learning and teaching activities, using concrete experiences with which students could engage.

Partnerships with the community, strategically, formed part of the reconstruction and development plan of the post-apartheid Government. These partnerships were essential to eradicate social and economic disparities and inequalities in South African societies. Partnerships with communities are commitments to social transformation, operationalising knowledge-based collaborations that inspires all partners with strengths, which contribute to the learning of all involved. Typically, these partnerships are referred to as tripartite partnerships in SL. In this current study, partnerships were limited to those modules that participated in CE, through educational practices, namely, in year Level 4, CUR311/324, and year Level 5, NRS401 and NRS412. The other modules rely solely on partnerships with the DoH and CoC, which are formalised. SL partnerships with communities are scheduled through informal partnerships, by service agencies. Prescribing to the SL pedagogy, would expand educational opportunities for the nursing curriculum. Educational institutions, especially those focusing on nursing, have been indicted in a disjuncture, because of the mismatch between their core practices and the needs of the communities (Armstrong & Rispel, 2015).

The curriculum outcomes and limited educational opportunities that relate to clinical learning, do not match the needs of the community, which is evident in the burden of disease that is on the increase (Armstrong & Rispel, 2015) This is disturbing, especially considering the transformation of the healthcare system, which will be characterised as a re-engineering of primary health, with elements that follow a discourse of prevention, rehabilitation, and promotion, as opposed to the originally curative mainstream approach followed currently. Consequently, it is recommended that acceptable approaches foster the new vision for

healthcare, to facilitate the nursing curriculum. Forming partnerships are required, with the service agencies that address the concerns explained in the literature. SL relies on partnerships with communities to fulfil its potential; therefore, it is proposed as a consideration, when changing landscape for healthcare training.

Reciprocity is responding to needs that should be defined, collaboratively, by community and service agencies, and therefore, should not be imposed from outside. This would also establish a long-term reciprocal relationship that would be beneficial in the articulation of reciprocal goals. Reciprocity is a central characteristic of service-learning (HEQC, 2006). Reciprocity could also refer to reciprocal learning, which implies that services should be related to improving the quality of life for the community, as well as the achievement of module outcomes, evident through learning for students. Ultimately, it should be meaningful, in the sense that the community deems it worthwhile and necessary, while simultaneously, students' interests and skills are valued.

Service-learning is a pedagogy, where institution, community, and service agencies, as well as service and learning, are symbiotically related; where balance and reciprocity prevail, not to satisfy one at the expense of the other (Howard, 2001, p. 23). Service-learning demonstrates reciprocity between the HEI and the community, when the service-learning is "organised to meet both the learning outcomes of the module and the service needs identified by the community" (Bringle & Hatcher, 2002, p. 505)

The HEQC stipulates that reflection provides a medium for the synthesising of theory and service, as well as the assessment of the effectiveness of learning. In the nursing curriculum, a wide range of learning and teaching activities exist (Chapter 5, Table 5.5). Reflection is often underscored in such practices. Reflection activities include journal writing, other written reflection formats, in-class discussions, or a combination of these, with guidelines that inform the students on how to engage in these reflection activities. Reflection, therefore, could be both autonomous and collective (Jacobs, 2016). Through the use of models to reflect, and assessment activities that include writing assignments, discussion of topics, readings, presentations, and other activities, reflection embeds a strong element of assessment. In this current study, reflection is practised frequently.

Minimal evidence that specified criteria used to reflect was yielded. In selective year levels, reflection forms a strong part of the assessments, for example in NRS401, reflective practices are facilitated, using the Gibbs model of reflection (Gibbs, 2013). The Gibbs reflection model facilitates reflective practices, which provide more structure, to achieve educational outcomes through feedback, and allow opportunities to modify the module, as required. Bean and Patel-Stevens (2002, p. 210) connect reflection to scaffolding, termed "scaffolded reflection", using shared reflection and references to past, present, and future experiences. Therefore, it is important to define reflective practices and set limits for students to progress educationally, by meeting standards of programme outcomes. Practices should be standardised within the nursing curriculum to maintain the integrity of reflectionb and its educational position, as reflection is essential to the praxis of critical information literacy (Jacobs, 2016). Jacobs (2016) argues that reflection (and the corresponding actions that work to create praxis) should be a habit of the mind, which strives to naturalise. It should be a regular practice (and requirement), before class, during class, and after class.

Acknowledging the relevance, value, and complexity, related to social accountability, and the potential of such revisions for curriculum accessibility, as well as the quality improvement of healthcare services, through socially accountable nurse graduates, is irrefutable. One of the key elements of SL is the criterion of reciprocity. Reciprocity requires co-design and horizontal approaches, where the community is acknowledged when planning, evaluating, and assessing community engaged activities. Firstly, in Table 7.6 the *Essence of curriculum design and need for conceptual underpinning (ideology)* is depicted, with constructed, well-aligned, and scaffolded educational outcomes and objectives, alongside the level of impact. Secondly, as demonstrated in Table 7.6, the *Epistemic rationale* that underpins the curriculum, should be imbedded into outcomes, as well as graduate attributes, and should be activated in the learning outcomes. It should demonstrate the levels of social obligation or social good, as it accumulates across the year level, nurturing responsibility, responsiveness, and lastly, accountability towards the graduate, developing a health system change agent in the graduate. Thirdly, in Table 7.6, the *Conceptualisation of attitudes and beliefs about learning* is also demonstrated, embedding that SL presents in different forms, which could be applied, according to the needs of the curriculum. It was identified that, at the core of the curriculum, year Level 1, 2 and 3 related to the entry point in the curriculum, where foundational knowledge needed to be transferred to the discipline. It was recommended that Discipline-Based Service Learning (DBSL) should be adopted for these

levels, as it places a strong emphasis on the knowledge and skills required by the discipline, which could be regarded as general knowledge in the curriculum.

Table 7.6: Service Learning Pedagogy

SERVICE LEARNING PEDAGOGY

PRINCIPLES FOR CURRICULUM DEVELOPMENT	CRITERIA	INSTITUTIONALISING SL IN UNDERGRADUATE NURSING CURRICULUM				ANTICIPATED OUTCOME
Essence of curriculum design and need for conceptual underpinning (ideology)	Constructive alignment/Scaffolding Curricular objective & Graduate attributes along the levels of the B Nursing	LVL1&2 NQF5&6 LOW IMPACT	LVL3 NQF6 MED. IMPACT	LVL4 NQF7 MED. IMPACT	LVL5 NQF8 HIGH IMPACT	Constructed and Well aligned and scaffolded educational outcomes and objectives alongside the level of impact
Epistemic rationale	Social Good	Responsibility	Responsive		Accountable	Levels of social obligation (nurturing a health system change agent)
Conceptualisation of attitudes and beliefs about learning	Typology of CE	Discipline-Based SL	Problem-Based SL		Capstone SL	Typology of Service Learning (To transform the curriculum
	Nature, goal & beneficiary of service activities/learning & teaching activities	The nature of the service should be graded according goal and beneficiary of the services. It should be scaffolded and aligned from the learning needs of student and should progress gradually to a level where the community needs and learning needs is balanced to bring about transformation.				Service provision which facilitate student learning
	Authentic experiences imbedded in the community	Student should be in engaged in community activities and it should be connected to achieving learning outcomes	Student should be in engaged in community activities like providing services should be connected to achieving learning outcomes	Student should be in engaged in providing services which allows them to apply skill and knowledge to evaluate the learning outcomes		Learning and teaching tasks connected with service provision experiences
	Reflection using structured model (pre/during/after service provision)	Across all year levels students should be engaged in reflective practices to nurture praxis needs. This will make student more aware of the needs of society. This will raise critical awareness of learning needs when they negotiate interventions to facilitate community needs				Meaningful reflection with potential for assessment criteria at pertinent times
	Reciprocal learning (community &student)	Reciprocal learning should be encouraged for all year levels. In principle student learning and community services should be envisioned when engaging the student in the community.				Reciprocal Learning to all involved. (Student Learning) and Community Service)
Political realities	Recognising the social interactions or systems between the service and learning to transform community.	Social interaction between the student and the community should be enhanced to increase the potential of transformation in student and community.				Collaborative partnerships in co-construction of knowledge
Curriculum development/planning process	To transform student learning through service provision in community	Curriculum should foster the ideology to facilitate transformation of student in scaffolded and aligned to year level e.g. level 1&2: responsibility, level 3&4 responsiveness, level 5: accountability				Transforming the curriculum of greater societal good in communities

SOCIAL ACCOUNTABLE GRADUATE

The SL pedagogy proposes Problem-Based Service Learning (PBSL) for year Level 4, where students are presented with specialties within nursing. With PBSL, more emphasis is placed on providing services that extend over multiple disciplines and specialities. Using such an approach would foster the ability in students to work in consultation with the community, to address a problem, or a need. This approach is feasible, if the students have developed this knowledge during the previous levels of the curriculum, and put it to use, by making recommendations to develop a solution to the problem.

In year Level 5, the SL pedagogy promotes the use of Capstone SL approaches, which encapsulate, and allow the student to draw on previous knowledge gained throughout the curriculum, as well as the synthesis of information gained in their community service. The HEQC claims that it is even more valuable to attach this type of activity to professional development and leadership, as it has the potential to develop a fully rounded graduate (HEQC, 2006). These approaches are pre-determined according to complexity, and provide the perfect conditions to be aligned to the progression of learning in the nursing curriculum.

Additionally, the pedagogy prescribes that the most important elements of SL should be fully integrated in the delivering the curriculum. These elements include: authentic experiences, imbedded in the community; meaningful reflection, using a structured model at prescribed times of the activity; as well as reciprocal learning and partnerships, which may be collaborative in kind. This element is important to transform practices, and should be used in all aspects of the delivery of the curriculum. Adhering to these would improve the ability to develop a socially accountable graduate, essentially, and simultaneously, transform the curricula.

Lastly, in Table 7.6, the *Political realities* and the *Curriculum development/ planning process* are established, linked intricately to the transformation agenda of South Africa, which should be the cornerstone of the curricula practices, to nurture a socially accountable graduate.

7.4. Summary

This chapter was devoted to a discussion of the main themes (Chapter 6, Table 6.1) that were developed, based on the document analysis in Phase 1, and the semi-structured interviews, held with the nurse educators. The discussion was based on the collective interpretation of the data that was generated in this current study.

The following chapter provides a summary of the key findings, a short overview of the characteristics of the SL pedagogy, recommendations for practice, education, research and policy, dissemination and further development, as well as an evaluation of the research process, which includes the identified limitations of this current study, followed by a conclusion.

CHAPTER EIGHT

KEY FINDINGS, RECOMMENDATIONS AND CONCLUSION

8.1. Introduction

In the previous chapter, the findings of the study were discussed, in terms of the SL pedagogy, as guided by the conceptual framework. A discussion followed, which was entrenched in the scrutiny of five guiding principles of curriculum development. In this chapter, the key findings, recommendations, validation of findings, as well as the implications for practice, education, policy and research are presented. Before terminating the chapter and dissertation, the limitations of the research are provided, followed by an overview of the evaluation of this current study (in terms of the research process), and, ultimately, the conclusion.

8.2. Key findings

The ideology of the existing curricular practices at the institution provides a complimentary environment for the utilisation of SL pedagogy, through its vision, mission, and institutional graduate attributes. It became evident that the climate would contribute to the institutionalisation of a pedagogy that fosters social accountability. In addition, it was identified that the curricular objectives, as well as learning and teaching activities, were inconsistent on the implementation level, as scant evidence existed to justify how social accountability transpired from the values and attitudes that were presently defined within the curriculum.

a) The strategic policies and guidelines, which direct CE and SL at the institution are entrenched on three levels, which profoundly uphold the curriculum. This is consistent with recommendations from international standards guiding SL institutionalisation (Bringle et al., 2002).

b) The learning and teaching practices remain true to the traditional learning and teaching methods, despite the strong case-based learning orientation. This was also evident through assessment practices, which indicate that tests remain the primary method for determining competence during formative and summative assessments. This nature of assessment practices provides direct evidence, which is indicative of how the knowledge is transferred, using direct methods of assessments, such as tests, essays, and presentations.

c) GA have a consensual role to play between the specific outcomes and curricular content. GA relate to citizenship, as well as social good, and place emphasis on social awareness. It was unclear how citizenship and social good were operationalised during learning and teaching activities.

d) During the document analysis, it was challenging to compare and contrast the specific outcomes with one another. There was an intricate relationship between the specific outcomes of the modules and the GA. It was clear that specific outcomes were linked and grouped per year level of the Bachelor of Nursing curriculum. The manner in which the curriculum was structured was provided, as well as how the NQF level increased, as the student progressed through the curriculum, allowing opportunities for practices to become constructively aligned and scaffolded. Despite these pedagogical practices within the programme, they remain standard, and do not support or complement this finding.

e) An apparent gap was identified in the structuring of specific outcomes of all modules in this current study, as limited, or absent information was scheduled to activate social obligation values and attitudes, as it should relate to social responsibility, responsiveness, or accountability.

f) The participants in this current study alluded to the fact that it was essential to change the manner in which nursing was provided, by acknowledging the changing landscape of nursing to provide nursing care. Currently, community-based intervention is restricted to a minimum and does not create a consistent stimulation, to develop social obligation in students.

g) The document review yielded inconsistencies between curricular content and societal needs. Consequently, the findings of this current study alerts to the following, in line with South African literature, stating that in SA, challenges and inconsistencies have been reported, including the following: a mismatch between professional competencies, and patient and population health priorities; poor teamwork; insufficient emphasis on primary health care (Armstrong & Rispel, 2015, p. 1).

h) During the semi structured interviews, the participants revealed a variety of learning and teaching methods they apply. Many of them were silent on the module guides, which needed to be defined to provide clarity of operational usage.

Within the conceptualisation of attitudes and beliefs of learning, major deficits were identified. There was an imbalance between the educational positions identified that were stretched over the first three year levels of the curriculum, which is traditionally inclined to favour transaction and transmission positions of learning. This makes it almost impossible to nurture, or merely to gradually develop social accountability, when views about learning do not transform to benefit such a notion.

a) Learning and teaching activities relate profoundly to the transmission and transaction position of learning. The act of transmitting knowledge implies that knowledge is transferred from one individual to another, usually in a teacher-centred environment, or in the transaction position, which implies interaction, in order to construct knowledge.

b) Learning and teaching strategies that are used to complement pedagogical strategies were undefined and silent. These strategies are frequently used, and include group work, discussions, blended learning, etc.

c) A need exists to re-organise and restructure theory and the clinical components, to enhance each other, in order to meet the praxis needs of the curriculum. The module guides did not integrate clinical learning into the theory component. In some cases, this was evident through total separation of these two equally important components of a nursing curriculum. Two modules (CUR311/324 and NRS 401) proved that integration was possible, when priority is shared between the theory and practical components.

d) There was a need to transform students to be equipped with entrepreneurial skills, which could engender self-regulation, self-directedness, and self-efficiency. This became evident in the responses of the participants.

e) Inconsistencies existed with the implementation of CE, and a destitute management of SL elements in the undergraduate nursing curriculum.

8.3. Recommendations

a) Strengthen coherence between national directives, expressed by HEQC, the IOP of the institution. and the learning and teaching practices in the nursing curriculum, by aligning curricular content with institutional graduate attributes, as expressed by the vision for learning and teaching in the IOP;

b) *"To promote excellence in a learning-focused and research academic environment that facilitates local and global engagement and is responsive to a rapidly changing 21st century context."* (UWC, 2015a, p. 11);

c) Embrace transformative learning that is imbedded in the learning and teaching practices in the nursing curriculum;

d) Encourage responsive leadership and representation at a departmental level, to safeguard the alignment with institutional, faculty, and departmental vision and mission. This should provide strategic leadership within the department, and coordinate these learning and teaching activities. Establish a close relationship with the Community Engagement Unit of the institution, in order to activate, plan, deliver, and promote the important tenants of the goal areas as expressed by the GA;

e) Recognise in-class and out-of-class activities, and place value on real life experiences, as well as service activities in the community, to nurture a social just society;

f) Extend the boundaries of the classroom into the communities, to allow community-based interventions to be scheduled;

g) Revisit skills and competencies in the curriculum, to ensure that they are in line with primary health care principles, as captured in the NHI Bill, and UHC, as prioritised by the SDG's. This would support the transformation of the context of the changing views on the health care system;

h) Recognise the strong relationships that remain consistent within traditional class-based activities in the module. These types of learning and teaching pedagogies and strategies remain consistent, as the student progresses through the curriculum. Transforming pedagogical practices by reviewing, is a way in which knowledge could be transferred to students;

i) Encourage reflexivity, with an acceptable and standardised model such as the GIBBS model, which could be adopted to direct learning and teaching practices, from a strategic point of view. Reflexivity should be encouraged in students, before, during, and after all learning and teaching activities. Reflexivity holds the potential to transform assessment practices, from direct methods to include indirect methods;

j) Embrace educational possibilities through scaffolding and constructive alignment of social accountability, as well as the values that nurture it. This should be transferred to all dimensions of the curriculum;

k) Foster community awareness and engagement activities that are critical and essential components, to ensure preventative healthcare, as well as the continuing maintenance of

appropriate care in curative care practices. Nurses have the social obligation to ensure that communities are educated and informed about the conditions in the community, which influence disease profiles, and contribute to the burden of disease. Those responsible for the implementation of national and provincial health initiatives, should seek to identify and realise all the factors that influence health;

l) Transform the current health system, and consider it an urgency to transform the curricula in nursing. The current curriculum does not provide acceptable integration of outcomes that relate to societal issues, and therefore, is absent regarding the way curricular practices are structured in learning and teaching activities;

m) Strengthen and nurture the relationship between health and politics in the curriculum, with reference to students, as well as nurse educators. This would allow both students and nurse educators to re-evaluate the meaning of health, as perceived by the community they serve.

n) Create opportunities, which demonstrate that learning and teaching activities are conditioned to engage students with the potential to transform the learner, in order to transform the health care worker, after graduation. This relates to the transformative world view, which requires the student to be conscious of situations that lead to a greater understanding of, and care for self, others, and the environment.

o) Orientate the students to the teaching pedagogy, methodologies, and strategies, in their pre-pedagogical training. This is regarded as important to maintain a sustainable professional interest (Sadovaya, Luchinina, & Reznikov, 2016).

p) Enhance the praxis needs of the curriculum as an inherent requirement of the curriculum, and the profession at large. Clinical learning and teaching activities are rarely connected to the learning and teaching activities in the class. This was evident, based on the fact that educators in the programme were often confronted with situations in classroom settings, in which they attempted to create reality, to stimulate the students.

q) Determine learning and teaching practices, according to the role of the community. It is strongly recommended that the utilisation of the SL pedagogy relationship with communities be expanded, to involve the community at all levels, including planning, implementation, and evaluation phases of knowledge construction. The community should be appropriately acknowledged and engaged, to avoid any issues that may indicate a power imbalance among the stakeholders.

These recommendations should be managed, because logical connections exist between and among them, even though they were managed separately in the recommendation that aided the development of the SL pedagogy. These provide a symbolic meaning related to the pedagogical and curricula practice. In addition, it would strengthen the understanding of the reasons for the inclusion of SL in the undergraduate curriculum, as well as the promise to operationalise SL, meaningfully, in educational practices.

8.4. Validation of SL pedagogy

Validation incorporates the presentation of the stated findings (yielded in this current study) to the participants in pursuit of corroboration, as well as justified impressions, to ensure that they corresponded with those held by the participants. Additionally, validation was exercised for "respondent feedback or validation" (Bryman, 2012, p. 391), as well as clarifications from the research participants, regarding whether the developed SL pedagogy would ensure socially accountable pedagogical and curricula practices. It was crucial to validate the proposed SL pedagogy with peers and SL champions in nursing education, to ensure that the described practices would make sense to those in the field. This transpired during a session of 30-to-45 minutes that was conducted with the participants. This process was facilitated through discussion, which was concluded with the main points that were summarised, using the voice of the participants.

The criteria for validation included the clarity, adequacy, usefulness, and significance of the SL pedagogy. Three participants, who were involved in service learning, were asked whether the illustration that depicted the SL pedagogy was clear, and whether the developed pedagogy could be used by nurse educators. Their opinions and contributions were summarised and presented in the following overview:

Question 1: Does the SL pedagogy provide in the needs for supporting the facilitation of socially accountability in the nursing curricula? Is it clear?

> *Response: The SL pedagogy provides support for the facilitation of social accountability for student nurses. It is structured and clear to understand.*

Question 2: The developed SL pedagogy is offered to be used by nurse educationalists to facilitate social accountability among graduates of the Bachelor of Nursing programme. Will the developed elements and activities be sufficient for the purpose it sets out to achieve?

> *Response: It is evident that the processes and elements articulated in the illustration will assist in realising the intended significance of the SL pedagogy that will guide*

nurse educators with facilitation of social accountability among graduates of the nursing curriculum.

Question 3: Is the SL pedagogy useful to nursing education?

Response: The SL pedagogy adds purpose to operationalise values associated with social accountability in nursing education.

Question 4: Does the SL pedagogy make an important contribution to nursing education and the quality of the graduates of such a curriculum?

Response: The SL pedagogy contributes to the understanding and importance to operationalise values and attitudes that fosters social accountability in the nursing curriculum.

8.5. Implications for practice, education, policy, and research

Figure 8.1 is an illustration of the intentions and the significance of this current study that has been met. It illustrates that the framework for the developed SL pedagogy was fit for the purpose of the undergraduate curriculum. It is imbedded in the findings of this current study, and is supported with pertinent literature to uphold the associated values. The illustration supports the assumptions held at the beginning of this current study, as well as those that were expressed in the conceptual framework, and the complementary literature subsequently consulted in this study. Additionally, it demonstrates the two main actors in the pedagogy, namely, the student and the community, who fulfil significant roles in the formulation of learning and teaching activities. Students should articulate with social obligation, which Boelen et al. (2012) adopt in their views of the levels of social obligation.

In this current study, social obligation is also synonymously employed as social good. As a requirement, students should be self-directed, self-aware and self-reflective, while the community is in need of services, expressed as community service (CS). CS is expressed through the typology of community engagement (CE). The community, therefore, should assume its role, as co-constructors of knowledge. This is supported by reciprocity, one of the core elements for the management of the quality of service learning (HEQC, 2006). Reciprocity exhibits the relationship between these two actors, and a missed alignment of the intentions and actions of this element, would further disadvantage the core purpose of this pedagogy. An imbalance between the reciprocal contributions of the two actors would result in political reality, characterised by

imbalance, and naturally leading to discriminatory practices. In South Africa the Batho Pele (which means putting people first) principles, which are based on general standards for service delivery in South Africa, strengthen the values that enclose reciprocity. Batho Pele is based on the following eight principles: *Consultation, Standards Redress, Access, Courtesy, Information, Openness and transparency, and Value for money.* The Batho Pele principles, therefore, encapsulates the values that should be fostered in this reciprocal relationship.

The most dominant form of CE advocated in this pedagogy is Service Learning, because of its potential to transform curricula, and ability to be institutionalised in a curriculum (Julie, 2014; HEQC, 2006).

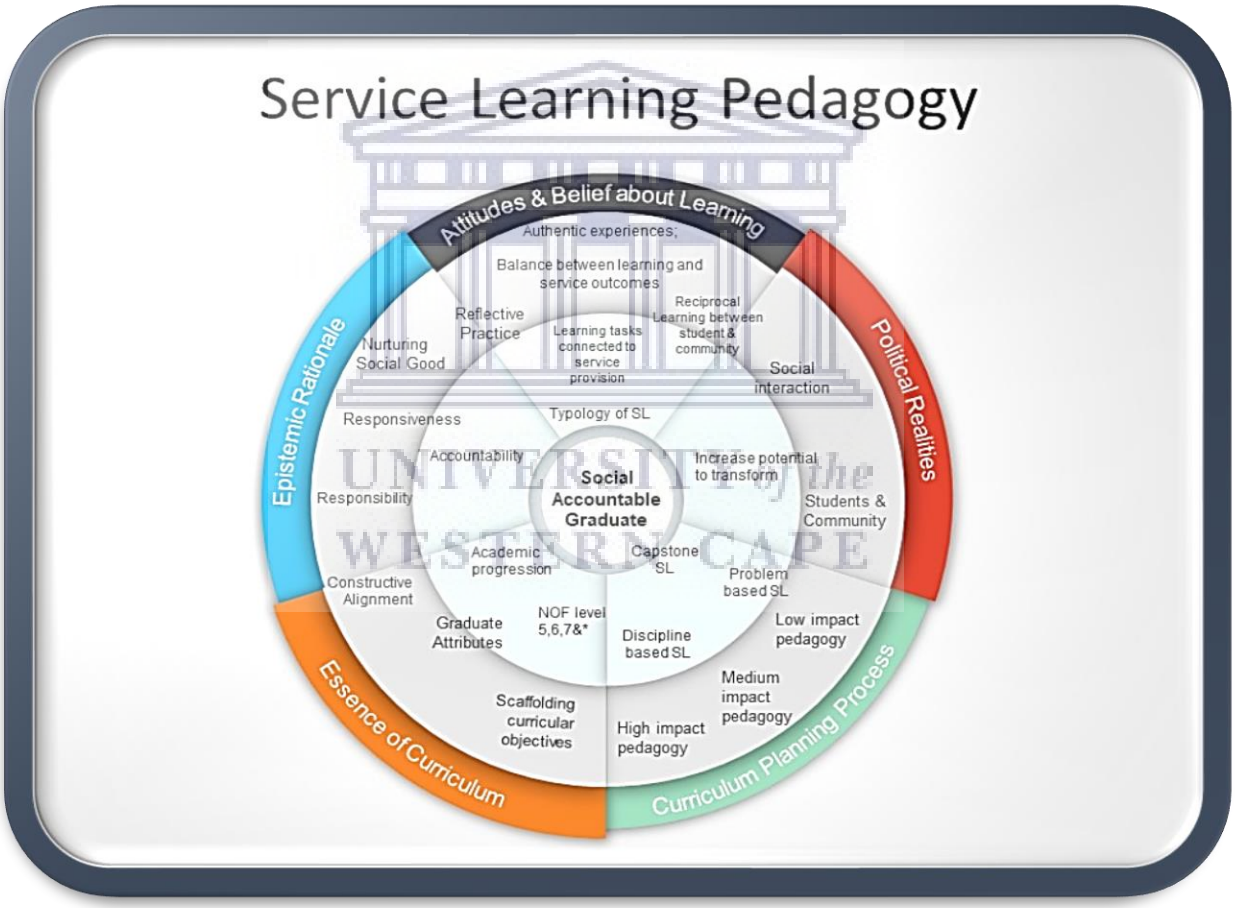

Figure 8.1: Principles of the SL pedagogy

The SL pedagogy is illustrated in Figure 8.1, and proposes 5 educational principles that should be imbedded into the nursing curriculum, which advocates for the development of social accountability in graduates. The SL pedagogy was conceptually developed through a process that was applied to the first and second dimensions of Kotter's Organisation Change Model (see Table 2.1). In Phase 1 of this current study, which comprised a document analysis, *Dimension 1: Create a climate for change,* was achieved by reviewing current learning and teaching practices of the undergraduate nursing curriculum. The Second phase of the conceptual framework, regarded the *Dimension 2: Engagement and enabling the organisation* of Kotter's Organisational Change Model, by engaging nurse academics, who were responsible for learning and teaching. Each of the first two phases of this current study, guided by Kotter's dimensions, promoted the integration of the 5 educational principles applied, namely:

- The essence of the curriculum (ideology) that should underpin curriculum practices;
- Conceptualising the attitude and beliefs about learning;
- Epistemological rationale;
- Political realities; and
- The curriculum development and planning process.

The essence of the curriculum reflects the underlying educational tools and concepts that provide meaning, through the articulation of year level progression, while aligning itself through the national qualifications' framework, and the degree of learning and teaching impact pedagogies. This requires learning and teaching practices to scaffold social good across the year levels, according to the gradient levels, as advocated by Boelen et al. (2012), to reflect responsibility, responsiveness, and accountability. The latter introduced the second principle of the SL pedagogy, namely, *conceptualising the attitudes and beliefs* about the position advocated in the SL pedagogy, which is based on the transfer of knowledge and values, through a transformation position, as acquired through the gradient levels. This pedagogy stipulates that a typology of SL should be embraced, providing opportunities, which balance the goal and beneficiaries of the service provided. It requires that learning should be aligned to service activities, through authentic experiences. The third principle refers to the *epistemological rationale*, which relays the philosophy that deals with the origin, the nature, and the limitations of knowledge. The pedagogy views learning as the transfer of knowledge within the context of the curriculum. In the nursing curriculum, providing service is linked to classroom learning,

which is inherently connected to the nursing profession. This refers to praxis that is defined as the ability to connect knowledge to a situation. In this process, meta-cognitively, a student should develop through the following levels of providing care, which scaffolds according to the gradient levels, built into the SL pedagogy (see Table 7.6). It further demonstrates the educational potential of scaffolding and alignment, according to year levels of the Bachelors of Nursing. Additionally, in Figure 8.1, the concepts and beliefs of learning are affirmed, chastised in SL elements, as corroborated in Chapter 1 (Figure 1.1, 1.2 and 1.3), and discussed in Chapter 4 of this current dissertation. The fourth principle concludes the political connotation of the transformation agenda of South Africa that the curriculum should foster social interaction between the student and the community, which should be enhanced to increase the potential of transformation in student and community. This would create a conscious awareness and sensitivity to the current nature of the requirements of the communities. The SL pedagogy concludes its last principle, *the curriculum development and planning process*, which maintains that learning activities should be structured through a transformative view that combines the constituent needs, reflecting those of the community, with meaningful learning and teaching experiences.

To conclude, the two dimensions of Kotter's Organisational Change Model provided freedom to conduct this current study, through a challenging and complex educational environment, as educational reform and recirculation are in progress. A Service Learning pedagogy was developed, which provided conceptual guidelines on how to transform the curriculum, and produce socially accountable graduates. The last dimension of Kotter organisational change model: *Implementing and sustaining change*, was not activated in this current study, due to the complexity of curriculum reform, and requires further exploration in future research endeavours.

8.6. Study limitations

The following limitations of this current study are acknowledged. Institutional and faculty participation was intended, but due to conflicting schedules, it was not possible. Participation and representation at that level could have reinforced and channelled the limits of the current vision and mission statements, as expressed through institutional and faculty support structures. Initially, the intention was to conduct workshops with each year level, following the document analysis, to yield rich data; however, on implementation of Objective 4, a challenge was

encountered, related to the number of nurse educators per year level. Three of the year levels only had two nurse educators responsible for the modules in the year level or discipline. Consequently, this was replaced by convening semi-structured interviews, which could possibly influence the type of data that was generated. The study was conducted, using conventional qualitative methods, as it was intended to remain true to the set of beliefs embraced in this paradigm. However, if this current study were to coincide with the review of the curriculum, it would add value to blend the conventional research methods with action research.

During the development of the CEGR, only one module was used to pilot the rubric. The CEGR is a new rubric that requires more refinement, which will be conducted on completion of this project. Kotter's Organisational Change Model was incorporated into the conceptual framework, to guide and direct the study; however, it should be noted that only two of its dimensions were applied in this current study.

8.7. Evaluation of study

Reporting on the quality of qualitative research is common practice, which enhances the rigor of the study. A conscious decision was made to incorporate a further evaluation of the quality of this research, at the conclusion of the study. This would allow the reader to appraise the strength of the interventions, to ensure the rigor in this research, after consuming the reported study in its entirety.

8.7.1. Rigor

Distinct differences exist in the research paradigms of quantitative and qualitative research, which filters down to all elements of the implemented research. Quantitative research uses set criteria to assess validity and reliability, which proves to be insufficient to determine the quality of qualitative research, due to the distinct differences between the two paradigms (Cutcliffe & McKenna, 1999). Qualitative research also has preferred criteria, often used in qualitative studies, as defined by Lincoln and Guba (1985), which include the following: credibility, dependability, conformability and transferability.

Tracy (2010) prescribes to a model with the following criteria, namely, worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethics and meaningful

coherence, in order to evaluate the quality of a qualitative research study. This model allowed the opportunity to demonstrate the quality of this current study in an organised and accurate manner, without the rigidity of other described criteria. In the literature, this model has been described as appropriate, universal, and flexible (Gordon & Patterson, 2013). The decision was made to use these defined criteria to evaluate the study, in terms of more general aspects of this current research.

8.7.2. Worthy topic

The topic of developing a SL pedagogical model could be deemed worthy from a political/human rights and academic perspective. The healthcare system is currently underway to implement one of its biggest changes since the dawn of democracy, and it becomes important to review how a nursing curriculum could be transformed to embrace the views expressed by national guidelines and policies, to advance the agenda to provide Universal Health Coverage. The South African context and situation might seem different, in terms of its ideological position that embraces democracy; however, South Africa forms part of Africa, and should also adhere to global standards in healthcare, as expressed by the sustainable development goals.

The situation of healthcare is in dire need of being revitalised. This current study could be regarded as a way of addressing the situation in South Africa, through the provision of basic primary health care services, as expressed in the proposed NHI bill. It was considered that this topic was interesting, timely, and significant in the current political and educational atmosphere in Africa, in order to advocate for the training and developing of graduate attributes, with unique skill sets, which would be characterised by their ability to be socially accountable.

8.7.3. Rich rigor

The detailed process of the manner in which this current study was conducted, has been clearly explained in this research report, to demonstrate the rigor, as discussed in Chapter 3. It describes the confidence of how truthful or credible the findings of a study are, which refers to the rigor of the study. Ensuring rigor in a qualitative study requires that it be evaluated against a set of criteria to enhance trustworthiness. Trustworthiness was achieved by adhering to the following: “credibility, dependability, conformability and transferability of the data” (Polit & Hungler, 1999, p. 427).

Credibility: The interviews were transcribed verbatim and presented for participant checking, as well as an independent coder, who validated the findings. This current study was also characterised by prolonged engagement, which refers to the extended time spent with the participants, in their native culture and everyday world, in order to gain a better understanding within a certain context (Given, 2008). This was followed by peer reviews between the researcher and the supervisor that were scheduled. The interviews were checked by the participants, in order to achieve persistent observation, triangulation, and peer debriefing (reviewing the pedagogy). Lastly, detailed descriptions were provided to ascertain the meaning of the data, by viewing the bigger picture of the learning and teaching practices, and converting the raw empirical data into a thorough description.

Dependability: The dependability of the findings was ensured by keeping an audit trail of the process and the procedures (Brink et al., 2012), which allowed triangulation and independent coding. An independent coder was employed to achieve inter-rater reliability of the CEGR (Thomas, 2006). Triangulation was confirmed through expert feedback form the independent coder (Thomas, 2006). This is regarded as a reflexive exercise, with two or more people analysing the same data (researcher and independent coder). This exercise revealed that consistency between two persons could be achieved, using the same set of data. These measures ensured congruence between the findings, the conclusions, and the recommendations (Brink et al., 2012).

Conformability: An audit trail assures quality in qualitative research (Koch, 2006), which is also in line with reflexive methodology. This exercise would indicate that the research was carried out with precision and care. Lincoln and Guba (1985), as expressed by Polit and Beck (2012), describes six steps: raw data, data reduction and analysis notes, data reconstruction and synthesis products, process notes, material related to intentions and dispositions and preliminary development of information, referring to all stages, to accomplish this audit trail of the research study. It was presented as a reflective report on the implementation of the research methodology in this current study. This reflexive report on the audit inquiry is discussed as a self-evaluation in this chapter.

Transferability: Transferability is equivalent to external validity, and is the extent to which findings from the data could be transferred to other settings or groups. The findings of this current research were limited to the context and environmental factors of the

institution where the study was conducted, and therefore, would be difficult to be transferred to other contexts.

8.7.4. Sincerity

During this current study, self-reflexivity with transparency was combined in this research. This allowed the research to be conducted in the most authentic manner, as far as possible. All sources of data used were also acknowledged, and recognition was given where necessary in the reference list. In Chapter 1 of this dissertation, a statement was made in which assumptions were declared for this current study. This addressed assumptions regarding the meta-theoretical, theoretical, and methodological aspects of this study. Bracketing and critical reflection, as strategies, were also adopted to minimise the influence of undue bias on the participants, the data, the analysis, and the reporting of the data.

8.7.5. Credibility

This current study is reported in the voice of the main instrument, utilised to gather the data for this study. Other voices (the voice of the participants) were used in this study to provide thick descriptions of the participants, and were included in this dissertation. The descriptions provided, allow the reader to judge whether the interpretations made, are grounded within the voices of the participants. A balance was maintained between the participants in this study, in order to allow synergy between their voices. The sampling approach implemented in this research, allowed participants to be recruited through purposive sampling to address Objective 4. This sampling strategy yielded participants (nurse educators) who were from all year levels in the undergraduate nursing curriculum.

8.7.6. Resonance

According to Tracy (2010), in order to achieve resonance in a qualitative study, it should attempt to achieve aesthetic merit and transferability. These attempts are made to affect and reverberate with the audience in a meaningful manner. In this dissertation, simple language was used to allow the data, and inevitably, the voice of the participants, to emerge, while articulating the experiences of participants to a level of interpretation. A conscious decision was taken to avoid the use of jargon in this dissertation, and every attempt was made to clarify any terminology, which might be challenging to the reader. The dissertation is also structured in a manner that introduces the reader, systematically,

to the problem, the process, and the results of this research. As stated previously, the findings of this research cannot be generalised; however, the findings could be transferred to those providing nursing training in South Africa.

8.7.7. Significant contribution

Qualitative research could be observed to make a significant contribution, when it demonstrates theoretical, experiential, and practical significance, among others (Tracy, 2010). This study is significant, as it makes an impact on the following levels:

- Aligning nursing education and training with national standards and regulations, to respond to the healthcare needs of society, through social obligation;
- The SL pedagogy was developed to institutionalise SL in the undergraduate nursing curriculum, with the aim of aligning SL practices with transformational standards of education;
- The CEGR was developed to allow educators to determine the SL potential of modules; and
- It would transform undergraduate curricula to be more relevant to the current healthcare needs of society.

8.7.8. Ethics

This current study was initiated with the submission of a research proposal that was presented to the research ethics committee of the School of Nursing, University of the Western Cape, in September 2016, and subsequently reviewed by a higher degrees committee, comprising senior researchers for scientific and ethical soundness. After the approval, the research proposal was submitted to the Health Science Research and Ethics Committee of University of the Western Cape. After approval of the ethical soundness of the proposed study, ethical clearance was granted to conduct the study (Appendix G). It was also expected that the ethics of the study be reviewed on a yearly basis, while data collection was still in progress. Besides the institutional ethics adhered to in this current study, the researcher adhered to various ethical issues associated with conducting a research study. The ethical considerations expressed in Chapter 3 was aligned to the Declaration of Helsinki, which is regarded as a cornerstone, to ensure the ethical soundness of the proposed study (WMA, 2013).

8.7.9. Meaningful coherence

In qualitative research meaningful coherence is viewed in various ways, depending on who is reviewing the research. This dissertation was prepared for presentation to examiners, with the aim of presenting it in a meaningfully coherent manner, by presenting the following aspects in the report:

- The institution, at which this current study is registered, has prescriptive guidelines to complete the dissertation. Every effort was made to adhere strictly to the prescribed protocol.
- The objectives of this study were clearly stated in the first chapter, which served as a framework in the presentation of the analysis, discussion, and recommendations.
- The method of inquiry used in this research was observed to be suitable to answer the research objectives.
- The discussion and recommendations are imbedded in the findings of this research.
- Literature was used appropriately to support findings and direct the discussion, meaningfully.
- This dissertation was structured in a logical manner.

8.8. Guidelines for dissemination, advocacy for use of SL pedagogy, and further development

The study was conducted to understand the current position of the nursing curriculum, regarding the development of social accountability in graduates, as well as to nurture such values that address current societal needs. There is a need to advance the validation of the illustrated SL pedagogy. The intention was to present this SL pedagogy to an international audience, to add to the validity of the pedagogy on a platform for nurse educators and social accountable activists, who gather to discuss the current trends in education and healthcare. The aim was also to present this pedagogy to the School where the study was conducted, to determine how the findings could be integrated, as well as advance the agenda of this study.

In this study, the researcher produced a rubric, namely the CEGR, which yielded acceptable inter-rater and intra-rater reliability. One module guide was reviewed for this exercise. In future, or for further development, this exercise should be repeated on all module guides, to determine the usability, and confirm similar, or improved results, under similar conditions. In addition, further development, in the form of a replica, should be embraced, using a participatory action research design or model, with the aim of developing a model for the SL pedagogy. This future study should add, and consider the voice of the community, as it would add to the dimensions that relate to the community. A comparative study could be conducted to cross-examine the context and results of this study, preferably with an international institution, as such findings could add a global perspective to the SL pedagogy.

8.9. Conclusion

The aim of the research was achieved, namely, to develop a Service Learning Pedagogy for the undergraduate nursing curriculum. The conceptual underpinning in this current study led to the presentation of the SL pedagogy, which was characterised by its ideology, conceptualising the attitude and beliefs of learning, providing the epistemological rationale for the curriculum, addressing the associated political realities, and lastly, providing guidance on developing such curricular and pedagogical practices. The pedagogy expressed by the underlying principles provided an account of transforming pedagogy, to fit societal needs, and usher graduate into being more socially accountable.

In conclusion, the social accountability values and beliefs of the nursing school should be expressed in its mission statement, and aligned to those fostered and prescribed by the institution. It should fulfil its educational practices, through curricular and discipline content, the types and locations of educational opportunities, in which the probability is evidenced by specific outcome measures that are aligned to national and institutional standards, to produce a socially accountable graduate. This SL pedagogy, if promoted, would also transform learning and teaching practices to become more engaged in character.

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APPENDICES

Appendix A: INFORMATION SHEET

Project Title:
Developing a service learning pedagogy for an undergraduate Bachelor of Nursing curriculum

What is this study about?
This is a research project being conducted by **Jeffrey Hoffman** at the University of the Western Cape. The invitation to participate in the study is extended to all nurse educators and facilitators teaching the B Nursing curriculum. The purpose of this research project is to develop a Service Learning pedagogy for the undergraduate Bachelor of Nursing curriculum.

What will I be asked to do if I agree to participate?
You will be asked to avail yourself for an interview at a venue of your convenience to share your learning and teaching experiences of being a nurse educator teaching on the Bachelor of Nursing curriculum.

Would my participation in this study be kept confidential?
The researcher and his supervisor undertake to protect your identity and the nature of your contribution. To ensure your anonymity, no personal information will be used or disclosed during the subsequent steps of the research process. Coded identifiable information of your name will not be included on transcriptions of the collected data.

To further ensure your confidentiality, information collected and disclosed will not be linked to your identity. During subsequent phases, the researcher will use pseudo names to protect the identity of participants. The audio recordings used will be saved as password protected documents that will only be known to the researcher and his supervisor.

The research report and other publications resulting from this research project, will protect your identity in every way.

What are the risks of this research?
There may be some risks from participating in this research study.

All human interactions and talking about self or others carry some amount of risks. Nevertheless, we will minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise, during the process of your participation in this study.

Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

Your participation will improve *understanding and enhancing teaching practices and strategies.* This research is not designed to help you personally, but the results may help you and the investigator learn more about the pedagogy used in an undergraduate Bachelor of

nursing curriculum. We hope that this becomes a model on which current teaching practices could be based.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits for which you otherwise would qualify.

What if I have questions?

This research is being conducted by ***Jeffrey C. Hoffman, School of Nursing*** at the University of the Western Cape. If you have any questions about the research study itself, please contact him on 021 959 2278 or jhoffman@uwc.ac.za

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

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

REFERENCE NUMBER: *HS18/3/5)*

Appendix B: INFORMED CONSENT SHEET

Informed consent is a process, not just a form. Information must be presented to enable persons to voluntarily decide whether or not to participate as a research subject. Therefore, informed consent language and its documentation will be written in language that is understandable to the people being asked to participate.

Audio taping/Digital Recordings

This research project involves making *Audiotapes/Digital recording* of what you impart. The data collected will be recorded and transcribed to provide the researcher with a precise description of the interview.

___ I agree to be audiotaped/digitally recorded during my participation in this study.

___ I do not agree to be audiotaped/digitally recorded during my participation in this study.

Participant's name	
Participant's signature	
Date	

Appendix C: INTERVIEW BINDING FORM

Title of Research Project:

Developing a service learning pedagogy for an undergraduate Bachelor of Nursing curriculum

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without providing a reason and without fear of negative consequences or loss of benefits.

Participant's name	
Participant's signature	
Date	

Appendix D: INTERVIEW SCHEDULE

Briefing:

You have been approached to participate in this study as your experiences can help me to understand important issues that relate to your learning and teaching. The interview will be guided by a few broad questions. The researcher may use probing questions to explore pertinent issues of interest to add value and depth to the information collected.

Background:

Would you briefly introduce yourself as a nurse, nurse educator or clinical facilitator.

- Explain your philosophy of nursing
- Explain your teaching philosophy

Interview Questions:

1. Please tell me about the modules you teach or are involved before entering this position.
2. What is the purpose of the modules? (Main outcomes and objectives and clinical requirements of the module - theory and clinical)?
3. Tell me about the philosophy of learning and teaching that underpins the module and how it is being delivered.
4. How do you prepare for your learning and teaching sessions?
5. How much time is spent during the module to engage with students?
6. How do you engage students?
7. Which learning and teaching activities do you use?
8. What learning and teaching activities and strategies work and which do not work?
9. How do you integrate the clinical and theory sections in your sessions?
10. How would you improve your learning and teaching practices?

Probing questions may be asked based on the responses provided.

Appendix E: EXAMPLE OF TRANSCRIPTED INTERVIEW

I = Interviewer P = Participant

I Good afternoon, Ms.

P *Good afternoon, Mr Hoffman.*

I Thank you for agreeing to see me at such short notice so that we can conduct this interview. You have been approached to participate in the study based on your experiences as a registered nurse and a nurse educator. What I am specifically interested in is your teaching and learning experiences. The interview will be guided by a few questions and I will ask some probing questions when necessary. So to start, can you briefly introduce yourself to me as a nurse, nurse educator, your experiences basically as a nurse.

P *Okay. So I am GD …. I have been nursing for more than, in the profession for more than 20 years. Started in the early mid-90s and worked in all of the wards; general, medical, pharmacology, paediatrics, trauma. So I have a broad general knowledge about nursing. I started at UWC in 2010 after my degree and I did supervision first. After supervision in 2014 I was relieving a lecturer from 2014; 2015 relieving, 2016 I got a contract post and 2017 a permanent post. So I've been teaching the second-year module and this year co-ordinating the second-year module.*

I So can you briefly tell me if you have a philosophy or an understanding of nursing? What is your views of nursing?

P *My philosophy would be based on my experience and what is currently needed in the profession and being able to adapt to change, and being an educator I see myself as a mode of transferring or helping the neophyte to become an expert. So my philosophy would be instilling that knowledge or trying to guide the students in developing into the professional that the society requires.*

I So am I correct if I say that your philosophy is based on what is currently needed in society?

P *Yes.*

I And what are the needs of our communities.

P *Yes.*

I And that will influence how you deal with nursing?

P *Nursing.*

I And your teaching philosophy, do you have any beliefs regarding teaching?

P *Teaching has changed based on the current students that we also get. So we need to change with the type of modern students that we have. So it would be a blended social media, you are working on the iPads or iPhones or getting the information. However, as an educator I need to guide them to get the correct information. So teaching in class would be the traditional lecture. However, we would incorporate other modes of teaching as well.*

I So you basically say that you use a blended teaching approach and you are sensitive about the things that comes with the generation that we are dealing with like social media, internet and different approaches.

P *Different approaches, yes.*

I Can you perhaps give me some… just help me to understand…

P *Examples.*

I Different, what do you mean with different approaches?

P *Okay, so because students usually are very active on their phones. What I've seen is their lack of how to properly communicate. What I would nowadays do is would be to start the session also including what is currently happening now in our current societies. For example reshuffling of the Cabinet, for example what happened now the other day with all the gangs fighting with the different protests that are happening? So then I would start a debate and then latch on to what the students know and listen to the different viewpoints. However, instilling respect for the other's viewpoints and tolerance and patience as well. So we would start with a debate; something different. And then I would tell one… go on your phone go and see what is the current Act or policy regarding that you're saying we can legalise prostitution for example. So then I would bring in the Act what would it say now. And then I would go on how do they feel about that? So it would be starting with that and then bring in perhaps the lecture that we have. Whether it is a debate or whether it is a presentation or whether we're just chatting but it would be something incorporated what is current.*

I Are you referring now this is conversations, this chatting and stuff is happening in class?

P *In class.*

I But it is relevant to what is happening outside.

P *Outside.*

I In the community. So if I can summarise that: you are referring to that you are tackling real issues.

P *Real issues, ja.*

I That affects society within your grasp and your teaching strategies.

P *It also instructs them how to verbalise and how to debate in a matter as you can see the school bullying happening. Children do not know how to debate. Children do not know how to express themselves verbally. So in your class where it is a safe environment where I can have a controlled…okay, right so I can stop there and okay, so what do you think? And we would start speaking and understanding and even if opinions differ then, as the profession teaches us, you need to respect all race, religion, culture and …*

I Okay, you've mentioned now something very interesting to me – a safe environment. What is a safe environment for you?

P *Where we speak, especially stuff that is happening in the hospital that might have been traumatic where we can bring it to the classroom and we can discuss it and know if it is too much for the student where to refer them but they feel safe to express whatever they are feeling.*

I So you're basically saying that whatever students are going through in the clinical setting the student brings back to class so the student can debrief, reflect and learn from that situation.

P *And all of the other students. We'll make it a learning opportunity.*

I Wonderful. We know with your introduction we went right into some of the things we needed to discuss. What modules are you responsible for?

P *For second year level, it would be the General Nursing Science, the NRS modules.*

I Can you give a bit of background of the modules?

P *The module itself, the NRS contains a theory part and a clinical part as well. It is a 20 credit module. However, it is over two days. Two hours per lecture.*

I What are the main outcomes for the clinical and the theoretical components? Because you said that the modules have two components – a theoretical and a clinical component. So what would the main outcomes of this module be in your own words?

P *The general nursing science, mostly, the outcome would be to enable our current students, to be able they need to comprehensively understand and manage patients with illnesses; not only primary but secondary or tertiary institutions as well. And because in our current year they do pharmacology and human biology further in human biology they need to apply scientific knowledge and principles in the method of managing the patients.*

I Earlier, you were referring to … that you would have conversations about gangsterism and violence. So I want to ask you now seeing that we're talking about the main focus of your module, how does your module prepare the students to be able to transfer the knowledge to community settings where gangsterism and violence is a problem?

P *It all starts with, I will call my students you are educators and you are managers. Educators meaning to prevent stuff. So before it gets too violent they need to be able to speak out and prevent whatever. So if they see something they need to be educating the community. They first need to be able to educate themselves to be able to educate the family, educate the community and in that prevention is tried at primary health level.*

I Do you think that looking after the community is an important function of …?

P *Yes.*

I Is an important role for your students to learn?

P *Yes, community, I think it is part of nursing because where ultimately our care is for the community. The patient, yes, but if you go into the different year levels or if you go into paediatrics it is not only the patient but it is the patient'' parents or the mother and that latches on for the support from the community or whoever as is part of referral as well.*

I And you've mentioned around primary healthcare focus, so I assume that your modules have a primary healthcare focus.

P *Prevention.*

I Prevention, which is prevention and you've mentioned prevention. So it is important to prevent things like gangsterism and other social ills.

P *It is not only social ills but if they know how the disease starts, TB, how does it start. Educate how to prevent. If they know how HIV starts. Educate how to prevent. So holistically… I look at stuff…*

I Holistically. You mentioned that your module covers comprehensive understanding and management of conditions.

P *Yes.*

I Okay, so is there any specific objectives for your clinical, the clinical component?

P *Clinical component also would be also to enable the students how to deal with certain skills, specifically pertaining to second year. So that is why we do certain skills that relate to the theory as well that (inaudible)… the theory.*

I So the clinical and the theory relates directly to each other?

P *To each other, for example if we start with, in first year they start with first aid. In second year they do emergency trolley. So it links with first year and it goes a little bit further with emergency care. In class, they do emergency trauma and the theory and where in the clinical facilities they actually need to understand and demonstrate a knowledge of the emergency trolley which are in every ward.*

I So basically what I understand is that the emergency trolley is more advance than the first aid that they do in the first year.

P *Yes.*

I So it is on a higher level.

P *It is a bit higher than the first year. A bit deeper or more than what they used to know in first year.*

I Okay. Is there anything else with regards to your teaching and your theory and the clinical components of the modules that you can share with us?

P *Hmm.*

I How do you offer your clinical programme?

P *Students were introduced from first year to the skills lab. So the skills lab is also part of the safe environments where they will practice certain skills before they are introduced to the real injury in hospital. So the skills, as our module, you need to have clinical and you have theory. There's certain stuff that you need to be able to do before you qualify to do the clinical OSCE. So those skills are being taught in a safe environment first and they are then demonstrated and they are being evaluated in the facilities, all of the clinical facilities.*

I So there's a process that you take the students through and it starts in the skills lab.

P *It starts in the …*

I Or where does it start?

P *It starts in the skills lab. It starts from orientation where they are orientated regarding everything pertaining to second year, what is expected of them. Where the clinical skills are concerned, they are also showed videos regarding skills. They are also able to come and book skills lab sessions where they want to view the videos themselves or self-directed learning. So all skills will be demonstrated to the student. They will have an opportunity to practice it and with the evaluation, they need to be found competent. Should they not be found competent they will be doing a re-evaluation in order for them to understand and comprehend a skill.*

I You mentioned something now, which I am interested in – self-directed learning. How does self-directed learning fit in with your module?

P *For a second-year student, especially for this year, our year is so compact that we're actually really developing that student to become a professional that need to learn how to manage time and how to positively view the programme. However, self-directed learning is specifically where the student see where they have available time, plan when they can do a skill in the skills lab and do it by themselves. So it actually is a learning process where students at the end realise but I actually need to do self-directed learning as well. So it is part of development. It is part of the unspoken word where we actually do see students are becoming that young professional that understands or manage their time and do self-directed learning as well. It is learning where they are doing it either by themselves, however, under supervision in the skills lab.*

I Let's for example say if the student is engaged in self-directed learning activities, do you have activities that are self-directed?

P *Ja. However, because of time, our programme is so full usually the self-directed learning the skills that are mostly required for them to do. For example should the student need to be competent in injection then they would book themselves in just to… after they've done the demonstration, the practice then they would practice by themselves for self-directed learning.*

I Where do they practice by themselves?

P *Skills lab.*

I Only the skills lab.

P *Yes and for example they now need to prepare for the OSCE as well they would have opportunities for self-directed learning.*

I What other opportunities exist so the students can gain clinical skills and even have an opportunity to explore the theory? Is there other opportunities in their year level?

P *So they are being placed two times a week at the clinical facilities. I believe that learning really occurs there as well. Although there's a clinical supervisor, a student working eleven hours a day for two consecutive, currently this year for two consecutive days, is actually a continuation of learning where whatever they have learnt in class should they be placed in a ward where perhaps that topic was covered they actually can see it, experience it and understand a little bit more and then also…*

I You say now, sorry that I interrupt you, see it, experience it and interpret it.

P *Ja, so they will obviously part of learning is also before you fall asleep you reflect back and that is what we teach the students also. Learning does not occur only the spot but can occur afterwards as well. So you will lay before you fall asleep you will reflect on the day. You would have seen oh, I could have done this or that is good or what, you know, you reflect back. So that is part of learning that is clinical theory as well.*

I Okay, so when you're talking now about reflection. How do you manage reflection as a teaching and learning activity?

P *It should be part of every class preparation as well because before I usually start a class I would recap or I would reflect. Whether it is first year knowledge or just what we did last week or just reflect what did we do so that we can latch on to the new knowledge. So the old knowledge versus the new knowledge and then we can explore.*

I So you try to build up on previous existing knowledge that the student may have.

P *Yes.*

I Okay, is there any guidance that you give to students when they reflect?

P *It's supposed to start in the first year already where reflection is part of learning as well. However, in second year, a little bit more because, like I said, reflection is a big part of learning as well. And in class when we recap we would actually latch onto each other's thoughts and everybody is making it a learning opportunity.*

I Can I ask you to detail a learning opportunity for me to include all the steps?

P *So for example, let me think.*

I In your year level in your class, how would you see a learning opportunity unfold?

P *So we had a disagreement. It started with, what was the lecture, every lecture is exciting because they would… because I would bring in what is current and what is… where…was it the Constitution? Because it was about tax, oh, it was the time when we heard that the tax is now 15% so I brought that into the*

class. And then they had their group discussion what do they think about that. And the one said that not everybody pays tax like prostitutes, they don't pay tax. And then some of the groups said but no, wait they shouldn't be paying tax because it is not a business and we were discussing that. And the one proposed that it is supposed to be a business and they're supposed to pay tax as well. So it was all about what they know, reflecting about it, what they saw in the hospital, all of the diseases that come in; latching it on and talking about but we were doing HIV and Aids – that was the lecture reflecting on that. And the possible, I was going into the statistics about the HIV how it was, the most current…

I Because the way I understand it that influences the burden of disease.

P Ja, so that is why people were thinking how can we bring the stats down. So I was giving them an opportunity to think, reflect what is happening, why do you think… because why 10 years ago we knew about it, stuff was put in place but why is the stats still like that. And everyone was coming up with lots of interesting … and one of the things was obviously prostitution and stuff like that and then I let the one go and read up the Act…

I So am I correct in saying that again, you try and bring back the problems and the needs of the community into your class?

P Into the class.

I So that it fits.

P And continues thinking and they have to think as well. That's beside the ethical part of not being prejudiced and all of that other stuff but stuff like that they're reflecting, they're coming back and thinking about it. What can we do to better it? Because I always tell them you're educators and managers. For educating how are you going to do this? For managers, how are you going to manage that? So ja, then I bring the Act in, what does the Act says? You were suggesting this but you don't agree with it, you don't agree with it. Are we going to come to a solution?

I You've mentioned something now - you manage the prejudices of students, how do you do that? How do you manage prejudice?

P By always bringing in the fold of nursing. We are a religion on our own. We cannot, if you nurse anybody, you cannot have any feelings of negativity whether it is a different race, culture or … because it… it is the values of nursing. Then I bring the old nursing back into the class and how we're supposed to be. Looking past what is currently happening with the racial issues and stuff. So once you're in the fold of nursing there shouldn't be anything and I always remind them that – whenever they are nursing they must see it as nursing either their mother, their father, their sister or their brother. So it is something that they, you know, to bring the love for nursing back; to bring the passion for nursing back.

I Let's move to another question. How do you prepare for your teaching and learning sessions?

P Obviously, you know already the lecture that needs to be done and many times you would tell the students before the time because they have the module guide what lecture to prepare for and then it would be the traditional, the PowerPoint slide and obviously, the lecture, the traditional lecture. And then all students are divided into groups where I just on the stop right, you are the Minister of Health group, you need to speak about this. You are now this. You need to speak about pathophysiology. So they have on the spot scenarios perhaps also and then they have the time when they have to prepare in advance a topic. So they would have like a few minutes to prepare for that and then they will present it and then the lecture, I would obviously introduce the lecture, do that and then conclude with summarising all their ideas and their topics and give them the main outcomes of the lecture.

I Obviously, you mentioned now about that you're using scenarios, where do you get your scenarios from?

P Scenarios are built into the module guide but it gives usually the case-base, what everybody is using and it is built on the topic that I usually … and it is

I So what do you mean with the word "it is relevant to the community"?

P So the cases, for example, students at the beginning of the semester, are introduced to a family. A family for example x, y and z. Now this family goes through if we cover HIV, this one is exposed to HIV. And

then students need to know how to understand it and manage it in their year level. The same with the other family members, cases. Something happened. The father is maybe a mechanical worker and then he lifted something heavy and then he landed in your trauma where you are currently working, what are you doing to him? Stuff like that.

I How much time do you engage students for this module?

P We have a set out time but it depends on the topic because especially if you make the topics like relevant or interesting there would be many times where there's a lot of engagement with the students versus other times where you can see they need more understanding. So you will explain a little bit more. So every lecture varies but there is time for preparation. There's time for giving the lecture and there's time for presentation or summarising the whole lecture but it is usually in the two-hour space per day.

I And the students participate in all those spaces? Preparation, presentation, and the discussions?

P Ja, they prepare for that.

I So can you describe some of the preparation work that students are required to do?

P If it is for them to prepare in advance then they would have the topic. They would go and research the topic and then depends on what they need – if it is pathophysiology, if it is signs and symptoms, they have to prepare for that and each member of the group would present it.

I We've covered most of the questions. But I want to ask the question. How do you engage your students? How do you engage your students?

P So engaging…

I …to meet the requirements of the module?

P It is usually per topic and for these students, it was at the beginning a bit difficult Because usually at the beginning of the year; not that they're new to each other but they are coming from first year, second year was something different, and for this year especially the first weeks you could see they did not want to engage with each other and if they do stand up to answer something they would be intolerant of other students. So then I would come in and especially the first weeks because you could see the different groups and I would come in and I would speak about humanity, humanism, the fold of nursing, what we're supposed to be and all of that till I could feel no, these students are now actually participating when I ask the one to speak. Stand up and speak – nobody laughs at the accent or the way they speak because why I have taught them respect. And if there is one speaker, and what does the other do? They listen. So the presentation skills are then reiterated again and in that way all of the students after a while and especially now today the students they feel they are able to stand up. They're not scared. They're not anxious because why it was instilled in them from the beginning, it took a while but you can see the groups respect each other. Nobody is saying, because your opinion is different to mine nobody is interjecting. If they do they would do it politely but there would always be an engagement because why they feel assured that nobody is going to look down on them. For me I will always instil in them no answer would be a correct answer. They are free to talk whether it is laughable… if we laugh we all laugh together in a class. So there is a relaxation atmosphere in class where students feel free to engage.

I Ms, you've been (inaudible)… that this modules have got theory and clinical, could you elaborate a bit more on the integration of the clinical and theory? How do you integrate clinical with theory during your teachings sessions and do you integrate when the students for example say in the clinical setting, theory how do you integrate it?

P Say for example when they did the intracranial pressure and the neurological function it relates to neurology and … then obviously, we would just see who worked neurological wards, what they did and

especially link it to the skills because the students need to be able to do the [Glaucoma] scale. The students need to be able to know how to do a neurological assessment. So in class when we touch on intracranial pressure, this is what happened theoretically or scientifically or what is currently happen in pathophysiology in the body that is why you will see pupils dilate or the arms, the weakness of the limbs because of certain stuff that is happening and so they will get the theory get it in class and understand it, link it to their HUB and especially also pharmacology so that they can understand that this medication helps with that in the …

I I've got one last question for you. What teaching and language strategies work for you and what doesn't work for you?

P Teaching and learning strategies that work for me, I like the active face-to-face discussion with students. I like to stand in class and see the students, speak to the students, hear their thoughts, and understand their thoughts and where they're coming from. However, I also like to incorporate the internet and especially students need to learn more advance, know how to do online tests. So that works for me. What doesn't work for me would be … hmmm… What doesn't work for me? Students not readiness. The type of students that we get from school. Student readiness. They're not really … especially for nursing where I fear long-term safety of our community, the patient itself because why we had many students that did not know that they have to do clinical during the week the same time as theory. So it is a burden on the student especially if the student doesn't do well. It always comes back to us.

I So you're saying the fact that theory and clinical, the theory, the clinical … you said that it is a burden on the student. How can we … does that burden influence the way they learn?

P I think it is especially in second year. Second year is not only our general … you see in second year because of the deeper knowledge that we need to get from the student it is a little bit more advanced general nursing. However, there's human biology which is tough on the student. Pharmacology which is tough on the students and the modules but the modules complement each other. However it is difficult on the students especially if they have two days of clinical; two days of clinical and the next day they write a test perhaps. And all of the modules, pharmacology, human biology, NRS we do tests throughout the year. It is a bit difficult on the student. It is tough.

I Is there any bridge to assist the student in that regard?

P One of the things that we have is the tutoring modules where we inform the students about all the tutoring that are available for HUB, pharmacology. We met with pharmacology how they can link, bring it back to nursing what is currently… and align it with our theory. So there are certain resources available for students to make it easier. It is just for second year, because their year, because their time table is so compact they don't have time for anything else.

I Is there anything that you can do to improve your teaching practice as a nurse educator?

P (coughing) Sorry. To improve nursing practices? Provide quality teaching, appoint people with experience, more clinical supervisors. The HR needs to have experience and registered… you cannot have somebody that has less than two years for a clinical supervisor. So if you can bring the quality people that have more years of experience in teaching or nursing that would benefit the student but if they go into the money, it become a real HR issue for the school.

I The HR issues.

P The HR issues, it is not beneficial for a nurse educator with all the years of experience to come and supervise or lecture here compared to other universities.

I One last question, honestly, the last question. Do you ever engage your students in any activities in the community?

P *At our year level, not in our year level because they actually do clinics as part of their training they have to work in community clinic but extra other stuff we can only advise. But the community stuff that they are doing would be hospitals and communities and then we have extra programmes built into the year such as the open day where they will perhaps ask voluntary for blood pressures or nurse's day or where we ask them to do certain stuff.*

I But I am now interested in this open day stuff.

P *Ja.*

I Is it voluntary?

P *Yes, it is voluntary.*

I How do these opportunities empower your students?

P *It is not only empowering them but also giving them the experience that they are actually (inaudible)… that people come randomly and they don't have an idea about their history because usually you would have a folder of a patient in hospitals and clinics. But here a random person comes and do the blood pressure. When you get an abnormality what do you do? So, it is experiencing how you speak on a different level to the client; it is not a patient now. So they get to experience on a different level how to address or speak to people.*

I So would you describe this as a real experience?

P *Most definitely.*

I Is it a real experience?

P *Most definitely. It is a real experience. It is also part of developing them when they reflect as well they can maybe differentiate the difference between hospital and just doing a quick blood pressure of somebody that's walking past them screaming.*

I And you mentioned something about reflection, how do you think can reflection aid in such an activity?

P *I think reflection, like I said, is part of learning. I think if reflection is used in a positive manner it can really aid in all phases of learning where you can reflect what was good, what was not good, how can I better it? Or where you can analyse oh, okay this was that way. So I think reflection if used in a proper or educational way is a method of learning as well.*

I Do you use reflection often?

P *As much as I can because before you can instil anything new you have to understand or reflect on what happened previously.*

I Do you use any… is there any guideline that you use?

P *For reflection?*

I For you and your student to reflect?

P *No, no, it's based on experience.*

I Based on experience.

P *When I reflect I call it like stories.*

I Stories.

P *Then I will tell them what happened in the nineties. What happened when I was working oncology in those years and what is currently happening now. So I would tell them stories. I would tell them stories or reflecting stories when I first met a dying patient as a new nurse.*

I Is this now based on your experience?

P *My experience. So I bring my experience to the class and then I latch it onto what is currently happening and some of them would actually contribute with what they're actually experiencing as well.*

I Really the last question.

P *(laughs)*

I Really the last question. I am so sorry. (laughs)

P *"Ek moet maar my mond hou, want dit is nou te interesting vir Jef" (Afrikaans).*

I You make me forget… I wanted to ask you about your assessments. What do you do to assess students and how do you know students are competent?

P *Assessments are just basically done with a tool that we have. So that tool is like a guideline for the assessor. It is a competency assessment. So students, if they learn it parrot fashion and they know the tool they can do it. However, what our tool used to have is like … does the student integrate theory into the… so that you cannot just learn parrot fashion. And we would like ask random questions about anything theory pertaining to see if the student really understood what they say.*

I I'm assuming you're referring to your clinical component and the theory component? How do you assess students for the theory component?

P *With the theory component, our students are usually based on the lectures or the weekly lectures that they have then continuous assessment would be what we have covered thus far. And then the main exams would be about also the stuff that was not covered yet. So all the theory components that was done in class the students get tested on.*

I So what is the task that make up your assessment?

P *A task? So assessments for theory, we would have three tasks, a test. There would be a quiz which is 25%; test 1 which is 35%, and test 2 – that is the three. It equals 100 %. However, it has different weighs, but it weighs 50% towards the initial [cammark] when you have your clinical, you have different tasks for clinical. Clinical we have the case study which is 40% and then we have the … (interruption) then we have the assessments that need to be done for the portfolio.*

I Tell me quickly about the case study.

P *The case study is usually cases that students need to be able to … students would do it in hospital or in facilities. They would have a patient and they would need to do a case study based on a topic that we previously covered in semester… where for instance diabetes and the student needs to go and interview a patient with diabetes, they're getting the information but do they understand without looking in the books how to refer them, what was lacking in the hospital, do they understand the patient's rights, the Batho Pele, do they understand how to manage this patient and stuff like that, and write up a nursing care plan for that patient.*

I And you've mentioned how to say the case study, does the case study contribute because I see it is a real learning situation. It is based on something that is real. It is a real patient. How does it contribute to the development of the student?

P *They need to understand clinically, first, how to speak to the patient, how to do an interview with a patient, see that they get all the information and integrate it and they have to understand at the end how to with all this information what do we do with the information if you have all the signs and symptoms and the patient is telling you this where would I have sent the patient for diagnosis? Do I send him for x-ray? Do I send him for a TB test or do I send him for whatever test. So they have to understand that. And then after that, where do I refer them, how do I manage them, nursing management plan. If the patient has a cough what do I do? It is part of the theory versus linking it with the clinical.*

I And can you quickly describe the portfolio and what are the benefits of the portfolio?

P *The portfolio weighs about 60%. They need to do two clinical assessments. It is the assessment that they did starting from the skills lab where certain assessments were demonstrated to them. So they would have to do for example two skills (interjection) and then they would have a progress report. The progress report would be from the ward itself, the ward Sister where the ward Sister gives some feedback how was the student as they saw them in the ward. So it is progress for a specific period of time. And then there would also be the weekly competencies like the SDL, what they do in skills lab but besides the assessments, the compulsory assessments, there's also other stuff that the students did. So for example if you work in theatre, do they know how to counter all the … do they know how to scrub? So that is the weekly competencies. So they would have an allocated mark percentage for that as well and that is the portfolio.*

I Does the portfolio assist the students?

P *It does assist the students a lot especially if they do what is required of them.*

I Do they use the portfolio? Do they reflect on it?

P *For this year we do not, I know in first year, they ask for a reflection report but we do not have a reflection report for that. But they know because why clinically and theory, for both they need to be able to qualify for the entrance into the exam. And in order for the entrance to the exam they need to have at least done clinically and theory, at least 40% for each.*

I Ms, you can chat so much.

P *(laughs)*

I Thank you so much. Sorry for smashing a full hour of your time.

P *(laughs)*

---End of audio---

Appendix F: MODULE SCHEDULE 2017

Week	Date	Facilitate learning topics/ content	Assessment/Tasks	Self-Study topics in preparation for the next week
	Orientation 21/07/2017 Lecture Contact	Introduction to the course Service Learning • Project • E-learning and structure of course • Social construct of gender		• Read course guide thoroughly, familiarise yourself with service learning, reflection and its principles Johari window and the social construct of gender. • In addition, do a literature search on what is a needs assessment and how to conduct a needs assessment.
1	10 AUG	Site Visits	• Conduct a needs assessment (*)	
2	17 AUG E-Week	Group work/Blog: • Reflective practice post/response • Blog post: Construct of gender exercise	• Group submit first reflective practice post (500 words) on needs assessment of a service learning project in gender based violence. Refer to previous SL reports provided on Ikamva. • In addition to the above, ALL groups write one reflective post (max 500 words) on the most easy/ most difficult social construct of gender exercise, using the Johari window to explain why it was easy or difficult and relate it to possible client experiences of disclosing personal information.	• WHO REPORT ON GBV • Theoretical frameworks for gender based violence • Classification of GBV according to life cycles
3	24 AUG Lecture Contact	Theoretical frameworks for understanding gender based violence Life-cycles and types of gender based violence		• WHO REPORT ON GBV
4	31 AUG E- Week	Group work/Blog: • Reflective practice post/response • Blog post: Theoretical frameworks for understanding gender based violence	• Groups submit their reflective practice post: 500 words about the planning phase of their service learning project in gender based violence. Link theory of GBV into the reflective practice post. • Submit a summary report about the theoretical frameworks for understanding gender based violence that were covered in the previous lecture session and other frameworks for understanding gender based violence	• Magnitude of gender based violence and GBV in the media
5	7 SEP LECTURE	Magnitude of gender-based violence as public health issue and GBV in media		
6	14 SEP E-WEEK	Group work/Blog: • Reflective practice post/response • Blog post Magnitude of gender based violence as public health issue and GBV in the media (each group to select a province)	• Groups submit their reflective practice post: 500 words about the implementation phase of their service-learning project in gender based violence. Link theory of GBV into the reflective practice post. • Individual contribution to group: Submit your summary report about reported issues of gender based violence in the media in a province of your choice in South Africa and the recent WHO Report on Violence against Women. • In addition to the above, ALL groups write one reflective post (500 words) on the magnitude of gender based violence and why your group believes it is a public health issue. Include the causes and prevalence of GBV.	• Consequences of GBV on health outcomes
7	21 SEP LECTURE	Consequences of GBV on health outcomes		

8	28 SEPT	E- Week Group work/Blog: ◆ Reflective practice post Blog post: ◆ Consequences GBV on the health outcomes	◆ Groups submit their reflective practice post: 500 words about the implementation phase (update on progress) of their service-learning project in gender based violence. Link theory of GBV into the reflective practice post. ◆ Individual contribution to group: Submit your summary report on the Consequences GBV on the health outcomes of the individual and the country. ◆ ALL groups write one reflective post (500 words) on the consequences reported in the MOST RECENT WHO Report on GBV. ◆ Refer to the Cycle of violence and coping mechanisms after being abused; Physical and psychological effects of violence	◆ The Protocols for managing GBV ◆ Domestic Violence Act (No 116 of 1998)
8	29 SEP	**TEST 1 Week 1-4 (50%)**		
UNIVERSITY VAC-				
9	12 OCT	Lecture Contact Gender based violence Management Protocols. Domestic Violence Act (No. 116 of 1998) – DVA.		◆ In your placement at your facility, identify protocols, or lack thereof, for management of gender-based violence – keep for next week's group work- this needs to be contributed to your group
10	19 OCT	E Week: Group work/Blog: ◆ Reflective practice post Blog post: ◆ Protocols for GBV in Health Care Facilities	◆ Groups submit a reflective practice post (500 words) about the implementation of their service learning project in gender based violence. Link theory of GBV into the reflective practice post. ◆ ALL groups write one reflective post (500 words) on the protocols, or lack thereof, for the management of gender based violence IN HEALTH FACILITIES	◆ Interventions strategies and Barriers to reporting of GBV and Health professional attitudes towards GBV
11	26 OCT	Lecture contact: Interventions strategies (including the role) and Barriers to reporting of GBV and Health professional attitudes towards GBV		◆ Screening of GBV and readiness of healthcare workers to deal with GBV
12	2 NOV	E-WEEK Reflective post: Compiling a your final report on your service learning your service learning project Group work/Blog: ◆ Blog post: screening of gender based violence in health care settings Start preparing your individual reflection / contribution for your group: a reflection on your SL project	◆ In your group, submit a screening tool for gender based violence in a health care setting of your choice and provide a reflection on your screening tool. This will be presented in class- you can project your final product	◆ Prepare an individual reflective practice post about the service learning project in gender based violence. Make explicit the links with the outcomes of the GBV module (NRS 401). To be submitted with your final report. ◆ Finalising your presentation for class presentation re: the screening tool.
13	9 NOV	Lecture **Presentation: SCREENING TOOL**	◆ ALL groups submit FINAL SL report Submit SL project file for evaluation due 13 NOV 2017	◆ Submit your SL Project NEXT WEEK 13 NOV 2017
12	13 NOV	**SUBMISSION OF SL PROJECT REPORT**		
13	16 NOV	EXAM PREPARATION	REVISION USING WEEK 12 CASE STUDIES and all other content of week 4 - 12	
14	20-24 NOV	**EXAMINATIONS**		

Appendix G: ETHICS CLEARANCE

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07 April 2017

Mr J Hoffman
School of Nursing
Faculty of Community and Health Sciences

Ethics Reference Number: HS17/1/19

Project Title: Developing a service learning pedagogical model for the undergraduate nursing program.

Approval Period: 03 February 2017 – 03 February 2018

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

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

PROVISIONAL REC NUMBER - 130416-049

Appendix H: EDITORIAL CERTIFICATE

Idea Corporation t/a
AQUARIAN PUBLICATIONS

29 January 2021

To whom it may concern

Dear Sir/Madam

RE: Editorial certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, spelling, as well as overall layout and style by myself, publisher/proprietor of Aquarian Publications, a native English speaking editor.

Thesis title

A SERVICE LEARNING PEDAGOGY FOR AN UNDERGRADUATE BACHELOR OF NURSING CURRICULUM

Author

Jeffrey Cornè Hoffman

The research content, or the author's intentions, were not altered in any way during the editing process, and the author has the authority to accept, or reject my suggestions and changes.

Should you have any questions or concerns about this edited document, I can be contacted at the listed telephone and fax numbers or e-mail addresses.

Yours truly

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