UNIVERSITY OF THE WESTERN CAPE
FACULTY OF COMMUNITY HEALTH SCIENCE

Bachelor of Nursing students at a higher education institution in the Western Cape's experience of preparation for and perceptions about their readiness for clinical placement in emergency

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A Mini-thesis submitted in fulfilment of the requirements for
the degree of Master of Nursing (Structured) in the School of Nursing,
Faculty of Community and Health Sciences,
University of the Western Cape

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Date: November 2022

KEYWORDS

Clinical learning

Clinical placement

Emergency care

Emergency nurses

Emergency units

Experience

Nursing education

Nursing student

LIST OF ABBREVIATIONS

CPR	Cardiopulmonary resuscitation
DOH	Department of Health
ECG	Electrocardiogram
EDNA	Emergency Department Nurses' Association
ENA	Emergency Nurses Association
EBP	Evidence-Based Practice
HIV	Human Immuno-Deficiency Virus
HEQSF	Higher Education Qualifications Sub-framework
HSSREC	Humanities and Social Science Research Ethics Committee
ICU	Intensive Care Unit
NEI	Nursing Education Institution
NQF	National Qualification Framework
OBE	Outcome-Based Education
SA	South Africa
SANC	South African Nursing Council
SAQA	South African Qualifications Authority
SON	School of Nursing
WHO	World Health Organization

DECLARATION

I declared that “Bachelor of Nursing students at a higher education institution in the Western Cape’s experience of preparation for and perceptions about their readiness for clinical placement in emergency units’’ is my own work and done under the guidance of Professor F. Daniels. All the resources used has been acknowledged in-text and by means of a complete reference list. This mini-thesis has not been submitted before for any degree to any institution.

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ACKNOWLEDGEMENTS

First, and foremost, I would like to thank the powerful almighty God, my saviour, for unending grace, mercy upon my strength, wisdom, and health, who is obviously the one who has always guided me. Without His grace, this project could not have become a reality.

I would also like to express my sincere gratitude and appreciation to Professor Felicity Daniels. I can never thank you enough not for your dedication, guidance, and support. You believed in me and in my project from the beginning until its completion. Thank you for your encouragement, expertise and passion and for investing your invaluable time in my project. I would have not completed my master's degree if not for your spirit of adventure and tenacity.

I would like to express my deepest appreciation to my family and friends for their love, support and encouragement through the hardships that I encountered during this study.

DEDICATION

This thesis is wholeheartedly dedicated to my now late parents, grandmother, siblings, my children and close relatives. Thank you for being a never-ending source of inspiration, support, strength and motivation when I was on the edge of giving up. Thank you for unconditional support in all my endeavours in life, your wisdom encouraged me to complete this study.

ABSTRACT

Background: Nurses are the frontline healthcare professionals in the emergency units, charged with providing ethical, safe and effective emergency care. They are required to have specific knowledge and skills about emergency care. Emergency nursing is a speciality requiring high acuity as it is complex, acute and sometimes chaotic in nature. It is centred on the level of severity, urgent intervention, prioritization, resuscitative measures and stabilization to prevent, mortality and morbidity.

Traumatic injuries are a global health crisis leading to death among many people under the age of 45 years and creates a massive burden to the health care system and society. These injuries are caused mainly by road accidents, intentional injuries and alcohol-induced violence.

In South Africa, trauma and emergency nursing programmes are offered by both nursing colleges and universities. Undergraduate nursing students are allocated to accredited clinical facilities, including emergency units, for work integrated learning. However, at present, there are no clear trauma and emergency core competences, standards and guidelines for the undergraduate nursing programme. This results in poor preparation of students, challenges with integration of theory into practice, inadequate clinical supervision, and student absenteeism.

Purpose of the study: To explore Bachelor of Nursing students' experience of their theoretical and clinical preparation for, and perceptions about their readiness for clinical placement in emergency units.

Objectives: To explore student nurses' experience of their theoretical and clinical preparation for placement in emergency units; and to explore student nurses' perceptions about their readiness for clinical placement in emergency units

Research methods: This study followed a qualitative approach using an exploratory, descriptive design. The target population was registered third-and fourth-year nursing students at a university in the Western Cape, who had clinical placements in the emergency units. A total of five focus group discussions were conducted with 34 participants, sampled through non-probability purposive sampling. Focus group discussions were audio-recorded and transcribed verbatim. Thematic analysis was employed for the purpose of data analysis.

Findings: Four themes and 12 categories were generated from the data namely; insufficient emergency-based education; challenges with educational planning; lack of readiness for clinical placement in emergency units; and positive and negative learning experiences in emergency units

The findings revealed that nursing students have poor theoretical and practical preparation for emergency-based practice. In particular, the findings showed that students experienced challenges regarding the planning and implementation of a clinical placement in emergency units. The findings revealed that the following factors contribute to the theory-practice gap and inhibit students' clinical learning in emergency units: inconsistent communication, anxiety, conflict of interest, nurse-student expectations and the reality of emergency units. The findings also indicated that meaningful clinical placements in the emergency units might be achieved through ensuring that students have the requisite knowledge, specific learning outcomes and consistent and sufficient clinical supervision.

Ethics: The university research ethics committee granted ethical clearance for the study. The Registrar of the university gave permission to conduct the study. All the participants signed informed consent and confidentiality binding forms. Participation was voluntary. The data was kept confidential and anonymous.

Recommendations: The nursing education institution must implement a realistic emergency-based simulation session prior a clinical placement in the emergency unit. Student accompaniment in emergency units must be structured and consistent, and must include bedside teaching and learning. The clinical rotation of students must ensure that they are exposed to all areas of emergency nursing such as triage, minor injury room, major injury room and resuscitation room. Students must be placed in all types of emergency units such as medical, trauma, and surgical units.

Conclusion: Emergency-based theoretical and clinical preparation is required before nursing students are placed for work integrated learning, to improve their emergency care readiness. Student nurses' learning experience and readiness for clinical placement in emergency units is reliant on specific emergency knowledge, skills, communication, support, and sufficient clinical supervision.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 Introduction

Globally, nurses are the frontline workers in the emergency units, often the first to interact with the patient presenting with a traumatic injury or acute illness. They are required to have specialized knowledge, skills and competences and be familiar with and capable of using technology and equipment required to provide effective emergency care (Husebo & Olsen, 2019; Dulandas & Brysiewicz, 2018; Jones, Shaban & Creedy, 2015 & Bell et al., 2014). Emergency care is critical in the provision of lifesaving treatment, an access route to the health care system and a gatekeeper for the hospital admission (Kim et al., 2021). Accordingly, knowledge and skills among the emergency nurses is essential for optimal emergency care (Phukubye, Mbombi & Mothiba, 2021). However, evidence suggests that nurses working in emergency departments lack formal emergency care education, which results in poor provision of emergency care (Jamshidi, Tabrizi, Fallahi-Khoshknab, Dalvandi, Vizeshfar & Khankeh, 2021; Dulandas & Brysiewicz, 2018).

Until recently, in South Africa (SA), education and training in emergency and trauma nursing was available only after the completion of a nursing undergraduate diploma or degree programme (South African Nursing Council, 2010). However, the South African Nursing Council (SANC) (2013) mandates that undergraduate student nurses must have experiential learning in emergency units. It is, therefore, important to explore the theoretical and clinical emergency nursing preparation of undergraduate nursing students.

This study is inspired by Lev Vygotsky's socio-cultural theory of cognitive development and scaffolding, which suggests that learning occurs through interaction, support, guidance, and that students build new knowledge based on prior knowledge (Shoaib & Alexander, 2017). The constructivists assert that students learn better when they are active, independent, and be able to make meaning from experience, social discourse; and integrate new information with what they already know in the real world (Tuerah, 2019).

However, the researcher, who works in an emergency unit, identified a potential gap in the curriculum on emergency care for undergraduate nursing students. The researcher observed that nursing students who are placed for work integrated learning in emergency units demonstrated insufficient pre-requisite knowledge, unclear learning outcomes, and limited clinical supervision.

Until now, no similar research has been undertaken to explore the experience of Bachelor of Nursing students' preparation for, and perceptions regarding their readiness for clinical placement in emergency units. Based on the researcher's observations, a qualitative exploratory-descriptive research design was used to collect, analyse, and interpret data gathered through focus group discussions with students to better understand the research problem.

This chapter describes the background of the study, its rationale, followed by emergency nursing history, scope of emergency nursing care, and emergency nursing education in SA. It proceeds to present the problem statement, significance, aim, research questions, objectives, definition of operational concepts and study outline.

1.2 Background

The World Health Organisation (WHO) provides that traumatic injuries are one of the main causes of mortality in the world, with 90% of the injuries estimated to occur in low-and middle- income countries and developing countries (Van de Ruit, Lahri & Wallis, 2020; Edem et al., 2019; Manwana, Mokone, Kebaetse & Young, 2018). Globally, traumatic injuries are a public health crisis with more than 4,8 million per annum which leaves many patients with disabilities (Lourens, Parker & Hodkinson, 2020). Trauma-related mortality accounts for 1 in 10 deaths worldwide (Oyeniyi, Fox, Scerbo, Tomasek, Wade & Holcomb, 2017).

In SA, traumatic injuries account for a significant number of admissions in public hospital emergency units (Aspelund, Patel, Kurlanda, McCauld & Van Hovinge, 2019). This is because traumatic injuries are seven times more than the global burden of disease and leads to enormous proportion of the national burden of disease in SA (Chu et al., 2022). Traumatic injuries result in long-term impairments that is physical, behavioural and psychological. In general, these injuries are a burden on the already constrained health care system because of inpatient costs, surgery, and diagnostic investigations and resources (Marle & Mash, 2021). The treatment and rehabilitation of the injured patients account for significant proportion of many national health budgets (Da Costa, Laing, Kong, Bruce, Laing & Clarke, 2019). The traumatic injury related death and disability represents a significant loss of economy in many countries (Marle & Mash, 2021). Overall, traumatic injuries create immense burden on the society and healthcare system (Da Costa et al., 2021).

Traumatic injuries are mainly caused by road traffic accidents and intentional injuries such as suicide, domestic violence, gunshots (Zaide et al., 2019).

Traumatic injuries are the leading cause of mortality among people under the age of 45 years in United States (US) (DiMaggio et al., 2016; Ibrahim et al., 2015). In SA, they are part of quadruple burden of disease comprises maternal and child health; non-communicable disease; HIV/AIDS, violence, and traumatic injuries (Zaide et al., 2019). For this reason, emergency units' functions are at the heart of a hospital's provision of healthcare services (Botes & Langley, 2016).

Provision of effective emergency care is dependent on multidisciplinary collaboration between the doctors, nurses, radiologist, and physiotherapist, among other healthcare practitioners (Husebo & Olsen, 2019; Cochran, 2019). The multidisciplinary collaboration within emergency services is necessary to enhance patient outcomes (Seale & De Villers, 2015). However, team collaboration is impacted by high patient admissions due to trauma, surgical, medical, psychiatric, geriatric, paediatric maternal and neonatal emergencies, within 24 hours (Afaya et al., 2021; Dulandas & Brysiewicz, 2018).

1.2.1 History of emergency nursing

Emergency care has its genesis at Henry Street settlement of New York City where a nurse by the name, Lillian Wald started a ''first aid room'', which provided minor emergency care for cuts, local infections, rashes, and injuries from accidents (Antony, 2019). During this era, doctors were limited, and as a result, there was no clear scope of practice for emergency nurses. Nurses were therefore forced to work beyond their scope of practice to care for the injured patients (Wie, 2021). Nurses also performed

physical assessments on patients during the night, weekends, holidays and provided immediate care while waiting for the doctor's arrival (McQuillan & Makic, 2019).

These conditions necessitated the need for an emergency nursing education programme for nurses. This would assist in preparing them to perform specific emergency care service, such as history taking, initiating cardiopulmonary resuscitation (CPR), performing an electrocardiogram (ECG), stopping bleeding, wound care, management of fractures and helping the doctors with patient care (McQuillan & Makic, 2019; Kennedy, Curtis & Waters, 2014). Emergency nursing and medicine continue to develop into specialities (Kennedy et al., 2014). The development of emergency nursing specialization is intertwined with the Emergency Nurses Association (ENA), which was registered in 1970 and is responsible for the development and implementation of position statements, to ensure evidence-based practice (EBP), provision of quality emergency care, educational products, and several publications (Wie, 2021).

1.2.2 The scope of emergency nursing care

Emergency care is rooted on a level of severity, urgent interventions, prioritization, resuscitative measures, stabilization of patients of all ages, who present with medical, surgical, and traumatic injuries, with or without technology to prevent morbidity and mortality (Campo et al., 2016; Japiong et al., 2016; SANC, 2010). It starts from the scene of an accident or initial illness and transfers inter-facility to the emergency unit (Mamalelala, Mokone & Obeng-Adu, 2022). Emergency care is carried out in healthcare facilities, which is not limited to emergency units, but includes pre-hospital response such as, disaster management, inter-facility care and hazardous occupational environments (Van de Ruit, Lahri & Wallis, 2020).

An emergency nurse practitioner is a nurse who has specific training and practice in emergency situations to care for patients with minor injuries or acute illnesses without doctor's supervision (Van Wyk, Heyns & Coetzee, 2015). Emergency nursing is a speciality, classified as unique, chaotic, predominant, unpredictable, and acute in nature (Campo et al., 2016; SANC, 2010). These nurses encounter continuous challenges such as, overcrowding, limited resources, violence, poor communication, bullying and shortage of nursing staff (Staempfli, Lamarche & Perry, 2021; Afaya et al., 2021). These factors are worsened by increased admissions, lack of resources and coexisting illnesses, leading to disruption of patient care continuity, reduced patient contact and reduced student nurses' opportunity for learning (Van de Ruit, Lahri & Wallis, 2020). Correspondingly, the reduction of patient contact and poor communication in emergency units poses a threat to the provision of effective quality care and patient satisfaction (Atakro, Ninnoni, Adatara, Gross & Agbavor, 2016).

1.2.3 Emergency nursing education in South Africa

In SA, trauma and emergency nursing programmes are offered as specialisations by both nursing colleges and universities (Ding, Metacalfe, Galagher & Hamdorf, 2016). Nevertheless, nursing students completing their undergraduate nursing programmes, are still allocated to accredited clinical facilities, including emergency units for work integrated learning purposes necessary for meeting the requirement for nursing qualification registered on National Qualification Framework (NQF) (SANC, 2014). While this is the case, there are no clear trauma and emergency core competencies, standards and guidelines for the undergraduate nursing programme.

Availability of competencies, standards and guidelines are important, because clinical education should be underpinned by theory, which is a cornerstone of nursing

education. According to Ekstedt, Lindblad and Lofmark (2019) the nature of clinical education creates a positive or negative clinical learning experience which may either promote or inhibit student learning. Clinical learning is dependent on a conducive clinical learning environment as well an effective clinical supervision (Baraz, Memarian & Vanaki, 2015). Maintaining a supportive relationship enables students to achieve their learning outcomes, enhances their learning towards becoming accountable, responsible, and independent professional nurses who are able to effectively discharge duties falling within their scope of practice (Wagoro & Rakuom, 2015).

The emergency unit is a complex and dynamic space associated with rich learning and teaching opportunities (Atakro et al., 2019). This is possible because emergency nursing involves a variety of acute conditions, different clinical procedures, a collaborative-based patient management and leadership styles, and the development of interpersonal and communication skills (Chaou, Yu, Ngerng, Monrouxe, Chang, & Chang, 2019). It serves as both a stimulus and hindering factor which create a positive or negative learning experience (Afaya et al., 2021). Breedt and Labuschagne (2019) argue that frequently, student nurse's perceptions of a demanding, hostile, fast-paced, clinical environment trigger negative feelings which have inhibitory effects for learning.

1.3 Problem statement

The SANC is a statutory, regulatory body initially established in terms of the Nursing Act No. 45 of 1944 and currently operating in terms of the Nursing Act No. 33 2005. SANC's obligations include, among other things, provision of qualification frameworks for the development of nursing programmes according to promulgated regulations (SANC, 2020). Each programme has a set of exit level learning outcomes. Nursing education institutions are tasked with develop nursing curricula based on these

programmes exit level outcomes (SANC, 2014). The specific learning outcomes, as designed and packaged by nursing education institution provides differentiation of offering, for a particular programme, across institutions. The Bachelor of Nursing qualification framework, however, does not specify expected learning outcomes for emergency nursing, yet nursing students are placed in the emergency units for experiential or work integrated learning purposes.

The researcher, a professional nurse who works in a trauma unit, observed that second, third and fourth-year undergraduate nursing students from a higher education institution are placed in the emergency units; however, the learning outcomes for this clinical placement remain unclear and there is little information from supervisor and students about what students are expected to learn during the placements. This has implications for student learning - such as synchrony of theory with clinical learning opportunities. It may also lead to poor clinical supervision, increased student absenteeism and conflict between the student's expectations and traditions of the emergency units.

1.4. Significance of the study

The information gained from this study might guide the School of Nursing on the theoretical preparation that students need before they are placed in emergency units. It might also provide guidance on student's clinical preparation and the supervision students require during work integrated learning in emergency units. The study might also develop an awareness amongst the staff in practice about the learning needs of students when placed in emergency units for work integrated learning.

1.5 Study purpose

The purpose of this study was to explore Bachelor of Nursing students' experience of their theoretical and clinical preparation for, and perceptions about their readiness for clinical placement in emergency units.

1.6 Study objectives

- To explore student nurses' experience of their theoretical and clinical preparation for placement in emergency units
- To explore student nurses' perceptions about their readiness for clinical placement in emergency units

1.7 Research questions

- What is the Bachelor of Nursing student nurse's experience of their preparation for clinical placement in emergency unit?
- What is the Bachelor of Nursing student nurse's perception about their readiness for clinical placement in emergency units?

1.8 Operational definitions

1.8.1 Clinical placement

It is the period spent by a student in a clinical environment, where theoretical knowledge, skills and attitude are applied and integrated in real situations (Tiwaken, Caranto & David, 2015).

In this study, clinical placement is the period spent by the student in the emergency unit for work integrated learning and the development of clinical competence.

1.8.2 Medical emergency

The sudden onset of a health medical condition which requires immediate medical treatment (Ibrahim et al., 2015).

In this study it refers to an acute medical condition which needs urgent medical management.

1.8.3 Readiness

It is the state of being fully prepared (Merriam-Webster, n.d). In this study, it refers to student nurse's theoretical and clinical preparedness to provide emergency care.

1.8.4 Student nurse

It is a nurse registered with the SANC as a learner nurse (SANC, 2014). In this study, it refers to a nursing student registered in R425 nursing programme at a university in the Western Cape.

1.8.5 Surgical emergency

An acute life-threatening disease in which immediate surgical intervention is the only therapy to save the patient's life (Ibrahim et al., 2015).

In this study, it refers to an acute surgical illness which necessitates emergency surgical management.

1.8.6 Trauma unit

A health care facility which is equipped to provide emergency care to a patient who has suffered from a traumatic injury through violence, car collisions, falls, gunshot and stab wounds (Botes & Langley, 2016).

In this study, it refers to clinical environment which provides emergency care to a patient diagnosed with traumatic injuries.

1.9 Research methodology

This section briefly describes the research methods used in the study. A detailed report on the methodology is provided in Chapter 3.

1.9.1 Research approach and design

A qualitative research approach with an exploratory, descriptive design was used to explore the Bachelor of Nursing students' experience of the theoretical and clinical preparation for, and perception about their readiness for clinical placement in emergency units.

1.9.2 Population and sample

The population of this study comprised third and fourth-year nursing students who are registered at university in the Western Cape for R425, and had a clinical placement in any of the emergency units such as medical, trauma, and surgical. A non-probability, purposive sampling was used, a total of 34 participants who met the inclusion criteria.

1.9.3 Data collection

A self-developed interview guide was used for data collection during the focus groups discussions and this is provided as (Appendix E). Objectives of the study guided the broad questions and probing questions were used where necessary to stimulate focus group discussions and gain deeper insight regarding the phenomenon that was researched. Data collection occurred during COVID-19 pandemic when there were no face-to-face classes. Focus group discussions were conducted at physiotherapy gym on campus, because it was quiet, well-ventilated, and spacious area which allowed the adherence to strict COVID-19 protocols of social distance. The focus group discussions were conducted in English, audio-recorded, lasted between 30 to 45 minutes, and transcribed verbatim.

1.9.4 Data analysis

Analysis of data commenced after each focus group discussions. Thematic analysis was done to identify, explore, and report emerging themes as described by six steps of Creswell's (2014). This qualitative research study adhered the principles of trustworthiness namely, credibility, transferability, dependability and confirmability (Grove, Gray & Burns, 2015).

1.9.5 Ethical considerations

The researcher adhered to the ethical principles advocated by the Declaration of Helsinki (Brink, Van der Walt & Van Rensburg, 2018). The study obtain approval from Humanities and Social Science Research Ethics Committee (HSSREC), on the

25/11/2020, ethics reference number HS20/9/36 included as (Appendix A). The researcher sought permission to conduct the study from the Registrar of the university. The researcher adhered to the ethical principles of basic human rights, dignity, freedom, autonomy and justice (Creswell, 2014). The researcher allowed participants to decide independently and voluntarily whether to participate in the research study. Participants were informed of their right to withdraw from the study anytime without prejudice. Participants were provided information about purpose of the study purpose, its benefits and the risks involved, as outlined in (Appendix B). No participants were coerced or forced to participate in the study. All the participants signed informed consent included in (Appendix C) and a focus group binding form included in (Appendix D) prior the focus group discussions.

The participants were assured that their personal information would be kept private and confidential. Participants identifiable information was anonymized by allocation pseudonyms during data collection. All the participants had equal right to participate in the study without discrimination. All the consent forms, focus group binding forms, transcripts and field notes were locked in a safe place.

1.10 Outline of the thesis

Chapter 1: Orientation to the study

This chapter introduced the foundation of the study with the significance of the problem. It proceeds to purpose, objectives, research questions, operational definitions.

Chapter 2: Literature review

This chapter provides a detailed review of literature on the following topics, emergency care, barriers of emergency care, clinical placement, clinical supervision and readiness for the emergency unit.

Chapter 3: Methodology

This chapter provides qualitative methods used in this study and steps taken during the research process**.** It further explains exploratory research, setting, population, sampling, data collection process, instrument, data analysis, trustworthiness and ethical considerations.

Chapter 4: Findings and discussion

This chapter presents data analysis of this study and themes that emerged the data line with literature.

Chapter 5: Summary, recommendations, and limitations

This is the final chapter and shows the key findings and recommendations and presents the limitations of the study. The research report ends with concluding remarks.

1.11 Summary

This chapter presented the introduction and background of this study. The researcher explained a problem statement, purpose, objectives, research questions, operational definition and significance of the study. Chapter two outlines a detailed literature review in relation to the researched phenomenon.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Literature review is a systematic analysis, evaluation, and synthesis of the research findings, theories, and practises on the research topic (Efron & Ravid, 2019). It provides existing knowledge, identifies methodology and gaps in relation to a research topic (Brink et al., 2018).

This literature review focuses on emergency care, some barriers in emergency nursing care, clinical placement, and clinical supervision in the emergency unit. The review intends to provide some context to emergency care, into which student nurses are placed, to highlight the background and problem statement of the study. The researcher employed Google scholar, Pudmed, Cinnall, e-sabinet and books. Search terms were *"emergency care and nursing student, "clinical placement experience and readiness nursing education or emergency nursing*".

2.2 Emergency care

Emergency care is seen as a fundamental human right (Ogunlade, Ayandiran, Oyediran, Oyelade & Olaogun, 2020). It is a tool used to address and prevent a substantial portion of death and disability worldwide **(**Tiwari, Naidoo, English & Chikte, 2021). The purpose of emergency care is to assist patients to recuperate from the acute sickness (Yarmohammadian, Rezaei, Haghshenas & Tavakoli, 2017). In SA, emergency care is delivered at two level of care namely, pre-hospital and hospital-based care (Tiwari et al., 2021). Failure to perform emergency care has been reported

to have adverse patient outcomes (Munroe, Curtis, Murphy, Strachan & Buckley, 2015).

The emergency unit is often referred to as, emergency department, accident and emergency and emergency room (Hellawell, Kyriacou & Sumal, 2021). The emergency unit set-up is different from hospital to hospital and patients are allocated to distinct areas according to their clinical presentation (Afaya et al., 2021). However, the most common areas in all the emergency units is a resuscitation room, major injuries room, minor injury room and triage (Munroe et al., 2015).

2.3 Barriers in emergency nursing care

2.3.1 Lack of scope of practice for specialist nurses

A scope of practice is a set of expected, legislative professional standards such as competence, code of ethics, conduct and practice needed to meet the public needs (Leslie et al., 2021). Scope of practice is defined as the range of roles, functions, responsibilities and activities which a registered nurse is educated and competent in, and has authority to perform (Cherry & Jacobs, 2015). In SA, the SANC is a statutory regulatory and quality assuring body that provides the scope of practice for nursing specialities (SANC, 2013). The scope of emergency nursing includes knowledge, clinical skills and the appropriate attitude to identify, manage, stabilize, prioritize provision of care for critically ill patients and perform resuscitation under a supervision of the doctor (Japiong et al., 2016; Van Wyk, Heyns, & Coetzee, 2015; SANC, 2010).

An emergency nurse specialist is a nurse that studied beyond general or undergraduate training. Emergency specialist nurses are expected to practice autonomously, perform advanced tasks and have extensive knowledge regarding the

emergency care (Japiong et al., 2016). Evidence suggests that, in African countries, the scope of practice for emergency nurse specialist remains undefined (Bosman, Levy-Malmberg & Fagerstrom, 2020; Wong, Gupta, Deckelbaum, Razek & Kusner, 2014).

Interestingly, the unclear scope of practice results in emergency nurse specialists and general professional nurses sharing the same roles, responsibility, accountability, and the inhibition of the emergency nurse specialist to apply the advance knowledge in the emergency units (Bosman et al., 2020). This increases the burden on the emergency nurse specialists who are relegated to working outside of their scope of practice because of task shifting (Atakro et al., 2016). In this study, the concept of "task shifting" implies that specific doctor's tasks are delegated to a lower level of specialisation or to a category of health worker with less training or qualification, such as nurses (Orkin, Rao & Venugupal, 2021). Often there is a shortage or junior doctors in the emergency unit which result in nurses taking on additional responsibilities without guidelines or standards (Ibrahim et al., 2015). The undefined scope of practice, task shifting and poor standardized protocol has negative adverse outcome on emergency practice (Husebo & Olsen, 2019).

Emergency specialist nurses and general professional nurses have additional more generic roles and functions, such as staff and student support and supervision (Bosman et al., 2020). In addition, the undefined scope of practise among the emergency nurses, causes frustration, compassion fatigue, job dissatisfaction, insufficient communication with the family and patients, which further amplifies the occupational hazard in emergency care (Dekeseredy, Landy & Sedney, 2019). It also

leads to the omission of fulfilling additional roles such as staff and student supervision. (Wong et al., 2014).

However, a recent study showed that internationally many nursing education programmes have incorporated emergency preparedness subjects and accreditation standards in their programmes (Macdonald, 2015). However, global, guidelines which regulate the level of emergency nursing education required to practice in the emergency unit remains inconsistence (Ndung'u, Ndirangu, Sarki & Isiaho, 2022).

2.3.2 Overcrowding in the emergency unit

Overcrowding in the emergency unit is defined as a situation in which provision of emergency care exceeds the resources for patient care (McKenna, Heslin, Viccellio, Mallon, Hernandez & Morley, 2019). Many studies revealed various factors contributing to overcrowding in emergency unit, such as the volume of patients (input), time, treatment, diagnosis, transfers (throughput), and number of patients leaving the emergency unit (output) (Sartini et al., 2022; Savioli et al., 2022; McKenna et al., 2019). The impact of overcrowding in emergency units leads to increased mortality, disability, prolonged length of stay, shortage of health care providers, readmissions, poor service delivery limited beds (Kim et al., 2021; Yarmohammadian et al., 2017; Burström, Letterstål, Engström, Berglund & Enlund, 2014).

Overcrowding in emergency unit is a global, concern, increasing health crisis and source of patient harm (Chan, Cheung, Graham & Rainer, 2015). In the United States of America (USA), admissions in emergency units increased by 17%, whereas, admissions in doctor's rooms and clinics decreased by 10% (Kim at el., 2021). Emergency unit admissions had increased by 60% since 1997 to about 146 million

and there were approximately 46 visits per 100 persons in 2016 at the doctor's office (Kelen et al., 2021).

A clinical environment with a high number of student placements and overcrowded emergency units is not conducive to clinical learning, because it limits the opportunities for students to practice clinical skills and which may result in limited achievement of learning outcomes (Motsaanaka, Makhene & Ally, 2020). Overcrowding in emergency units pose challenges to clinical learning, because patient care is prioritised above student nurses learning needs (Safazadeh, Irajpour, Alimohammadi & Haghani 2018). It also contributes to poor relationships between the student and clinical supervisor, because this interaction requires a calm environment for learning to occur (Sabzghabaei, Shojaee, Alimohammadi, Derakhshanfar, Kashani & Nassiriabrishamchi, 2015).

Student placement is for learning and role taking, which requires support from the already over-burdened emergency nursing staff, which is challenging. According to Sabzghabaei et al., (2015) high workload hinders interaction between the student and clinical supervisor or emergency nursing staff. Overcrowding in the emergency unit must be addressed because mortality rates remain higher among patients admitted to emergency units than in other units in a healthcare facility (Ogunlade at el., 2020).

While there are challenges of overcrowding in the emergency units, there are opportunities for nursing students to learn in this fast-paced environment. Exposure to the collaborative team approach and experiential learning assists nursing students to gain skills, such as resuscitation, which is often required in emergency care (Jianga,

Zengc, Kued, Lia, Shic & Chenc, 2018). Nursing students are also exposed to inter-professional education, which happens when students from different professions learn from each other to promote collaboration and improve patient outcomes (Giske, Kvangarsnes, Landstad, Hole & Dah, 2022).

2.3.3 Family- centred care in emergency unit

A family-centred approach is a system of planning, provision and evaluation of healthcare, focusing on a partnership between the patient, family, and designated healthcare worker (Almaze & De Beer, 2017). It honours, values and supports the psychological and cultural needs of the patient and family (Ghane & Esmaeili, 2019). It is necessary when the patient is aged, young, intubated and ventilated, to give information and assist with patient decision-making (Clay & Parsh, 2016).

Family-centred care in the emergency unit is equivalent to a holistic nursing approach, which means creating a therapeutic relationship between the family, patient and the nurse, in response to the patient's emotional, mental, physical and psychosocial needs (Herrin, Harris, Kenward, Hines, Joshi & Frosh, 2016). However, the admission of a loved one in an emergency unit is often traumatic, because the family members are not prepared psychologically for this sudden event (Hsaio, Redley & Hsaio, 2017). Moreover, the exposure to a patient's condition worsening, uncertainty about the patient's outcome, pain, discomfort and the patient being connected to high technological machinery triggers emotional reactions such as, shock, anger, worry, guilty, stress, and frustration (Dawood et al., 2018; Adams, Anderson, Docherty, Tulsky, Steinhauser & Bailey, 2014).

Despite these situations, healthcare workers are still required to be empathic, respectful, provide updates and timely support, create a favourable environment for the family of a patient admitted to the emergency unit, and to be considerate of their feelings and needs and implement strategies to alleviate anxiety (Bote & Langley, 2016). Developing nursing students' empathy results in positive interpersonal relationships with the patient and family (Gonzalez-Garcia, Lana, Zurron-Madera, Valcarcel-Alvarez & Fernandez-Feito, 2020).

Participation of nursing students in family-centred care in the emergency units improve emergency care (Wahyuningsih, Emaliyamuti & Widianti, 2020). However, it is difficult for nursing students to adhere to family-centred care in the emergency units because they lack emergency care experience and readiness (Macdonald, 2015).

Family centred care in emergency units is still challenging, because of the following factors: prioritisation of emergency care, emergency care deficit, staff shortages, and exposure to threats of violence and junior and sessional doctors working in the emergency unit (Adams et al., 2014). It is therefore, important that nursing students are ready for a clinical placement in emergency units, because high level of readiness results in maximum achievement of clinical learning, despite the aforementioned challenges (Waynhusing et al., 2020).

2.4 Clinical placement of nursing students in emergency units

Clinical placement is a work integrated learning opportunity provided outside the classroom, whereby theory is applied using clinical skills in real life situations (Simpsona & Sawatzkyb, 2020; Tiwaken et al., 2015). Clinical placement helps the student to gain clinical experience, and confidence to integrate theory to practice in

the real world (Mahasneh, Shoqirat, Alsaraireh, Singh & Thorpe, 2021; Zulu, du Plesis & Koen, 2021). In addition, it is essential to acquire competence, confidence and communication skills and develop professionally (Lee & Thoirs, 2016; Vatansever & Akansel, 2016). According to Mahasneh at el. (2021) there are four attributes which affect a student's learning experience namely, the physical space, psychosocial and interaction factors, organizational culture and teaching and learning components. This is affirmed by the Kolb's experiential learning theory, which suggests that a student should be active, use reflective-critical thinking and develop knowledge, skills, and values from direct experience outside the classroom (Morris, 2020). Nursing knowledge and skills are acquired from the theoretical aspect (knowing how) and further developed during clinical practice (showing how) (Ingavarsson, Verho & Rosengren, 2019).

In SA, the nursing education institutions place student nurses at the emergency units to obtain clinical learning experience (SANC, 2013). As mentioned earlier, placement in the emergency unit provides a student nurse with learning opportunities, different patients, a variety of acute presentations, multitasking skills, develops multidisciplinary teamwork approach to patient care, promotes communication skills and basic knowledge of technological procedures (Chaou et al., 2019).

Nursing students also experience challenges in this environment such as, frequent exposure to traumatic events, sudden death, failed resuscitation, and verbal abuse from the patient or patient's family (Hellawell et al., 2021). These challenges require the students to be ready, resilient and prepared to cope with these circumstances.

The literature so far sketches a picture of the challenges experienced in emergency units. Safazadeh at el. (2018) argues that clinical placement in emergency units

contributes to poor transformation of theory to practice, because of its complexity, shortage of staff, increased workload, type of equipment and focus on patient care over education. Similarly, a study done in Iran revealed, that student nurses did not achieve the appropriate competencies during a clinical placement in emergency care, because of inadequate clinical teachers and poor integration of theory into practice (De, Podder & Mahadalkar, 2016).

It is the responsibility of education and clinical institutions to understand these challenges and work collectively at improving the learning environments for students. Therefore, a positive learning experience in emergency units is dependent on collaboration between clinical supervisors, nursing staff and a conducive environment (Piquette, Moulton & LeBlanc, 2015). However, as already mentioned, clinical learning in an emergency unit is difficult because of the nature of emergency unit: it is a busy, manic, fast-paced, unpredictable environment with insufficient resources, overcrowded and insufficient trained emergency nurses (Chaou et al., 2019). As a result, student nurses are often seen as part of workforce in emergency units (Safazadeh at el., 2018). Scholars Jamshidi, Molazem, Sharif, Torabizadeh & Najafi Kalyani (2016) caution that using student nurses as an extra pair of hands results in inadequate exposure to learning experiences, thus leading to frustration amongst student nurses.

2.5 Clinical supervision of nursing students in emergency units

Clinical supervision is a process of introducing a student nurse to the art of nursing, alongside with the clinical supervisor and professional nurses at the clinical setting (Ahmady & Minouei, 2021). Clinical supervision is mainly focused on the development of the student, thus, providing support, transforming classroom knowledge to practice,

creating a conducive environment, encouraging reflective practice, developing confidence and competence and ultimately enhancing a safe, quality, independent and ethical practice (Donough & Van der Heever, 2018).

Clinical supervisors are therefore expected to adapt their level of supervision to the nature of a clinical environment and student (Lima et al., 2016). Effective clinical supervision is reliant on an interactive approach, which rests on active and mutual participation of the supervisor and supervisee (Piquette et al., 2015). This is congruent with a student-centred learning approach, which respects student's choices, autonomy, active participation, and encourages collaborative learning (Hoidn, 2017). Adherence to this approach has potential for contributing to patient care and yielding a positive learning experience in acute care facilities (Zulu et al., 2021).

Clinical placement is challenging in emergency units, because often students who are placed in speciality areas are not prepared, have insufficient knowledge and skills and are therefore perceived as a burden (Jianga et al., 2018; Macdonald, 2015). These conditions lead to deprivation of learning opportunity and poor integration of specialized knowledge (Baraz et al., 2015). Evidence revealed that clinical supervision in the emergency unit is hard because some clinical supervisors are inexperienced, have insufficient knowledge, showed incompetence of working with some equipment in emergency units and there is inadequate evaluation in these unit that (Atakro at el., 2019; Safazadeh at el., 2018). Scholars Alshahrani, Cusack, & Rasmussen (2018) argued that a clinical placement with many learning opportunities, with limited clinical supervision will not improve the undergraduate student's clinical competence and may lead to a poor relationship between a student and clinical supervisor (Donough & Van der Heever, 2018). Furthermore, inadequate supportive relationships have been found to have negative effects on the clinical learning experience (Bjork, Berntsen,

Brynildsen & Hestetun, 2014). This leads to nursing students expressing feelings of vulnerability, anxiety, worry, loss of confidence, motivation, isolation, and unpreparedness during clinical learning (Atakro et al., 2019; Farzi, Shahriari & Farzi, 2018). However, student nurses regard clinical supervision as a supportive system which alleviates fear and anxiety that nursing students encounter in the clinical facilities (Tomlinson, 2015).

To achieve the best clinical learning experience within the emergency unit requires prerequisite knowledge, clear learning outcomes, some clinical skills, good planning, guidance and support (Lourens et al., 2020). However, often a curricular gap leads to unfavourable learning experiences, incomplete, inconsistent nursing care, and inadequate preparation of student nurses in the emergency unit.

2.6 Readiness of nursing students for a clinical placement in emergency units

The nursing profession plays a significant role in all aspects of emergency care, including prevention, alleviation, preparedness, intervention and recovery (Brinjee, Thobaity, Almalki & Alahmari, 2021). Literature shows that there is insufficient emergency-based knowledge among the nurses (Straube et al., 2020; Dulandas & Brysiewicz, 2018; Alzahrani & Kyratsis, 2017; Atakro at el., 2016). A recent study, however, revealed that many nursing education programmes in the world, incorporated emergency preparedness subjects and accreditation standards in their programmes (Macdonald, 2015).

Readiness to practice is having the required prerequisite knowledge, skills, awareness of the equipment to provide holistic patient care (Haruzivishe & Macherera, 2021). It is therefore essential for the nursing school to develop emergency-based education which prepares nursing students with specific knowledge and skills to be ready for the

management of emergency situations. Emergency-based preparation of nursing students to handle emergency situations competently is difficult, because students might have a knowledge deficit, and fail to integrate knowledge in the unexpected and unfamiliar environment (Borg Sapiona, Sammut & Trapani, 2018). On the other hand, nursing students with high level of readiness result in increased learning achievement (Wahyuningsih et al., 2020). Thus, evidence suggests various pedagogical methods to improve nurse's preparedness, namely, seminars, workshops, conferences and courses (Brinjee at el., 2021). In addition, prolonged periods of clinical placement and intense clinical learning experience might contribute to a better practice readiness of nurses (Sharma, Arora & Belsiyal, 2020). Lastly, readiness for a clinical placement in emergency units requires motivation, confidence, enthusiasm, interactive learning, and a hands-on student, in order to produce a positive learning experience in the emergency unit.

2.7 Summary

This chapter identified literature relevant to the research phenomena. It used national and international literature. This included an exploration of six core elements namely; emergency care, barriers of emergency care, clinical experience, clinical supervision and readiness for a clinical placement in emergency units. The literature revealed that nursing students have insufficient knowledge and skills for a clinical placement in emergency units and this environment serves as a stimulus and inhibitory for clinical learning. The following chapter presents methodology used in this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

A qualitative study was conducted using an exploratory-descriptive design, in which focus group discussions were done to explore the Bachelor of Nursing students' experience of the theoretical and clinical preparation for, and perception about their readiness for clinical placement in emergency units.

This chapter presents the research methods used in this study. According to Aspers and Corte (2019) a research methodology is the blueprint followed to identify, select, process, and analyse information about a research topic. It also provides a guideline to formulate the research problem, objectives, and report results from the data collected and informs the reader on how the investigation was done to solve the problem (Swedberg, 2017).

This section proceeds to explain the research setting, population, sampling, and data collection. It also provides a detailed data analysis process, methods used to gain trustworthiness and ethical consideration taken for this study.

3.2 Qualitative research approach

Qualitative research is a holistic, interpretive, words oriented and naturalistic approach used in social sciences to explore interaction, systems, processes and produce an in-depth understanding and meaning of a phenomenon (Brink at el., 2018; Lichterman & Reed, 2014). It is a process of collecting and analysing non-numerical data, for example, text, videos, photographs, and audio to understand concepts, opinions, perceptions, and experiences (Brink at el., 2018; Swedberg, 2017). It is classified into

five types, including ground theory, phenomenology, ethnography, narrative, and action research (Busetto, Wick & Gumbinger, 2020). Data collection methods used in qualitative research include observations, interviews and focus groups (Swedberg, 2017).

3.3 Interpretive paradigm

This research study is underpinned by the interpretive paradigm, emphasizing the understanding of the subject world (Kivunja & Kuyini, 2017). The purpose of this paradigm is to know and interpret the participant's thinking or making meaning of a context (Khaldi, 2017). Interpretive researchers believe that reality is socially constructed, thus the questions become broad and general to stimulate interaction and construct meaning among the participants (Alharahsheh & Pius, 2020).

3.4 Study design

The present study used an exploratory-descriptive research design, using focus group discussions, because little is known about the Bachelor of Nursing students' experience of the theoretical and clinical preparation for clinical placement in emergency units as well, their perceptions about their readiness for this clinical placement. No similar study has been undertaken in the Western Cape, South Africa.

3.4.1 Exploratory research design

An exploratory research design is undertaken when little is known about a research problem, and to gain an in-depth understanding on the subject matter (Reiter, 2017). It provides insight to the research problem, might use a small sample size, is flexible, and unstructured, and is capable of addressing research questions of all kinds such as (what, when, why, how and who) (Hallingberg et al.,2018). However, it cannot be

generalized into large population and is unable to make definitive conclusion (Creswell, 2014).

In exploratory research data collection is categorised into primary and secondary methods (Neuman, 2014). In primary methods, data is collected directly from the primary source using methods, such as focus groups and interviews (Mbaka & Isiramen, 2021). In secondary methods, data is collected from pre-existing research, such as case studies and literature reviews (Mbaka & Isiramen, 2021).

In this study, exploratory research design was used to gain a deeper understanding of the experiences of the Bachelor of Nursing students' theoretical and clinical preparation for, and perceptions about their readiness for clinical placement in emergency units, thus enabling the generation of new ideas and knowledge.

3.4.2 Descriptive research design

A descriptive research design is a research method that observes, describes and documents the characteristics of the population, and describes events within a population as it naturally occurs (Siedlecki, 2020). Descriptive research design collects information without manipulating any variables, so it focuses on the 'what' of the research subject without covering 'why' it happens (Aggarwal & Ranganaathan, 2019).

A descriptive research design is used in health care studies and nursing related research to provide insight and rich information, and describes behaviour and perceptions (Doyle, McCabe, Keogh, Brady & McCann, 2020). It is also used when little is known about the research problem (Kalu & Bwalya, 2017). Thus, it is important

that the research question is clearly formulated to ensure trustworthiness of the findings (Kim at el., 2017).

Descriptive research designs enable both quantitative - using surveys - and qualitative data collection and provides significant amount of data for future research (Kim, Sefcik & Bradway, 2017). Qualitative descriptive designs make use of case studies, observations, focus groups and interviews for the purpose of data collection (Turale, 2020). Content and thematic analysis can be performed to make meaning of qualitative data (Doyle et al., 2020).

In this study, and exploratory, descriptive research design was used to explore and describe the experience of Bachelor of Nursing students theoretical and clinical preparation for, and perceptions about their readiness for a clinical placement in emergency units.

3.5 Research setting

According to Brink at el. (2018) a research setting is a habitat used to conduct the study and make meaning of participants in their physical, social, and cultural context. This study was conducted at a school of nursing, at a university in the Western Cape. This school of nursing is one of the largest nursing schools in South Africa and offers undergraduate, postgraduate diploma, masters and doctoral programmes. The school is part of the Faculty of Community and Health Sciences and is accredited by the South African Nursing Council. Currently, the school offers two undergraduate Bachelor of Nursing programmes which are regulated and accredited by SANC, namely, Bachelor of Nursing and Midwifery according to the Regulation relating to the approval of and the minimum requirements for education and training of a nurse (General, Psychiatric, community and midwife) leading to registration (R425) and

Bachelor of Nursing according to the Regulation relating to the approval of and the requirements for registration in the categories professional nurse and midwife (R174). The R174 is a new programme which commenced in January 2020. The R425 programme is currently being phased out. At the time of data collection, the R425 and R174 programmes had 689 and 289 registered students, respectively. This study included students from the R425 Bachelor of Nursing Programme.

3.6 Population

The population in this study consisted of third and fourth-year nursing students who were registered for the R425 programme at the university during 2018. The population size was N=447, made up of 249 third year and 198 fourth-year nursing students. This group was a combination of students from the extended curriculum and mainstream programmes. According to Creswell (2014) the population is a set of elements which possess similar characteristics as defined by the researcher's sampling criteria.

3.7 Sampling

This study used non-probability, purposive sampling method, where participant selection is based on their knowledge, proficiency, and experience on the research topic (Polit & Beck, 2017). Third and fourth-year nursing students were appropriate participants for this study because they are senior nursing students with the most exposure to clinical learning facilities including the emergency units, and are able to better respond to the research question.

3.7.1 Sampling criteria and sample size

Sampling criteria is the specific characteristics needed to describe the desired targeted population (Neuman, 2014).

In this study, the inclusion criteria were as follows:

- All third and fourth-year nursing students who were registered for the R425 programme and who had a clinical placement in any emergency unit such as medical, surgical, and trauma and were willing to participate.

The exclusion criteria were as follows:

- All third and fourth-year nursing students who, for whatever reason, did not have a placement in emergency units.
- All second-year students with advance registration in any third-year module were excluded.
- All students who were registered in the R174 programme were excluded because the 3rd year of the programme was only phased in at the beginning of 2022 and very few students would have been placed in the emergency units by the time of data collection.

A total of 34 students participated in this study because they met the inclusion criteria. The sample included 18 fourth-year students and 16 third-year nursing students. The researcher sampled until data saturation.

3.8 Data collection

Data gathering is a process of collecting information from the relevant sources to find solutions to research problem, test hypothesis and evaluate the outcomes (Creswell (2014).

3.8.1 Data collection method

Data was collected by focus group discussions, which is an interaction between a group of individuals to discuss a specific topic, with the purpose of drawing together participants' experiences about a phenomenon (Nyumba, Wilson, Derrick & Mukherjee, 2018). Focus group discussions are also important because of social interaction between participants often produce deeper and richer data, unlike one-on-one interviews (Gungumogula, 2020).

3.8.2 Data collection instrument

The researcher developed an interview guide to explore nursing students' preparation for, and perceptions about their readiness for clinical placement in emergency units The self-developed interview guide had six open-ended questions based on the study objectives (Appendix E), which allowed the participants to respond openly, based on their knowledge and understanding of the phenomenon being studied (Worley, 2016). The six key questions were followed by probing questions. The following questions were asked for each of the three types of emergency units: ''What is your experience of the theoretical and clinical preparation for placement in the medical/ surgical / and trauma unit?'', ''What are your perceptions about your theoretical and clinical readiness for placement in the medical emergency/ surgical/ trauma?''

3.8.3 Preparation for the focus group discussion

Preparation for data collection commenced after ethics approval for the study was obtained. The researcher obtained permission from the Registrar of the University and the Head of the School of Nursing, to conduct the study, and to gain access to the

students and the campus. Riese (2019) states that gaining and maintaining access and rapport for qualitative research is important for conducting the research project. Prior (2018) urged that rapport is the level of confirmability between the researcher and participants during interaction. Data collection took place in October 2021 until April 2022 when the university had not yet returned 100% to face to face classes, due to the COVID-19 pandemic. After receiving permission to conduct the study, the researcher emailed the clinical coordinators of the third and fourth-years to inquire about the student's availability and permission to meet them at a time suitable in terms of their programme. Participants were recruited at the skills laboratory on campus before and after simulation sessions. However, this was not an easy task because students were not available at the same time, and only came to campus in small groups. The researcher therefore went to campus several times to recruit the students to participate in the study, and made plans to meet them for data collection at a time convenient for them. The physiotherapy gym at the campus was booked for conducting the focus group discussions, because it is a quiet, well-ventilated, and spacious venue which allowed for adherence to strict covid19 protocols of minimizing student contact.

3.8.4 Test focus group discussion

According to Creswell (2014) the purpose of a pilot study is to verify the effectiveness of the instrument using the smaller scale. In this study, test focus group was done to test whether the questions elicited responses that answered the study objectives, to evaluate whether the researcher was able to ask in-depth questions and manage the focus group discussion. After the test interview, the researcher sent the audio recording to her supervisor who provided feedback. The supervisor noted the

following: during the focus group discussion, the participants are talking at the same time; the researcher sometimes asked closed-ended questions and was sometimes leading the participant's responses. The supervisor recommended the researcher to always focus on study objectives, to be reflective in the process, to use the interview guide and to ensure that participants speak one at a time. The supervisor listened to the second interview and gave feedback that the interviewing had improved. The researcher was given permission to continue with data collection.

3.8.5 Data collection process

On the day of data collection, the researcher ensured that she had a pen, notebook, working audio recorder, interview guide, file with consent forms and focus group binding forms, pseudonyms. The researcher placed a notice on the door written "do not disturb focus group in progress". There were no disruptions because of limited number of students on campus. The door was opened in line with the COVID19 protocol of ensuring ventilation at gatherings. The researcher ensured that ther e was sanitiser at the entrance and asked participants to sanitize their hands before entering and exiting the venue. Participants were also asked to wear their masks during the focus group discussion and to keep two metre space between each other.

The researcher greeted and introduced herself to the participants again, and gave them time to settle. The researcher presented the study information which included the background to the study, the aim and objectives, right to participate voluntarily and the right to withdraw from the study at any time. The researcher also explained the expectations from and during the focus group discussion, such as the need to respect each other's opinion, that all participant's views will be appreciated and that one participant should speak at a time to ensure a good recording.

The researcher reassured the participants of confidentiality and allowed them to ask questions and gave them time to make an informed decision on whether to consent to participating or not. The researcher also asked participants' permission to use an audio-recorder. The researcher handed out consent forms, focus group binding forms, to the participants and gave them time to complete them. Participants were addressed using unique numbers assigned to each one on a name tag and were asked to address each other using these pseudonyms during the focus discussion.

The focus groups were conducted by the researcher in English, as this was the medium of education at the institution. The duration of the focus group discussion was between 30 and 45 minutes. The researcher tested the recorder before commencing each focus group discussion. The focus groups were audio-recorded and the researcher also made field notes, capturing the participants' non-verbal ques. However, it was challenging because the participants were wearing masks during the discussion. The researcher used questioning, clarification, and paraphrasing to verify participant's contributions and maintained eye contact, to facilitate deep discussion. The focus group discussions conducted were face-to- face, however, one was online, because of students' availability. Data saturation was reached after 5 focus group discussions, when the researcher stopped finding new ideas, opinions and additional data. Data saturation is term used to indicate when no new data is obtained from the data collection process (Guest, Namey & Chen, 2020).

3.8.6 Field notes

Field notes is the descriptive and reflective record completed by the researcher in the field of study, to remember the behaviour, activities, and events, and gain understanding about the researched phenomenon (Schwandt, 2015). Commonly, field

notes are associated with records, journals, images, videos which are linked with the interview or focus group discussion and used during data analysis (Neuman, 2014). In this study, the researcher wrote the field notes during and after the focus group discussion to ensure the accuracy of the focus group discussion and to build an audit trail.

3.9 Data analysis

Data analysis refers to the categorising, ordering, manipulating, and summarising data into meaningful terms (Polit & Beck, 2017). This study used thematic analysis. Thematic analysis is a technique used to identify, analyse, organize, describe, and report themes found within a set of data (Nowell, Morris, White & Moules, 2017). It is used in qualitative analysis to understand people's views, perceptions, and experiences. It is flexible during data interpretation and allows the researcher to arrange large information into themes (Maguire & Delahunt, 2017).

Thematic analysis was employed based on Creswell's six steps. ***Step1: Familiarizing oneself with data***- The researcher repeatedly listened to the audio-recording, read and re-read the transcripts. The researcher highlighted the significant information related to the study objectives. ***Step 2: Generating initial codes-*** The researcher read and re-read the transcript to gain the deeper meaning, the identified significant texts were broken into smaller units which are referred to as codes. The researcher identified the following initial codes: supervision, emergency education, confidence, motivation, learning by doing, communication, expectations, traumatic events, preparation, busyness, lack of specific learning outcomes, routine work, loneliness, feeling lost, rejection, patient care, multi-disciplinary team, guidance, attitude, skills pre-term clinical placement, learning opportunities theory and practical gap. **Step 3:**

Searching for themes- the researcher grouped together all the codes that are related to each other and examined for patterns. The researcher allocated a meaning to each unit as they were related to a theme, which is a concept used to define and organize relevant repetitive ideas which enable the researcher to answer the researched question (Vaismoradi, Jones, Turunen & Snelgrove, 2016). The researcher identified the following while searching for themes; Patient care can affect student learning in the emergency unit, emergency knowledge affects student preparation, rejection of student during resuscitation minimizes learning opportunity, educational planning has negative implication on student learning, reality of the emergency unit affects student teaching and learning, positive experience of the emergency unit enhanced student preparation and negative experience of the emergency decreased students learning. The researcher read and re-read the transcripts and field notes. ***Step 4: Reviewing themes-*** the researcher provided a description of each unit***.*** The researcher sent all the transcripts and audio-recording to the researcher's supervisor for confirmation of the themes. **Step 5: *Defining and naming themes-*** the researcher wrote a detailed analysis explaining each theme, clarified by supporting quotes from the data comparing the similarities and differences with the existing literature. The researcher identified four themes and twelve categorises. ***Step 6: Produce the report-*** the researcher provided a coherent, concise, and clear report in chapter four***.***

3.10 Trustworthiness

Trustworthiness is used to establish reliability and validity of qualitative research (Earnest, 2020). It refers to methodological soundness and adequacy of the data collected (Korstjens & Moser, 2018). It is the degree of confidence in data, interpretation and the techniques followed to certify the quality of the study (Cypress,

2017). Trustworthiness relates to principles of credibility, dependability, transferability, and confirmability, as described by Lincoln and Guba (1985).

3.10.1 Credibility

Credibility is defined as confidence that the findings of the study are truthful (Cypress, 2017). The researcher made use of an audio recorder and kept field notes to ensure the accuracy of the data collected. Focus group discussions were conducted until data saturation. The researcher applied the following principles to ensure credibility:

3.10.1.1 Member checking

Member checking is also known as respondent validation, which is a method used to explore the credibility of the results (Birt, Scott, Cavers, Campbell & Walter, 2016). Data is returned to the participant to confirm accuracy and resonance with their experiences **(**Korstjens & Moser, 2018). Member checking was ensured by making the audio-recordings and transcripts available for participants to verify the collected data to ensure accuracy and authenticity. The researcher used reflections and paraphrasing throughout the focus group discussions to verify information provided by the participants. Participants were given the opportunity to refine the information to ensure the representation of their meaning and understanding of the phenomenon.

3.10.1.2 Prolonged engagement

Prolonged engagement refers to spending sufficient time with participants in their context to gain a better understanding of behaviour, values, and trust in the social context (Korstjens & Moser, 2018).

Participants were recruited prior the focus group discussions to build trust. Each participant was given enough time to express their feelings and opinions during the focus group discussions. The researcher listened attentively to each participant to show respect and value of the data provided. The researcher made the participants comfortable to disclose information regarding their perceptions, ideas, and views.

3.10.1.3 Peer debriefing

Peer debriefing includes having sessions with peers who are competent in qualitative research procedures, to review, analyse and explore numerous aspects of the inquiry (Earnest, 2020). The researcher consulted with the research supervisor throughout the research process for feedback to ensure quality of this study. To achieve truthfulness, the researcher discussed the participant's responses, audio-recordings, and transcripts with the supervisor to ensure relevance to the researched question.

3.10.2 Transferability

Transferability is the ability to apply the study in another context, situations, populations and at a different time (Korstjens & Moser, 2018). In qualitative research, transferability is also known as generalizability (Forero at el., 2018). To ensure transferability the researcher used a thick description or detailed description of the participants, setting, and research process, to enable the reader to assess whether the findings are transferable to another context (Stahl & King, 2020). The researcher explained the data collection process and the participants confirm prior the final data analysis process.

3.10.3 Confirmability

Confirmability is the degree to which findings of the study could be confirmed by other researchers (Korstjens & Moser, 2018). This criterion concerns neutrality of the researcher's interpretation of findings - which is unbiased (Nyirenda et al., 2020). The researcher provided a summary of steps taken from the beginning of the study until development of the findings. The researcher kept an audit trail by comparing the transcripts, field notes and audio-recordings. The researcher's findings were discussed with the supervisor to minimise bias and assumptions. The researcher used a reflective journal in which she recorded after each meeting and focus group discussion, to reflect on relevant information, participants behaviour, perceptions and personal experience during the research process.

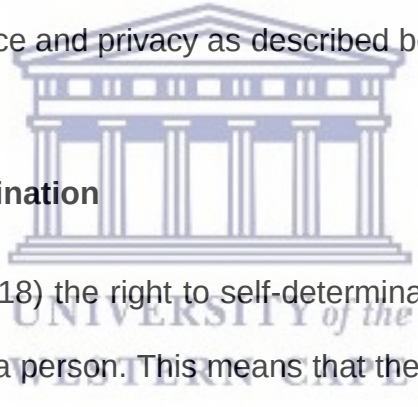
3.10.4 Dependability

Dependability is the consistency and stability of data gathered (Cypress, 2017). It is the extent to which the research could be repeatable in similar contexts (Stenfors, Kajamaa & Bennett, 2020). It is equivalent to reliability in quantitative research (Connelly, 2016). The researcher used the following methods to ensure dependability of this study; (a) the researcher provided a full description of the methodology used to conduct the study; (b) all the audio-recording, transcripts, field notes, interpretations and recommendations were kept; (c) a clear and accurate report was kept for auditing; (d) data was organised in categories and themes; (e) data was coded and discussed with the supervisor to eliminate bias; (f) data was made available and accessible to the supervisor for an audit trail.

3.11 Ethical considerations

Ethics is a set of moral principles that are followed when conducting research (Creswell, 2014). The Declaration of Helsinki established ethical principles to be applied in clinical research involving human participants, stipulating that the researcher is responsible for protecting the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of the personal information of the research participants (Yip, Han & Sng, 2016).

In this study permission was obtained from Humanities and Social Science Research Ethics Committee (HSSREC), on 25/11/2020, ethics reference number: HS20/9/36. The researcher sought permission from the Registrar of the university. The researcher adhered to the following principles, namely, right to self-determination, informed consent, confidentiality, justice and privacy as described below.



3.11.1 Right to self-determination

According to Brink at el. (2018) the right to self-determination is the ethical principle that is based on respect for a person. This means that the subjects are autonomous, are given information about the study, time to comprehend and make an informed decision on whether to participate or not and of their free will, without prejudicial treatment or penalty (Arifin, 2018). The researcher respected the participants time and views during the focus group discussions and no participant was forced to participate in the study.

3.11.2 Informed consent

Informed consent is a voluntary choice made whether to participate based on sufficient information provided (Appendix B), and an understanding of the implications for

participation in the research study (Xu, Baysari, Stocker, Leow, Day & Carland, 2020). Participants were informed of the purpose of the study, its procedures, risks, and benefits. They were given time to consider the information, ask questions, and then made an informed decision on whether or not to participate. Freedom to withdraw at any time, without penalty, was explained to the participants. A consent form (Appendix C) was provided and signed by all participants who took part in the study. Participants were not offered incentives or coerced to participate in this study. Participants were informed of the use of an audio recorder, and there were no objections.

3.11.3 Confidentiality

Confidentiality relates to the researcher's management or handling of private information shared by the participants, which must not share with others without the consent of the participants (Bailey, 2014). Participants were required to sign a confidentiality binding form with the understanding that information shared within the focus group will not be shared outside the group (Appendix D). The researcher ensured that participants identifiable information is kept safe and private in a place that was only accessible to the researcher and supervisor. No information that could link the participant's identity to the data was included in the research report.

Focus group discussions were identified by use of codes. All data transcripts and audio recording were stored and locked in a secure cupboard. The audio-recordings were stored in the private computer and password protected. All data will be kept for five years before being safely discarded by shredding of hard copied and deletion of all electronic files.

3.11.4 Anonymity

Anonymity is achieved when identifiable information is removed and not revealed during the data collection and analysis (Arifin, 2018). The participant's identifiable information was removed and anonymized using pseudonyms, hence the participants remained anonymous in the presentation of findings. However, because of the use of focus group discussion participants were aware of who took part in the discussion.

3.11.5 Privacy

It is the ethical principle in which the researcher must respect the participant's right to privacy (Fleming & Zegwaard, 2018). The researcher kept all personal matters private by maintaining confidentiality and anonymity.

3.11.6 Justice

The right to justice principle refers to fair selection and treatment of the participants (Bailey, 2014). All the participants had a fair chance of participation irrespective of gender and race. All the participants were treated equally with no prejudice.

3.12 Summary

This chapter presented a comprehensive description of the research methods used to address the purpose and objectives of the study. The study was aligned to an exploratory-descriptive research design with an interpretive paradigm. The following chapter presents the research findings which emerged from the data collected.

CHAPTER 4

FINDINGS AND DISCUSSION

4.1 Introduction

This section presents the findings of the qualitative exploratory data from the focus group discussions conducted on the third-and fourth-year Bachelor of Nursing students, with the intent to explore their experience of the theoretical and clinical preparation for, and perception about their readiness for clinical placement in emergency units. The participants were recruited through purposive sampling. The data collection started in October 2021 until April 2022. Written consent was obtained from all the participants. A total of five focus group discussions were conducted until data saturation. This chapter simultaneously discusses the findings, using the existing body of literature as control and to identify new insights this study brings to the existing body of knowledge on the topic.

4.2 Demographic information

A total of 34 students participated. The 18 fourth-year nursing students comprised 16 females and 2 males. The 16 third-year nursing student comprised 9 females and 7 males. Out of the 34 participants,19 students had a clinical placement in emergency units in community healthcare centres and 15 of them had a clinical placement in emergency units in a hospital setting.

4.3 Presentation and discussion of themes and categories

Four themes and twelve categories emerged from a thematic analysis of the data, namely: insufficient emergency-based education; challenges with educational planning; lack of readiness for clinical placement in emergency units; and experience of learning and challenges encountered in emergency units. These are tabulated and discussed below.

Table 4.1: Themes and categories from the focus group discussions

Themes	Categories
1. Insufficient emergency-based education	1.1 Insufficient exposure to clinical skills in the skills laboratory
	1.2 Lack of correlation between what is taught and how it is taught in skills laboratory versus practice
	1.3 Insufficient theoretical input in preparation for practice in emergency units
2. Challenges with educational planning	2.1 Theory and work integrated learning are not synchronized
	2.2 Lack of communication between education and practice regarding the learning outcomes for work integrated learning
3. Lack of readiness for clinical placement in emergency units	3.1 Lack of knowledge and skills
	3.2 Emotionally unprepared
4. Positive and negative learning experiences in emergency units	4.1 Learning by doing
	4.2 Feeling anxious and afraid
	4.3 Lack of clinical supervision
	4.4 Rejection of students during resuscitation
	4.5 Service delivery over education

4.3.1 Theme 1: Insufficient emergency-based education

Theme one relates to students' experiences of their educational preparation, which is both theoretical and clinical, for work integrated learning in emergency units.

4.3.1.1 Category 1.1: Insufficient exposure to clinical skills in the simulation laboratory

In this category, students reported being exposed only to checking the emergency trolley, which is a skill linked to emergency nursing. In their opinion, they were not exposed to sufficient skills required for emergency nursing such as resuscitation. Simulation should provide extensive emergency based clinical skills such as patient triage, to development and improve student's confidence and competence. This was indicated as follow: *"So, the only thing that we were prepared for was the emergency trolley of which it was only done like in skills lab. There was nothing that was practical like showing how to do it, it was only the trolley. What do you get under first drawer, second drawer, third drawer and some other equipment, you are told how to use them. But you are not really exposed on how to use them on real patients or real [humans]"* P1.

Another student said*: "I feel like they don't teach us basics like triaging a patient and nebulizing a patient or putting in a drip. We must learn all those things by ourselves"* P6.

The following was also mentioned: *"Okay, so maybe also the supervisors and the schools need to keep up with what is happening in the hospitals. And not only teach us like very few stuff, but expose us in terms of…the reality or draw us a picture of reality"* P7.

This finding is consistent with Salifu, Heymans and Christmas (2022) in their study in Ghana, on the exploration of nursing student experience and perception in the teaching and learning of clinical competence, which found non-prioritization of practical skills. The theme these authors presented comprised the following factors: limited opportunity to practice, time, difficulty in accessing skills laboratory and inadequate skills laboratory exposure. This is concerning, as patients who are admitted in emergency units are at high risk for acute deterioration and death (Bogossian et al., 2014). Evidence indicates that the failure to identify and respond to the patient clinical deterioration increases mortality rate in emergency units (Considine, Fry, Curtis & Shaban, 2021).

It is concerning when a nurse fails to recognize a worsening condition and intervene to prevent patient death, therefore nursing schools should prepare students in simulation laboratory to apply knowledge and develop clinical judgement in a safe, free environment to provide quality effective emergency care (Hart, Maguire, Brannan, Long, Robley & Brooks, 2014). Similary, Kaushir and Mancheri (2019) discovered that student nurses and clinical nurses have insufficient knowledge and practice regarding the emergency trolley. Yet, nurses are responsible for the checking, restocking, verification of expiry date of every item in the emergency trolley (Kaushik & Mancheri, 2019).

A study in Brazil by Citolino, Santos, Silva and Nogueira (2015) on factors affecting the quality of cardiopulmonary resuscitation in inpatients units, identified the following factors which affect (CPR): lack of familiarity with the emergency trolley (98.0%), lack of equipment (57.1%) and, lack of harmony during CPR.

The emergency trolley is also known as a “crash cart” which is a mobile specialized trolley comprising of various medical aid equipment, mainly used for cardiac

emergencies (Aruna et al., 2021). It consists of items such as a defibrillator, emergency drugs, suction pumps, intubation equipment and other life-saving apparatus (Citolino et al., 2015).

4.3.1.2 Category 2: Lack of correlation between what is taught and how it is taught in skills laboratory versus practice

The students identified a discrepancy between clinical preparation in the skills laboratory and practice in the emergency unit. They revealed that there is a difference in how a skill is taught and demonstrated in the skills laboratory as compared to the practice of the skill in emergency units. In their view, this situation contributed to a theory-practice gap.

This was indicated as follow: *..."so, if the patient doesn't have an airway or this is how you put in an airway, but they don't connect the dots as to during a resuscitation. This is how, this is the order in which we're going to do it. This is the order in which we're going to do the resus… So, it's not exactly like the same as here"* P1.

Another student said: *"…I didn't even know like some of the equipment. I know there is an emergency trolley and it's where I'm supposed to get things. But I didn't know how to connect things; how to and what to do to help them"* P3.

The following was also mentioned *"…And when we got to facilities to practice and stuff, clinical placement, like it's totally different as much as the way they manage the patient. But when it comes to the reality of being, seeing a patient that is epileptic at that time, it's sort of like scary"* P4.

This finding is parallel with the study of Kerthu and Nuuyoma (2019), on nursing students at the Satellite campus, which highlighted an inconsistency between theory

and practice in the clinical setting which made nursing student feel confused and discouraged. Theory-practice gap can be defined as the inconsistence between what nursing students acquire through theoretical classroom and what they experience in clinical studies (Abu Salah, Aljerjawy & Salama, 2018). Evidence suggests that there is a difference between doing a procedure in a simulated environment as compared to the real-life clinical area (Hashemiparast, Negarandeh & Theofanidis, 2019). Kalyani, Jamshidi, Molezam, Torabizadeh and Sharif (2019) suggest that certain clinical tasks and emergency conditions cannot be easily simulated. Therefore, simulation should be integrated with practice (Svellingen, Sovik, Roykenes & Brattebo, 2021). A study conducted in Iran identified student, instructor, environment, and organizational culture as four factors that contribute to theory-practice gap in emergency nursing education (Safazadeh et al., 2018).

Collaboration between higher education institutions and specialty clinical areas would assist nursing students to integrate theory into practice. The re-evaluation of the curriculum to ensure that the necessary knowledge and skills are successfully practiced in the educational programme is crucial (Abu Salah et al., 2018). Continuous curriculum modification is necessary to align learning to evolving nursing practice (Fawaz, Hamdan-Mansour & Tassi, 2018).

4.3.1.3 Category 3: Insufficient theoretical input in preparation for practice in emergency units

In this category, students showed dissatisfaction with theoretical teaching and learning in preparation for placement in the emergency units. They reported lack of prerequisite knowledge, specific learning outcomes, and assessment. According to them, the roles and duties in the emergency unit remain unclear.

This was mentioned as follow in the focus group: *"…Okay, I feel like a lot of what I learned in trauma, I learned it from the facilities itself. I didn't learn it here at the university"* P1.

Another student said*: "…In theory, what happen is they will just like say, okay, this is the guidelines of emergency but they won't go into detail. What do you do, like, management of it? They just okay, emergency trolley resus, but what in that areas, we don't know. Events that can take place"* P4.

More was added by the student who stated: ... *"there is no specific preparation for a trauma unit placement. Just generally nursing we are prepared with the diseases. We do the diseases in class, and then we get to go and practice how to manage them in skills. So, there is no specific preparation that we get okay. We're going to deal with the trauma unit now"* P7.

These findings are similar to the findings of a study by Dulandas and Brysiewicz (2018) in KwaZulu-Natal, and Aloyce, Leshabar and Brysiewicz (2014) in Dar es Salaam, which found that majority of nurses working in emergency units have no formal emergency training. A lack of emergency knowledge results in poor clinical judgment, which poses threats to immediate management, and thus increases the risk of mortality and disability (Aloyce et al., 2014). The provision of quality emergency care requires formal, structured emergency nursing guidelines and is reliant on a well-trained workforce (Hynus & Karama, 2017).

4.3.2. Theme 2: Challenges with educational planning

Theme two is related to students' experience of educational planning and implementation of a clinical placement in trauma, surgical and medical emergency units.

4.3.2.1 Category 1: Theory and work integrated learning are not synchronized

The students highlighted a lack of synchrony between what was taught and their placements in practice. Lectures on emergency nursing did not coincide with simulation in the skills laboratory and placement for work integrated learning. They experienced poor clinical placement planning, such as during the pre-term placement. Some students were only allocated in emergency units after 16h00, when there were no clinical supervisors on duty. In their view, they also had limited exposure to emergency units and did not rotate to all types of emergency units resulting in lost the learning opportunities.

This is indicated by the following: *"…So, I think in terms of placement, the theory and the placement periods don't match up. So, which means we are placed, say for example, in first semester, we are placed in trauma theatre or something like that. But only in second semester, we are taught theory on trauma…so…it doesn't match up"* P9. Another student said: *"…I think we mostly work trauma…like from four to seven. Because during the day, we were placed in the community for other things, from two to four and then from four to seven"* P9.

This finding is similar to a qualitative conducted study by Kalyani at el. (2019) on nursing students, which discovered that unfavorable educational planning resulted in students facing challenges such as, a lack of preparedness and lack of confidence when they are in clinical environment. Similarly, a study of Killam and Heershap (2013) in Canada, on nursing student's challenges of learning in clinical settings identified the following contributing factors: poor placement organization, ineffective program organization, not learning through written work, lack of practice time, inadequate focus on learning core sciences and critical thinking ability.

Poor educational planning contributes to students doing routine-based work in the emergency units (Safazadeh at el., 2018). Evidence suggests that parallelism between clinical practice and student theoretical and practical preparation is essential for optimal learning (Saifan, Devadas, Daradkeh, Abdel-fatah, Aljabery & Micheal, 2021). To achieve good educational planning, it is important for the teachers to clearly and accurately explain educational goals prior a clinical placement; as proper educational planning increases the quality of clinical education and lead to the achievement of educational goals (Kalyani at el., 2019).

4.3.2.2 Category 2: Lack of communication between education and practice regarding the learning outcomes for work integrated learning

In this category, the students experienced inconsistency in communication between the school of nursing and the healthcare facilities they are placed in. According to them, ineffective communication hinders their learning experience in emergency units. Their roles and goals were not communicated, therefore, resulting in poor guidance and supervision from the clinical nursing staff. They expressed anxiety to discuss their learning needs in the facility. In their opinion, effective communication between the school of nursing, facilities and nursing students might increase confidence and motivation to learn in emergency units.

This was mentioned as follow: *"…So, they [school of nursing] expect the facilities to teach us what we don't know. But then the facilities also expect us to know, so there are expectations from the school and the clinical that we are not meeting, so there's that gap in"* P4.

Another student said: *"…On the thought of alleviating the fear, I think what could help now is the hospitals or the facilities, keeping up with the universities in terms of the*

objectives and everything that is done, because the sisters or the RNs already know what is supposed to be done by students. Many students are scared to voice out their objectives and everything" P7.

Another student added: *"Sometimes they [students] are shy to ask and basically it is like I can say these responsibilities for the nurses to ask what do you want"* P2.

This phenomenon corresponds with a study done in Iran by Jahanpour, Azodi, Azodi and Khansir (2016) on nursing students, and another study by Fadana and Vember (2020) in the Western Cape, which found that poor communication between nursing educators, clinical nurses, and student nurses contributes negatively to the clinical learning experience. Communication is one of the major components in the nursing profession (Fadana & Vember, 2020). Poor interpersonal relationships might cause disharmony and unhappiness among students, hence, resulting in lack of achievement of the desired goals (Mostaanaka et al., 2020). This finding is supported by Mamaghani et al. (2018) in Iran, which reported that participants complained about educational confusion. Proper communication increases students' motivation (Jamshidi et al., 2016). However, inadequate supportive relationships have been found to have negative effects on the clinical learning experience (Bjork et al., 2014). This leads to nursing students expressing feelings of vulnerability, anxiety, worry, loss of confidence, motivation, isolation, and unpreparedness during the clinical learning (Atakro et al., 2019; Farzi, Shahriari, & Farzi, 2018; Atakro & Gross, 2016).

4.3.3 Theme 3: Lack of readiness for clinical placement in emergency units

This theme is about the students' perceptions regarding their readiness, both clinical and theoretical, for work integrated learning in trauma, and surgical and medical emergency units.

4.3.3.1 Category 1: Inadequate knowledge and skills

Students reported having inadequate knowledge and clinical skills prior to placement for work integrated learning in emergency units. They indicated that there is a lack of exposure to emergency units and conflict between the student expectations and the reality of the expectations in the emergency units. In their opinion, the deficit of knowledge and skills contributed to them not feeling ready for work integrated learning in emergency units. This was mentioned as follows*: "so, we haven't even had any theory. Well, we had some in second in first year, but it wasn't really trauma based or emergency setting based. So, I would say in my opinion, I was not ready"* P8.

A student also reported: *"We haven't had so many specific skills, I think the major skills were focused on in skills lab. But like they said, it's very unexpected in a trauma ward because anything can happen. But from my experience, I wasn't that exposed to a lot of traumatic experiences or emergency cases or medical emergencies. So, I would definitely need some more experience to find my feet in an emergency ward"* P3.

Another student said: *"But they don't really prepare you for the role that you will have when you are there at the adult resuscitation itself. It's all things that you have to adapt to while you are at the facility. But it's not like you are being prepared"* P1.

This is congruent with Baraz et al. (2015) study on nursing students in Iran, which identified factors reducing the effective learning in clinical environment, such as, inadequate knowledge, practical preparation, and clinical supervision. Scholars Wahyuningsih et al. (2020) discovered that 77,3% of nursing students were not ready to handle emergency because of their experience and education.

Literature suggests that skills must be practiced in a risk-free simulation environment, to ensure patient safety, improve technique, gain confidence prior a clinical emergency placement (Hellawell et al., 2021). Readiness to practice is defined as the ability of a

nurse to assume roles of care provision, design, manage and coordinate care (Jamieson, Sims, Basu & Pugh, 2019). Scholars believed that unknowledgeable students might show significant gaps in basic clinical knowledge, diagnosis and management of patients and perform poorly at the bedside (Mamaghani et al., 2018). Nurses are required to be competent in theoretical scientific knowledge, specific psychomotor practical skills, communication, cultural competence, professional values, and ethical conduct prior real clinical placement (Althiga, Mohidin, Park & Tekian 2017).

4.3.3.2 Category 2: Emotionally unprepared

Most of the students expressed experiencing emotional distress, because of exposure to traumatic events during placement, which they were not prepared for, and reported that as a result they required emotional support. However, supportive structures were limited. In their view, traumatic events trigger negative feelings, like fear, anxiety, and sadness. This was mentioned in the focus group discussion as follows: *"…Yes, some of them they come with…gunshot wounds and stuff. So…we are…scared, to fully participate in those things"* P4.

Another student said: *"…I think on my side I'm not prepared because of this reason, I was working at a hospital. It was a children's hospital. So, a five-year old was raped and she was bleeding on the mattress. So, on my side it is not something I can stand with. So yeah, that's what I can say and then just I feel like I can see such just heartbroken when I see someone comes with like a gunshot wound or a (inaudible), seeing like the blood is oozing like water from a pipe, it is not something I can see like, in front of me all the time"* P3.

This student reflected and mentioned: *"…no theory comes and tells you that gunshot is going to be on the arm or on the head. The events are too traumatic. And I don't think or I don't remember, maybe they can help me out, I don't remember if there was ever a class where you are told or you are learned how to be prepared, mentally prepared to deal with the traumatic events that comes that presents in the trauma unit"* P8.

Emotions play a critical role in the caring process (Peil, 2014). This finding is supported by Motsaanaka at el. (2020) study in Gauteng, on the nursing students' experience of clinical placement, which revealed that students had negative emotional experiences. These emotions might limit and block student's motivation to learn (Botma, Brysiewics, Chipps, Mthembu & Phillips, 2014). Evidence suggests that realistic simulation practice might help students to improve comprehension, communication, and psychological adjustment to complex environments (Zeng et al., 2020). Studies showed that nursing students develop emotional stress because they want to save life but lacked experience (Getierrez-Puertas, Marquez-Hernandez, Getierrez-Puertas, Rodriguez- Garcia, Garcia-Viola, & Aguilera-Manrique 2021). A study that was conducted by Jimenez-Herrera, Llaurado-Serra, Acebedo-Urdiales, Bazo-Herriandez, Font-Jimenez and Axelsson (2020) in Spain, revealed that emergency nurses experience negative emotions when it is impossible to follow the best practice. Nurses are morally sensitive to the patients' vulnerability and when they experience external factors preventing them from doing what is best for the patient, they have no control of the special situation (Jimenez-Herrera et al., 2020). This results in nurses feeling helplessness, frustration, anger, and guilt (Getierrez-Puertas et al., 2021).

4.3.4 Theme 4: Positive and negative learning experiences in emergency units

This theme describes the student's clinical learning experiences and challenges encountered during work integrated learning in trauma, and surgical and medical emergency units.

4.3.4.1 Category 1: Learning by doing

In this category, students shared their experiences of learning by doing and the exchange of knowledge between nurses. They identified various learning opportunities especially when they feel welcomed. They shared that they experienced emergency units as busy, complex and unpredictable environments with patients presenting with different conditions. They also found that emergency nursing requires specialized information; a nurse who is flexible, a critical thinker who focuses on prioritization, management, and resuscitative measures, working hand in hand with the multidisciplinary team. In their opinion, this environment provides a hands-on experience, motivates students for clinical learning and introduced them to the nature and specialty of emergency nursing practice. The following statements were made: *"I said I'm scared to put up a drip. They said, Oh, okay, and then show you how to do it so that you know, and it was for me that experience was good. Like, I actually didn't have any problem with it. It was fine"* P8. Another student mentioned: *"They were very nice, like, how can I say, I felt very at home there. And that's why I also learned a lot"* P5.

This student said: *"So then I felt a sense of, okay, now I know what to do. And when the sister saw that you were competent, that's when they actually gave me my freedom to be here on the floor. I didn't need the sister. They weren't…they were very supportive. Like she said also, they were very supportive of, maybe they will show you*

the first or the second time, but I mean you do get along. And then I felt very, I felt very big, or very grown after a while" P8.

This is congruent with a study done in Sweden by Ewertsson, Bagga-Gupta, Allvin, and Blomberg (2017) which showed that nursing students experience of hands-on learning is important to compliment previous knowledge and increase students' confidence. Porter, Morphet, Missen and Raymond (2013) believe that students gain new knowledge and skills when there are confident. Extensive clinical exposure of undergraduates nursing students is critical for the clinical experience and competences (Alhqwi & Taha, 2015). Evidence suggests that clinical experience in different specialty such as operating room, emergency area, and critical care enhance clinical learning (Althiga et al., 2017).

This is aligned with transformative learning theory which suggests that nursing students should be encouraged to think independently, make meaning of the knowledge from life experience (Tsimane & Downing, 2020). The emergency unit is a strange, novel department with different patients every day, thus, nursing students are motivated to learn, but they feel helpless and have fear of the unknown, hence, clinical supervisors should assess and familiarize students to eliminate the psychological impact (Meng, Zhou, Zhoa & Zhang, 2019).

The following categories highlight the challenges encountered in the emergency units.

4.3.4.2. Category: 2 Feeling anxious and afraid

The students expressed feeling of fear, nervousness and helpless in the emergency unit. Their anxiety developed from the uncertainty of handling unpredictable and unknown situations and lack of preparedness. Based on their reflection, experiences of unforeseen circumstances evoked negative emotions which hindered their clinical

learning experience in the emergency units. The following was mentioned by a student: *"Nervous, anxious, confused and yeah, I don't know how else to explain it. But I don't feel like I would be ready enough…I can work in an environment like that with other staff members. But if I'm left alone, I would be completely nervous"* P1.

Another student stated that: *"I saw a patient coming in with a massive gun gunshot wound…blood…coming out of it and you don't know where. So, the first thing that you do instead of helping - you freeze, because you're like how come this person is still alive in there is too much blood. So, instead of you thinking and acting fast, you freeze, because mentally you're not prepared to think that you ever going to see someone who's losing so much blood"* P8.

Yet another student: *"said it was kind of frightening, I would say, because the people that come there are in different conditions. So, it was my first time experiencing such trauma to someone that happened to someone. Yeah, it was kind of scary, but I got used to it. And since I knew that I chose this course for such reasons"* P4.

Fadana and Vember (2021) defined anxiety as a feeling of fear, nervousness, and uncertainty. This category is similar to the findings in a study done in Spain, by Gonzalez-Garcia at el. (2020) on student nurses, which discovered "intense emotional experience" on the students working in the emergency room and intensive care units. The study by Belayneh, Zegeye, Tadessa, Asrat, Ayano and Mekurian (2021), in Ethiopia, found that nurses who are working in emergency and intensive care had a higher level of anxiety. Some studies suggest that various work-related stresses, dissatisfaction, grief, anxiety at the emergency and intensive care units diminishes the provision of quality care, patient treatment outcomes and family satisfaction (Lee, Lee, Gillen, Krause, 2014; Zuniga, Asseurhofer, Hamers, Engberg, Simon & Schwendimann, 2015). To prevent anxiety in clinical placement, nurse educators

should implement effective strategies such as prerequisite clinical knowledge, orientation, pre-clinical workshops, and simulation (Simpsona & Sawatzkyb, 2020). Killam and Heercap (2013) reported that junior student feels scared and stressed in the clinical environment which necessitates support from clinical nursing staff and educators.

4.3.4.3 Category 3: Lack of clinical supervision

All the students mentioned that they experienced poor clinical supervision. According to them, the clinical supervisors only focused on the verification of clinical hours and not on clinical education. They did not know what to supervise in the emergency units, and as a result student were doing routine-based work, because there were no clear roles and specific learning outcomes for this clinical placement. This experience evoked negative feelings such as isolation, loneliness, rejection and confusion. According to the students' clinical supervision is critical to integrate theory to practice, and to eliminate negative feelings which hinder a clinical experience. A student said the following: *"So, there was no supervisors to even intervene in that case. And for me, I was placed in trauma, emergency, not medical, not surgical, so my supervisor, like did not touch around those areas. So, I got to know only trauma, only trauma emergency"* P2.

Another student said: *"I think our supervisors, they just come and then they check on us but they don't teach us. They don't give us the knowledge…for example, if you come to the hospital as a supervisor, you must tell me in this ward, now, this is what you're supposed to be doing. They just come in then they just check on us that we're there and then they leave without giving us the knowledge that it's supposed to have in that ward"* P6.

Their experiences are aligned with the findings of a study on student nurses by Berhe and Gebretensaye (2021) in Ethiopia, which reported on clinical supervision inadequacy. Clinical supervision is one of the pillars in nursing education, which is necessary for efficient learning and teaching in clinical education (Donough & Van der Heever, 2018). Clinical supervisors are the first source of student support, and guide the student support process (Jafarian-Amiri, Zabihi & Qalehsari, 2020). Scholars Atakro et al. (2019) and Safazadeh et al. (2018) revealed that clinical supervision in emergency units is difficult due to some clinical supervisors being inexperienced having insufficient knowledge, showing incompetence of working with some equipment in emergency units and there is inadequate evaluation in these units. Furthermore, inadequate supportive relationships have been found to have negative effects on the clinical learning experience (Bjork et al., 2014). This leads to nursing students expressing feelings of vulnerability, anxiety, worry, loss of confidence, motivation, isolation, and unpreparedness during clinical learning (Atakro et al., 2019; Farzi et al., 2018).

4.3.4.4 Category 4: Rejection of students during resuscitation

As mentioned earlier, students highlighted that emergency care is based on prioritization, immediate management and stabilization and requires specialized knowledge, skills, competences and working hand in hand with the multidisciplinary team. However, they reported feeling rejected during resuscitation. In their opinion, students lost the learning opportunity and socialization with the multidisciplinary team. One student mentioned that: *"…if it's an emergency case, they will not give much attention to second year students"* P9.

Another one said: *"…but especially with resuscitations, we were 'shooed' away, …go do medication while we resuscitate. Even if you wanted to help, they will be like, no, someone needs to be on the floor, someone needs medication to be given"* P6.

The following was also mentioned by one of the students *"…maybe resuscitation is happening, by the time you turn around the resus [resuscitation] is done, you don't really get to learn". "…maybe in trauma that mostly we are allowed to do is to manage an asthmatic patient because you must…give nebs [nebulizers] to this patient"* P8.

This finding supports that of a study done on nursing students in Iran by Jafarian-Amiri et al. (2020) which found various kinds of violence, namely, student humiliation, discrimination, rejection, exploitation, and bullying. Scholars Roel and Bjork (2020); Nasr-Esfahani, Yazdannik and Mohamidiriz (2019) argued that nursing students should be able to initiate and perform cardiopulmonary resuscitation (CPR) when they start their nursing career. Often the nurse arrives first at a scene of cardiac arrest in the hospital, therefore they must be competent in CPR. On the other hand, Dulandas and Brysiewicz (2018) suggest that resuscitation is a very complex area which requires a multidisciplinary approach, specific knowledge, specific equipment and immediate specific management according to the patient's needs.

Student rejection at the point of CPR result in loss of the opportunity to experience and perform the procedure, master the skill, transform theory into practice and reduces interaction with the multidisciplinary team, patient, and family (Baraz, et al., 2015). The main goal of CPR is to restore and revive cardiopulmonary function (Kozelj, Pogacar, Fijan, Strauss, Postuvan & Strnad, 2021). The implementation of debriefing session after resuscitation provides the nursing students the opportunity to share ideas and improve their technique, with the aim to deliver an effective quality emergency care (Getierrez-Puertas et al., 2021).

4.3.4.5 Category 5: Service delivery over education

Students indicated they being regarded as part of the team, and not a student with learning needs. Students reported that they often did routine work such as observations, transferring patients to the ward and theatre, and were asked to work in the other departments because of a shortage of nurses. Based on their reflections, emergency units focused on patient care over student learning needs. There was limited exposure, insufficient support, guidance and supervision both from clinical supervisors and facility staff. This student said: *"What we got was you have to take blood, you have to test urine, you have to take something like HBs. It was simple things like that, which has nothing to do with emergency"* P1.

Another student stated: *"…You triage that patient in trauma. And then where I worked, we usually send the patient to a surgical ward. And then from there, you as a student, hashtag a porter, you are going to transport the patient to theatre, and then it ends there. If the patient comes back, you as a porter hashtag a student you take that patient from theatre, you only do observations and then it ends there. So, there's not really much of an exposure in the facilities"* P7.

This student reported on the facility staff telling students: *"Do triage or do observations"* P9. She added that facility staff would say *"Please I will help you tomorrow because I'm busy. So, then tomorrow…it was the same busy day so please go help. I can't help you. So, because they saw we don't have any objectives - the competencies that we must achieve – so…they took chance…the 30 days the same thing. You find for the five days…you go home tired, but you learned nothing"* P9.

This finding concurs with the finding of Killam and Heerchap (2013) who conducted a study in Canada, and found that student nurses are often seen as the part of workforce in emergency units. However, using student nurses as an extra pair of hands results

in inadequate exposure to learning experiences and doing routine duties, which leads to frustration amongst student nurses (Jamsidi et al., 2016). Engaging in routine-based tasks and repetitive procedures reduces student motivation to learn (Tehran, 2021). Scholars Safazadeh et al. (2018) concluded that clinical placement in the emergency unit contributes to poor transformation of theory and practice, because of its complexity, shortage of staff, increased workload, equipment and focus on patient care over education.

5. Summary

In this chapter, the researcher described the research findings that emerged from the thematic analysis. Four themes and 12 sub-themes were generated and presented with support from empirical literature, to confirm and contrast the findings. The study revealed that student preparedness for a clinical placement in emergency units is strongly reliant on a sufficient knowledge, communication, good educational planning, effective clinical supervision, and a conducive emergency unit. However, the students reported inadequate readiness for a clinical placement in emergency units because they had insufficient emergency- based education, they experienced challenges with educational planning and the tradition and culture of the emergency units and the focus of service delivery over education. This clinical experience was perceived both positively and negatively because they were exposed to circumstances which either promoted or inhibited clinical learning. The findings highlight the need to create a relationship between the school of nursing and clinical facilities to ensure consistence in facilitation of learning and closing the curricular gap in emergency nursing.

The following chapter provides a summary of the findings, declares the study's limitations and makes recommendations based on the findings of the study.

CHAPTER 5

SUMMARY, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

The previous chapter presented the study findings of the study and used existing literature to support or counter the research findings. This chapter provides a summary of the findings, presents limitations of the study and makes recommendations for the nursing education, clinical practice and future research based on the findings of the study**.**

5.2 Summary of the research study

The purpose of the study was to explore Bachelor of Nursing students' experience of the theoretical and clinical preparation for, and perception about their readiness for clinical placement in emergency units. The methodology adopted was qualitative approach, using an exploratory-descriptive research design. Data was collected through face-to-face and online focus group discussions, conducted with 16 third and 18 fourth-year nursing students from a university in the Western Cape, South Africa, who were sampled purposefully and participated voluntarily. The focus group discussions used a self-developed interview guide, were conducted in English and were audio-taped. The recordings of the focus group discussions were transcribed verbatim and analysed through thematic analysis.

The researcher analysed the data independently and confirmed the findings with the supervisor. The study generated four themes namely, insufficient emergency-based education, challenges of educational planning, lack of readiness for work integrated in emergency unit, and positive and negative experiences in emergency unit. The study

adhered to the ethical principles of privacy, confidentiality, anonymity, respect for person and justice. Trustworthiness of data was ensured by the principles of credibility, dependability, transferability and confirmability (Lincoln & Guba, 1985).

5.3 Summary of major findings

The study produced four themes and twelve categories (see Table 4.1).

5.3.1 Theme 1: Insufficient emergency-based education

The findings of this study revealed insufficient emergency-based knowledge in the undergraduate programme. The findings highlighted the need for effective emergency-based education preparation both in theory and practice. The findings identified the contributing factors which inhibit student readiness for clinical placement in emergency units namely; unclear learning outcomes, lack of prerequisite knowledge, limited exposure to emergency clinical skills. The findings suggested that nurse educators and clinical supervisors should use realistic simulation and align the theoretical preparation with practice to close the curricular gap.

5.3.2 Theme 2: Challenges with educational planning

The findings revealed a gap between theory and practice related to emergency nursing. The students identified factors which contributed to theory-practice gap, such as, inconsistent communication between the school of nursing, the emergency units and students, poor organizational planning of a clinical placement in emergency units, and conflict of interest between student's expectations and reality in practice.

5.3.3 Theme 3: Lack of readiness for clinical placement in emergency units

The findings indicated that students perceived themselves not being ready for placement for work integrated learning in emergency units, because of knowledge and skills deficit. This situation is concerning because a nursing student might come across a patient presenting with an acute emergency at any time or place. Therefore, it is essential that nursing education institutions provide specific emergency information and skills for provision of safe, effective, ethical, and quality emergency nursing practice.

The students experienced low confidence, rejection, poor support, and anxiety to practice in the emergency units because of poor clinical supervision and guidance from both the nursing staff and clinical supervisors. This results in loss of clinical learning and development of learning experience. These circumstances are concerning because the clinical supervisors do not know what to supervise, and yet they are regarded as the student's source of clinical education and support.

5.3.4 Theme 4: Positive and negative experiences in emergency units

The findings indicated that students perceived the emergency unit as a learning environment which has various learning opportunities and provided them with a hands-on experience. The students were introduced to speciality of emergency nursing, collaborative approach. The findings discovered that learning in emergency units is challenging, because of its nature that is fast-paced, chaotic, complex and it focused on prioritization of patients' needs than education.

5.4 Limitations of the study

This study identified the following limitations namely**:**

- The study was only conducted at one higher education institution; therefore, the findings of this study cannot be generalised to students in other Bachelor of Nursing programmes at other institutions and in different contexts.
- The study focused only on the bachelor of nursing students, and excluded clinical supervisors, lecturers, nursing managers and clinical nursing staff.
- The COVID-19 pandemic lockdown restrictions prevented face-to-face interaction during the recruitment and data collection phases of this study. The researcher therefore had to move from face-to-face to and online interview for one of the focus groups. However, there were no obvious difference in process and depth between the face-to-face and online focus group discussions.
- The students wore face masks in respect of COVID-19 precautionary measures, thus it was difficulty for the audio-recording and to observe their facial expression regarding the researched phenomenon.
- This study only focused on medical, surgical, and trauma but excluded another component of emergencies such as paediatrics, forensics, obstetrics, disaster management and orthopaedics.
- The online focus group discussion was difficult to transcribe because of high volume of noise. However, the quotes used, indicate where the recording was inaudible.

5.5 Recommendations

The section provides recommendations for nursing education, practice, and further nursing research.

5.5.1 Recommendations for nursing education

The following recommendations are proposed for nursing education and are categorised into three aspects namely: nurse educators and clinical supervisors, school of nursing and nursing students**.**

5.5.1.1 Recommendations for nurse educators and clinical supervisors

- Deliver realistic emergency-based simulation sessions prior to clinical placement in the emergency unit.
- Create standard operating procedures / guidelines which correspond with clinical settings. This will reduce confusion for students.
- Conduct orientation sessions or workshops regarding emergency nursing care, types of emergency unit, students' expectations, roles, and responsibility.
- Recruit nurse educators and clinical supervisors who have a qualification in emergency nursing.

5.5.1.2 Recommendations for the school of nursing

- To build a relationship between nurse educators, nursing managers and clinical staff and implement clinical emergency education which support the integration of theory and practice.
- Provide clear learning outcomes for clinical placements in emergency units and increase the amount of direct clinical supervision.
- Create a clinical placement plan which discourage pre-term clinical placement in emergency units**.** This is to ensure the synchrony of theoretical and clinical exposure.

- Promote student accompaniment in emergency units which include bedside teaching and learning more than focusing on administrative aspect such as, signing time sheets and off-duties.
- Create a clinical rotation which exposes nursing students to all aspect of emergency units such as triage, minor injury room, major injury room, and resuscitation room and ensure that students are placed in all emergency units such as trauma, medical and surgical units.
- Create formative assessments that are case related such as emergency case-based assignment and presentations. This will keep students motivated to learning in the emergency units.

5.5.1.3 Recommendations for the nursing students

- Encourage students reflective learning by writing a reflective journal after clinical placement in emergency units. These reflective journals should be assessed by the nurse educator as they are powerful tools for obtaining feedback on the student's experiences – which can inform improvement plans.

5.5.2 Recommendations for nursing practice

The following recommendations are proposed for the nursing managers:

- Provide in-service training for nursing students focusing on emergency nursing care, to integrate theory to practice.
- Promote bedside teaching, support and guidance during ward rounds.
- Provide information regarding the system of emotional support available at the facility for the nursing students.
- Provide learning opportunities based on students learning needs.

- Provide a conducive working environment to promote clinical learning.

5.5.3 Recommendations for nursing research

The following recommendations are suggested for further nursing research studies

- This study was limited to the nursing students studying at a higher institution university in the Western Cape. This study could be done at different nursing education institutions and in different context, and should involve nurse educators, clinical supervisors and clinical staff in the emergency units.

5.6 Conclusion

This chapter explained the research design and methods employed for this study, discussed the summary and interpretation of the research findings. It showed limitations of this study and identified recommendations to improve nursing students theoretical and practical preparation for a clinical placement in emergency unit.

The study provides evidence that Bachelor of Nursing students are not ready for clinical placement in emergency units, because of inhibitory factors such as unclear specific learning outcomes, prerequisite knowledge, poor clinical exposure and competences. A clinical placement in emergency units provide a student nurse with a positive and negative clinical learning experience. This study revealed that poor educational planning such as inconsistent communication between the (NIE), clinical facility and student, insufficient clinical supervision contributes to a theory-practice gap in emergency units.

Emergency-based theoretical and practical preparation is necessary for undergraduate nursing students to improve their emergency care readiness. Student

nurse learning experience and readiness of a clinical placement in emergency units is reliant on specific emergency knowledge, skills, communication, support, and sufficient clinical supervision.

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APPENDIX A: ETHICAL CLEARANCE CERTIFICATE

UNIVERSITY of the WESTERN CAPE

60 YEARS of hope, action & knowledge

27 November 2020

Ms N Sipamla
School of Nursing
Faculty of Community and Health Sciences

Ethics Reference Number: HS20/9/36

Project Title: Bachelor of nursing students in the Western Cape's experiences of preparation for and perceptions about their readiness for clinical placements in emergency units.

Approval Period: 25 November 2020 – 25 November 2023

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 by 30 November each year for the duration of the project.

The permission to conduct the study must be submitted to HSSREC for record keeping purposes.

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

Director: Research Development
University of the Western Cape
Private Bag X 17
Bellville 7535
Republic of South Africa
Tel: +27 21 959 4111
Email: research-ethics@uwc.ac.za

NHREC Registration Number: HSSREC-130416-049

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

APPENDIX B: INFORMATION SHEET

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel : (021)959 2443 Fax : (021)959 2679

E-mail : 2842620@myuwc.ac.za

Project Title: Bachelor of nursing student in higher institution at Western Cape's experience of preparation for and perception about their readiness for clinical placement in emergency rooms

What is this study about?

This is a research project being conducted by Nomahlubi Sipamla at the University of the Western Cape. We are inviting you to participate in this research project because you are a third- or fourth-year student who have studied general nursing science and been exposed to most clinical learning facilities including the emergency units. The purpose of this research project is to explore the Bachelor of Nursing student's experience of the theoretical and clinical preparation for, and perception about their readiness for clinical placement in emergency units. The information gained from this study might provide guidance to the school of nursing to improve the curriculum and therefore the theoretical and clinical preparation of nursing students for placement in the emergency unit.

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

You will be asked to sit in the group. The researcher will introduce herself, distribute the information sheet, explain the purpose of this study, therefore, obtain a written consent, explain the group norms and assign a number on each participant's nametag. The researcher will use an icebreaker to grasp participant's attention, test the audiotape to ensure that it is working effectively, thus place it in the middle of the group. The group will approximately take 45- 60 minutes. The researcher will ask questions and use probes based on the interview guide, listen, observe and take notes. These questions will be asked per unit and include: What is your experience of the theoretical and practical preparation for placement in the medical emergency/ surgical emergency/trauma unit.

Would my participation in this study be kept confidential?

The researcher undertakes to protect your identity and the nature of your contribution. This study will use focus groups therefore the extent to which your identity will remain confidential is dependent on participants' in the focus group maintaining confidentiality. This research project involves making Audio tapes of you. The audiotape will be used

to collect data, to build rapport between the researcher and participant and therefore, encourage deep discussion. Anonymity and confidentiality will be ensured by removing the identifiable information thus, use pseudonyms. Only the researcher and supervisor will have access to the collected data. The data will be stored in a lockable, private place and be discarded after five years.

Please read the following sentences and tick the applicable answer.

___ I agree to be audiotaped during my participation in this study.
___ I do not agree to be audiotaped during my participation in this study

What are the risks of this research?

All human interactions and talking about self or others carry some amount of risks. We will nevertheless 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?

This research is not designed to help you personally, but the results may help the investigator learn more about the theoretical and practical preparation for placement in the emergency unit.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Nomahlubi Sipamla, who is coming from the nursing department, University in the Western Cape. If you have any questions about the research study itself, please contact Nomahlubi Sipamla at the following address: 44 Besmriet Street, Hamilton estate, Kuilsriver, 7580, on 0788355470 and 2842620@uwc.ac.za.

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

Prof. J. Chipps (Director at the time of data collection)
Head of Department: School of Nursing
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Prof Anthea Rhoda
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Tel: 021 959 4111
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APPENDIX C: CONSENT FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel : (021)959 2443 Fax : (021)959 2679

E-mail : 2842620@myuwc.ac.za

Title of Research Project: Bachelor of nursing student in a higher institution of Western Cape's experience of preparation for and perception about their readiness for a clinical placement in emergency units

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. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name……

Participant's signature……

Date……

APPENDIX D: FOCUS GROUP، CONFIDENTIALITY BINDING FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel : (021)959 2443 Fax : (021)959 2679

E-mail : 2842620@myuwc.ac.za

Title of Research Project: Bachelor of nursing student in a higher institution of Western Cape's experience of preparation for and perception about their readiness for a clinical placement in emergency units

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 giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

APPENDIX E: INTERVIEW GUIDE

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel : (021)959 2443 Fax : (021)959 2679

E-mail : 2842620@myuwc.ac.za

Title: Bachelor of nursing students at a higher education institution in the Western Cape's perceptions about their readiness for clinical placement in emergency units

This focus group will be guided by six self-developed and open- ended questions based on the objectives of the study research.

1. What is your experience of the theoretical and clinical preparation for a clinical placement in medical emergency unit?

Probes:

-Give an explanation

-Give example

2.What are your perception about your theoretical and clinical readiness for a clinical placement in the medical emergency unit.

Probes:

-Please elaborate

-Please support your statement

3. What is your experience of the theoretical and clinical preparation for clinical placement in surgical unit?

Probes:

-Give a description

-Tell me more

4.What are your perceptions about your theoretical and clinical readiness for clinical placement in surgical emergency unit.

Probes:

-Please clarify

-Please give us the details

5.What is your experience of the theoretical and clinical preparation for clinical placement in trauma unit?

Probes:

-Please simplify your statement

-Such as

6.What are your perceptions about your theoretical and clinical readiness for clinical placement in the trauma unit.

Probes:

-Please break it down

-For instance

APPENDIX F: TRANSCRIPT OF FOCUS GROUP DISCUSSION 2

I Okay, sorry, I will just rephrase to what we were discussing before. The question was: What is your theoretical and clinical preparation before allocation in trauma? Can I get someone now? Yes, number three.

P3: So the only thing that we were prepared for was the emergency trolley of which it was only done like in skills lab. There was nothing that was practically like showing it how to do it, it was only the trolley. What do you get under first drawer, second drawer, third drawer and some other equipment, you are told how to use them. But you are not really exposed on how to use them on real patients or real [humans]. I was working with when I was working for my clinic. There was also an emergency there. So it was me and the male sister. I didn't know what to do. I didn't even know like some of the equipments. I know there is an emergency trolley and it's where I'm supposed to get things. But I didn't know how to connect things; how to what to do to help them.

I So how do you how did you feel about it?

P3 Oh, I was I felt [dumb] like if I didn't know anything. So now you're standing right next to the doctors, the only thing I was writing was the medication that has been given and also the time, but at that time, it was an emergency and it was the only the only two of us; the doctors only came afterwards. (TEAM WORK)

I Okay. So what can be done to improve what you're telling me?

P8 So I just feel like they need to like number three, number three said they need to orientate us according to a real-life person.

I Who must orientate now? The school.

P8 The school with the facility because people do it differently according to their facility. So the way they pack their trolleys, the way they do their procedures of emergency has to come in. Where I was placed in Mitchell's Plain Community Health Centre, we were there. We were fresh because we didn't know what we had to do. But then there was a multiple gunshot wound and they just rushed in the students were just standing there. We didn't know what to do. We didn't know we were thrown everywhere - bring this, bring that, bring this bring that () there was I think there was only two doctors and only two professional nurses. There were only two students but they like throw us up and

down and we just felt like there was too much stuff going on. (We didn't know exactly what to do because we were still fresh in our second year when we just learned a few things in the skills lab.

I Okay. Anyone with anything?

P6 I feel like they don't teach us basics like triaging a patient and nebulizing a patient or putting in a drip. We must learn all those things by ourselves.

I Okay, so you're saying that if you get skills or they expose you on how to nebulize the patient from the institution do you think that you will have better experience when you are in clinical?

P Yes definitely.

P6 I feel like because when we can do we know nothing? We must learn everything from scratch. So if they do that, at least at least we'll have an idea what we can do.

P5 And then they like she say a sample thing like nebulizing like they say give (inaudible) now they see…they assume that you can get and now you as a student, I mean, all of us we have you aware our own private (inaudible) that now you're going to rather think it over to yourself. Hey, you're going to take out the equipment for the neb, you're going to stand there because you've seen this before but nobody has explained to you that you're gonna take this and this and this and this is the ration. Here comes the OM can you tell me what is the ratio of the nebs? One is to one. One is to two. All of this it is stuff that we learned there but it's basic things in trauma. Maybe it's not basic to us but if you're going to work in trauma that's basic thing. How many people don't walk through that doors. They just want to be on nebs quickly because they're pump is not working. They don't have this; they don't have…now you as a student … that's basic things – you're right that we're supposed to know how to do, but we haven't learned it in school. It's just something and then you come to the facility and the facility assumes that you now have to give nebs.

I Okay. Do you think that if you can show the sisters on your first day - I understand with trauma, any trauma changing like this one minute is quiet; the next minute is "deurmekaar" So do you think if you show as you're learning outcomes do you think that can improve your learning experience in there or your preparation?

P6 But for us working in trauma, we don't have specific outcomes, (cross-talking) (

P You just get a list.

P (inaudible) to do in trauma, to be honest, and you need to know.

I Okay.

P What we got was you have to take blood, you have to test urine, you have to take something like HBs. It was simple things like that, which has nothing to do with emergency. (ROUTINE WORK) The thing is, even the sister I told her about, like I showed her like on the first day, this is what we must do. And she's like, What are you guys been doing here? You never learning the right…)

I Actual thing that is happening in trauma.

P Exactly. We always get things that are like, out of where we are. It's not it has nothing to do with trauma - the things that we do is - like general yeah

I So how does that affect your experience and your readiness to be there in trauma? If you feel like you only learned basic stuff in the school in the skills lab? How does that make you feel? Or what can be improved for your learning to be to be more fruitful in the hospital? Do you think that you need to learn before they allocate you in the in the clinical setting?

P The thing is even like for … when we started doing emergency in second year, the only thing we got was slides with everything on emergency like small things we didn't even get like everything; like knowledge on this is emergency. You do this and you do that we got like, like a few points on triage only. And then the rest, we only got emergency trolley But then now we went, like, I remember my first day I went there and there was like a resusc, like happening in the morning, I'm standing there. And I like I have no idea what's going on. And this is like, you must observe nicely and learn and everything, but you feel like you're really not prepared. And even if we are to, like, get preparation from school, we don't have enough time. Because the curriculum only has enough space to fit certain things. Because we're going very fast; at a fast pace, like this is what I noticed. They don't have space to fit in what we need, like to learn in the facilities. So they expect the facilities to teach us what we don't know. So but then the facilities also expect us to know, so there is expectations from the school and the clinical that we are not meeting, so there's that gap in …

I That we need to close?

P Exactly.

I Okay, so what can be done to improve what you're saying?

P I don't know. That was just (inaudible) each other and just think together.

P4 I feel like there should also have like, trauma procedures, like we do have with Midwifery or something like that. Like as you said, like, you don't see supervisors in trauma like they don't come like I feel like there should be like, procedures that we do in trauma like this should come in and then they show us okay, guys, this is what is supposed to do and because now even if, what did I want to say now, okay you can…

I Okay, we'll come back to you.

7 So there are …even though trauma is not routine, there are things that are specific to trauma, like you can't say, say somebody comes in with a gunshot wound. That is a common thing. And I wrote now here …realistic situations. The must teach us like very specific things like now we in Midwifery, there's obstetric emergencies but they are teaching us. PPH specifically, this is what you do. What did we do now the other day? Then you do pre-eclampsia, it's also an obstetric emergency – this is what you do so if they can divide emergency and trauma into specific common… specific situations, gunshot wound is going to be common there. Respiratory distress, it's going to be common there so if I can be more specific about emergencies with… you get different types of emergencies, but trauma specific emergencies, how…what is the…

I management

P The management of trauma specific emergencies. You get different emergencies. And you can anybody can study a resusc trolley or emergency trolley. Anybody can put in a airway but when do you do that? You're going to if you have an emergency, as a student now you go to the emergency trolley, but there were steps that you had to do. None-drug management, drug management, there's steps that you do before somebody maybe went into cardiac arrest, maybe he's there for 10 minutes but he didn't go into cardiac arrest yet. The steps you take before that so now we're there.

We're standing next to the red trolley waiting for somebody to tell us this, that It is not specific where you know, guys we're doing… we have PPH, now let's get our catheter… let's get the (inaudible) selected. Let's get this. This is what we're going to need for this specific situation. It's not very realistic.

I But don't you get in classes I understand what you are learning theory and practicals before they send you to clinical setting. Do you want to get at the management of these emergency situation?

All Yes.

P It was not specific.

P7 In theory, what happen is they will just like say, Okay, this is the guidelines of emergency but they won't go into detail. What do you do, like, management of it? They just okay, emergency trolley resusc, but what in that areas, we don't know. Events that can take place.

I Okay. You wanted to say something number eight?

P8 Like I agree with what she said is that they like there is specific for, like, for Midwifery, PPH and whatever, but we weren't based on actual trauma cases, it was just the emergency trolley, it was just that, but nothing to do like gunshot wounds; cannot breathe; obstruction of the airway completely. Like we didn't do that, as we're doing now. Because they didn't also place trauma as also important, because that's emergency. So we don't actually have completely a nice background of emergency.

I Okay, so do you think that if you get lectures on maybe head injury or appendix management, do you think that that will make you ready and prepared to be allocated in the placement if like you are located in surgical? So if you get classes about a certain situation, because there are a lot of situations that are happening in trauma and that I think they are happening at the same time? So do you think that if you're getting maybe skills on appendix and then they allocate you in surgical emergency, will that close the gap or will that make you feel you are ready to be allocated in surgical emergency? Because you said that I there is a there is that there's a gap between what we are learning in class and what you are practicing in skills and what you are expected to do in the in the setting so do you think if there's a sort of

routine or balance, maybe your readiness towards placement in emergency will change? Or what can be done?

P6 I just realized more emphasis needs to be put on trauma as its own thing and not just a part of the general because you say like you said it is a specialty, but they don't treat it like a specialty. They teach you like any other thing.

I Okay. Did you say something?

P3 So what I was going to say like, what are solutions and everything? I feel like curriculum already is too much. Like what we are already learning in everything. So I feel like they have to educate or they have to tell the sisters in the wards that when students come like we like we are not really prepared because sometimes you feel like when you have to ask something to assist you feel like you're a burden I guess. So if sisters like if the sisters in the ward, like it would be easy for us to go to them and ask and want to know it was going to make a balance we wouldn't fill that void of like okay we would fill a void when it comes to theory but when it comes to practical at least you know what to do because you know that the sister is willing cause I feel like most of like I staying with my (inaudible). I was like, it feels like this when we go to work and we work with the sisters. It feels like they are expecting a lot or too much from us because the minute you ask, haibo, you don't know this thing. They forget that we are students. We are here to learn. We only know theory. We haven't done it practically. So I feel like if they're like not all sisters are like that, but we have experienced such things like whereby sisters and like they like they feel as if we are a burden like they don't want to like to teach us things.

I So do you think that if your supervisors can tell us what is expected from you and what you already know, will that make you feel better oh we would that would that enhance your experience in trauma?

P Yes.

P Their patience are not that high.

P And we will feel completely confident and we know what we're doing.

P5 And we feel confident that we can go and ask the sister this and that because she already knows that we are not entirely competent in trauma.

I You need to say something?

P3 I already said.

P1 In my experience, I remember being there and then for a long time this is just so that we knew nothing even like even resusc. So what they did is they even assigned us to only do like basic things like BP just go and do BP they like chase you away because they don't want you to mess up because you know nothing of resusc. And I remember once also being in a situation where I was alone with a patient, and the patient was seizing, like, I went blank, I didn't know what to do. So I ran out, I ran to the sister, and the sister wasn't there. So the doctor had like to come in and just help the patient turn on the other side. Like, at that time, I didn't learn like, how to

I The management of seizure.

P1 And even when we learned, it wasn't like in the like, what to do, like, in that situation. So I feel like if we, if like they say the sister know like, what we know and what we do not know, they would like lower the expectations and like, also not treat as bad because we do not know. It's not our fault that the university is not teaching us these things. So I think that will be helpful if they know what we don't know.

I Okay, thank you very much. So now I wanted the positive and the bad experience while you were in trauma, what was your positive and a bad experience while you were allocated in trauma? Anyone?

P I think positive. I don't remember a bad experience. But for me positive, I learned a lot in trauma, like putting on a drip; drawing blood – that's the things I learned there. Yeah, I learned a lot in trauma.

I Did you learn those procedures in school before you are allocated in trauma?

P No I got it from there. Like the sisters were willing to help if you don't know, they show you this is how you're supposed to be doing it. And then by the time I left, I already knew how to but we didn't learn it here at school, no.

I Okay. So is there anyone with a positive experience?

P5 I worked a lot in trauma. So, for me, it was very nice to work in trauma. I was working at Delft Hospital. The were very nice, like, how can I say, I felt very at home there. And that's why I also learned a lot. I wanted to say something now. (laughter) What did I want to say now? That's fine.

I It's fine. It's fine. It's fine. It's fine. Do you want to share your own experience?

P8 So what trauma like if majority, basically, we learn something new, like putting up a drip, throw up, and everything else besides what we would have still in the future learn at varsity. But it was really nice, like the staff that I worked with, they were very encouraging, encouraging, they said, if you need help, we are here to help you. So it depends on like, on the type of people, the type of facility, who is working there that are willing to help the students and to release that anxiety off you. Because, like, the first time that I was the I stood in one side and stood in one corner and just looked and observed. And then it's also you also feel so like you're not supposed to be here. Like it feels, but it was really nice, because they encourage you. They said okay, I said I'm scared to put up a drip. They said, Oh, okay, and then show you how to do it so that you know, and it was for me that experience was good. Like, I actually didn't have any problem with it. It was fine.

I Okay, anyone with a good experience?

P5 Okay I got it back now. I think I have adult ADHD – my mind. I try… I liked the sense of independence that I got, or that I felt when I got used to. So when you say for certain amount of time, you see, okay, this is common and that is common. So that is what I'm going to do next. I'll just inform the sister if she advises yes, it's fine. So the things we learn in first year, like wound care, doing dressings, da-da-da. There are gonna come a lot of that. So then I felt a sense of, okay, now I know what to do. And when the sister saw that you were competent, that's when they actually gave me my freedom to be here9 on the floor. I didn't need the sister. They weren't…they were very supportive. Like she said also, they were very supportive of, maybe they will show you the first or the second time, but I mean you do get along. And then I felt very, I felt very big, or very grown after a while. (laughter) And it was very exciting also to see new things every day. It's not the same. It's too boring. It's just the fact that if you are more prepared, I feel like you will enjoy it even more unless you have anxiety and you don't like what can you not knowing what's coming next. For me, it was exciting.

I Okay, is there anyone with a bad experience? Okay, so basically what you're saying that if you can be prepared from the School of Nursing, before they allocate you to trauma or wherever you will know what to do, because they seem like you're saying that most of the time you don't know what to do as a result, and then there's a high expectation from the sisters, we assume that you know why you are there and yet, you don't know. So it's like your outcomes are unclear on why you are located in there. So if they can clarify what is expected from you, then maybe we will have a better working relationship, and then it will give you more learning opportunities. Is that what you're saying?

Ps Yes. ‘

P5 Maybe we can use trauma, have trauma as a module, like we do general nursing for two years. So maybe we can take some of that time or maybe just a term and dedicate that term to for trauma. Then that will allow us to be more specific because if you think about it, we had two years GNS and only third and fourth year, we specialise in community, midwifery and psychiatry, part of that two years where they put trauma in they can use a term or semester and make it trauma specific.

I Okay, so how do the other people feel about what she's saying?

Ps We agree.

I You’re agreeing?

Ps Yes.

I If like they can be a term for trauma. So if you're saying that you also want to be if you're doing trauma in class, do you also want to be in trauma?

P A (inaudible)?

I No, I mean, you started trauma in class skills lab and then you are placed in trauma?

Ps Yes.

P5 Because I don't think trauma should fall under General Nursing. It is a specialty outside or if it's a postgraduate specialty, why is it not a specialty? Why is it general within the undergraduate program?

I Do you want to add?

P No she said everything.

I And you? You were raising your hand. (laughs)

P I was just (inaudible) with what you are saying. It makes sense year.

I Oh okay, then let's move to number two. I just have three questions. We shared a lot of experience about trauma and then number two you remember I said in the beginning trauma is surgical emergency, medical emergency and the trauma where you see fractures, gun shots, (chest) and that is also that is all trauma. So what is your experience, what is your clinical preparation and practical preparation before they allocate you in surgical emergency unit? Surgical is where you will see your appendicitis, peritonitis.

P Does it fall like… brain tumor?

I Yes, that is surgical. So what is your preparation towards that?

P3 I'm only finding out today that there are different types meaning that there was no preparation.

I There are different types of trauma.

P I only knew that today so meaning that there was no preparation. We were only told how to do…

I Emergency trolley. Wow.

P1 So what you're saying now, according to what you're saying now, what we are doing with what you've said, it's those procedures or those theatre emergencies they fall

under theatre by us because when I was placed in theatre that's when I saw everything that you just mentioned. So it doesn't fall under emergency. It falls under theatre.

I Yeah, but that's a surgical emergency before we transfer those patients to theatre, we stabilise them in surgical emergency before we send them to theatre.

P But I didn't say (inaudible)

I She needs to say something please hold on.

P2 No as for me, I just wanted to say I didn't know also that there is like surgical trauma. I only thought maybe trauma…

I Trauma is also … (cross-talking) (chest) gunshot, fractures.

P When I was working at trauma I only expect like gunshot, stabbing. Only that or car accident.

I Okay.

P5 Okay, so with that part I just wanted to add on what she said. It was like we were just basically, we had so much hours to do that. We put our concentration on the hours. I didn't even know about the surgical and medical split, but I found it out very late while I was already at the facility.

I That is different, trauma is different.

P5 And how I assumed it was on the placement trauma, then this medical trauma and surgical trauma, how I assumed that it was is that your hours will be placed under medical or under surgical because when we do hours, we are placed in medical wards and surgical wards. So when I saw trauma medical, I just assumed hi she's is going to put my extra trauma hours under the medical Or when I see trauma surgical I assume she's gonna put off because for trauma, we only need about 100 hours. So assume that when I'm done with my 100 trauma hours, she will put this extra trauma hours under surgical. So it was a lot of assumptions. We didn't like know this, like I also said earlier, like the realistic situations that this would be a surgical emergency' this would be a-679medical emergency.

I Who wanted to say something? Was it you? Okay. (inaudible) it seemed like you didn't know that trauma is divided into three. So with that, how do you feel about that? When it comes to preparation, you said that it will be better if you can find an example maybe you can get a term where you study all trauma cases in school, skills lab before you go to the clinical setting. Now that today you've learned that trauma is three aspects, so how do you feel about that in terms of your preparation for those departments?

P5 I feel like they… it seemed like they really deprived us of an opportunity to be a bit more advanced, saying that we are going to be registered nurses. It was an opportunity for us to learn advanced things but instead of us doing that we ended up doing vital signs four hourly; two hourly. You know, to be nurses, we general nurses. We're nurses before we are registered nurses before we are anything else. I'm not undermining that part of it but I'm saying it was a learning opportunity because we were in that facility, we could have learned more about it. Instead we end …we didn't end up learning we ended up working we were working there; working hours things that we knew how to do. So if you are just working and you are not learning; if you are just working and not learning anything new then you are not learning - you are working.

I Because you are included as part of the staff you're not …

P You are just working.

I You're not recognized as the student.

P5 And then when they was emergencies it would have been nice if we were included in that setting up and I mean, we did medication, we did injections. So we could have been part of that advance team that is busy there with an active resusc. Actively being part of the resusc; not standing there with a pen and paper; not doing vital signs. I know it is important aspects but there was more and now we have to learn these things when we are after when it's supposed to be part of the undergraduate programme where we could have where it was opportunity for us to learn advance things, because we were there. We were able to but it wasn't taught to us.

I But remember, you cannot be a specialist with 100 hours only. That is why they are giving you 100 hours. Because remember, you are you are just doing an undergraduate programme, but when you're doing the actual trauma course, then you will work from January to December in all the… it all the expert of trauma, but now you must remember that your programme is designed that you only have 100 hours in trauma.

P5 So what are they exposing us to?

P7 I feel as though even your place where you place for that 100 hours. If you're just doing the basic things, you're not going to learn anything so there's not going to make you want to do the advance course afterwards.

I Okay. Okay. So would we say that before they are located in trauma, they need to teach you a specific thing for that department before you are allocated in that department?

P Yes, so when you go there you don't feel as though oh, I don't want to be here. Or you think let me rather stay out. That makes you want to come to work because you know, you're going to be excited to test the theory part of it and make it into a practical scenario.

I Okay. Thank you very much for your cooperation. And then the last question is on medical. Remember we are finish with trauma. We also discussed the surgical emergency. Now we are going to discuss about the medical emergency. Medical emergency is like there's a trauma but that trauma is where you will see your patient with cardiac arrest, asthmatic attack, CVA your seizures, so are you how do you feel about the preparation before they allocate you in that department that is also emergency. You must remember emergencies - anything that, is any illness that seeks urgent intervention. So how are you prepared before they allocate you in medical emergency wards or units? Anyone?

P5 So we did first aid and I think a lot of those things were covered in first aid so they just assume that okay, no, maybe we should know this because they do like cardia arrests and unconscious patients and stuff like that. So maybe they just assumed, oh, no, we did the first aid course through them that we will be fine. So they placed us in a medical trauma, which is not really the same because if a person was admitted that that means that there are other things other than that first aid, that immediate action there are other management that's gonna take place. So what are those management because we're going to be there? What is the management because we're going to be there? Why did you admit the patient if you're just going to stabilize the patient that it doesn't end there. So first aid is not adequate in teaching us how to work with medical emergencies.

I Anyone?

P6 I want to add. What you're talking about we did the first aid but that was in like an outside scenario and not in hospitals scenario.

P8 Like with her, what she said like it was outside it was like more like if you find the person like first aid if you find a person on the…

I Road.

P8 street but it wasn't to do with medical base like a hospital based or trauma base. It was just there if you were there then you'd do it.

I What is expected of you to do.

P8 So it was just where the patient was there where we found him. It wasn't to do with hospital.

I Okay, okay, no, it's fine. Thank you for that. So above all, what is your recommendation as nursing student before you are located in emergency unit? It doesn't matter if you are located in trauma, surgical or emergency above all, what can be done to prepare you or what can be done to make you feel like I'm ready to be in trauma. I'm ready to be in surgical. I am ready to be in medical emergency or what can be done to improve your experiences or your theory or your practicals before you get a clinical placement in those departments what can be done?

P3 I think they already said it with the thing that we have to be prepared before we go in that we have to be given maybe a term just to learn about trauma. That we must divide it the way that you told us now that in medical trauma this is what you must know. In surgical, this is what we know and also and also the other ones so if they can teach us already when you go there maybe you get placed in surgical you can you know that okay, you know you're supposed to learn in surgical. So because now we are getting placed we don't even know what we must learn. The sister can ask you so what are your learning outcomes? We don't have any (inaudible)

I But is there nothing on the medical or on the module guide?

Ps No.

I Really?

P7 It is like one whole list for the whole year. It is not like specific.

P And then they just divide into the drugs, the airway and the (inaudible)

I So you're saying that you're in second year you're only placed for emergency trolley?

P Yes.

P Not really placed for emergency trolley. (inaudible) the thing else inside you don't even know if you're in medical trauma or surgical trauma. You know that you're only there. Because you asked us now where did I work and I told you that in clinic and you said that I'm going to know a lot but no I know nothing.

P5 And I feel like this is very like I feel like they're using. If they're not going to teach us anything in trauma and they're gonna place us there they are using us as workers.

I Who is using you? The staff?

P The staff.

P5 No honestly it's the university that send you there with this minimal knowledge so now you are just working there and now some people let's talk about it some nursing staff they are very wonderful ones and then the others are just like they're still not gonna bother to teach you does just do that because that's what you can do. So they push you aside so what am I doing there? I'm working. And not to mention (inaudible)? So you're just working, not learning. I don't mind if I'm learning because that's what I'm here for. But at the end of the day if I'm just working.

P You don't see the point in anything.

P5 You don't learn anything I'm not interested. It's boring.

P My transport is here.

I Transport is here? Okay, no, it's just a (inaudible) and then we can go. Thank you very much for your time. I hope I what I gained from you mighty I hope they will do something about what we discussed today. Otherwise, thank you very much. Good luck with your exam and everything. Thank you for your time.

P Good luck to you also.

I Oh thank you.

APPENDIX G: TURNITIN REPORT