

GUIDELINES FOR PROFESSIONAL SOCIALISATION OF STUDENT NURSES

by

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DECLARATION

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I declare that **GUIDELINES FOR PROFESSIONAL SOCIALISATION OF STUDENT NURSES** is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

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ABSTRACT

An increase in reports of undesirable professional behaviour in the nursing profession has prompted the question: *How could the internalisation of skills, knowledge, values and beliefs be guided in student nurses to help them become effectively socialised as professional nurses?* Using a sequential exploratory mixed-methods approach, the study addressed the above question. The researcher used focus-group interviews and field notes to explore and describe the perceptions of professional nurses and experiences of student nurses regarding the professional socialisation of students. The data generated from these findings were further used to determine and describe educators' (N=128) perceptions on their teaching and facilitation of professional socialisation of students, using a self-administered questionnaire. The findings of both the qualitative and quantitative data were integrated to develop and validate guidelines to support educators and professional nurses in the professional socialisation of students. To establish rigour, the researcher applied measures of trustworthiness and performed validity and reliability tests.

The qualitative data were analysed by utilising Tesch's method of data analysis. The themes that emerged as influential in the professional socialisation of students were related to the professional nurse as role model, clinical supervisor, the educator, clinical learning environment, values and beliefs of the nursing profession and cultural and gender orientations. The quantitative data were analysed using descriptive and inferential statistics. Educators' teaching and facilitation strategies revealed that the educator as a role model, the clinical environment, teaching approaches and cultural awareness were important social determinants in the professional socialisation of students. The qualitative and quantitative data were integrated to develop guidelines that were validated by field and guideline experts. The guidelines for educators and

professional nurses addressed issues such as the professional nurse as role model and clinical supervisor, the creation of a positive clinical learning environment, the educator as role model, the teaching and support of students, the work ethic of the professional nurse and educator, the students' behaviour and cultural awareness. These guidelines propose recommendations for educators and professional nurses to support the professional socialisation of students.

KEY WORDS

Professional socialisation, guidelines, student nurses, professional nurse, nurse educator, cultural awareness, values, beliefs, mixed methods research, role model.

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Dedication

This study is dedicated to my husband Laumi, my children Leonore and Gaulaumi and his fiancé Mieke and my mom Nora, with love and appreciation.

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List of abbreviations

CHE	Council on Higher Education
CPD	Continuous Professional Development
DoH	Department of Health
DoHE	Department of Higher Education
NEA	Nursing Education Association
NEI	Nursing Education Institution
PPE	Positive Practice Environment
RNAO	Registered Nurses' Association of Ontario
SA	South Africa
SANC	South African Nursing Council
SAS	Statistical Analysis System
UK	United Kingdom
Unisa	University of South Africa
US	United States of America

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The fundamental goal of teaching student nurses is to ensure that they will be able to provide quality nursing care to patients. Since the first school of nursing was founded in 1800 at the University of Heidelberg in Germany, doctors and nurses have attempted to prepare nurses that are well trained (Kotzé 2008:114). William Osler (1849–1919), a Canadian doctor, said of a well-trained nurse: “The trained nurse has become one of the great blessings of humanity, taking a place beside the physician and the priest, and not inferior to either in her mission” (Qotd.org 2012).

To become a “trained” nurse, or in current terminology a professional nurse, involves a complex process. This process includes the socialisation of a person into the nursing profession. Socialisation of an individual commences with childhood, followed by adulthood and continues when entering into an occupation. During primary socialisation in childhood, the emphasis is on the development of language, motor skills and learning values. Adulthood, or secondary socialisation, focuses on the development of role behaviours and values associated with a specific role as an adult (Edles & Appelrouth 2011:295). Socialisation can be divided into re-socialisation and anticipatory socialisation. Re-socialisation aims to change former behaviour patterns, while anticipatory socialisation comprises the beliefs and attitudes an individual holds regarding a group or occupation before he or she becomes a member of that group (Elias 2006:85).

Professional socialisation, also considered as anticipatory socialisation, refers to the formation and internalisation of the characteristics that are typical of a profession (Brennan & McSherry 2007:207). These characteristics involve the development of skills, knowledge, values and beliefs to form a professional identity (Chitty & Black 2011:131). During the socialisation process, a student nurse learns and applies certain skills, knowledge, norms and values of the nursing profession in order to fit into the nursing culture (Kotzé 2008:92).

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Socialisation does not occur in a vacuum; social institutions act as agents in the process of socialising a person into a certain role. Social institutions are related systems of norms, patterns of behaviour, tradition and attitudes that will determine a person's social function. Examples of such social institutions are religion, education, economy and the family (Miller 2012). Education as an agent may significantly influence students' professional socialisation (Cornelissen 2006:132).

The process of professional socialisation differentiates between formal and informal socialisation (Chitty & Black 2011:132). The formal process is guided by a curriculum, which is a documented plan of a programme based on scientific and didactic principles (Meyer & Van Niekerk 2008:49). It is imperative that a nursing school carefully plans learning and teaching strategies, as well as organises the content of nursing curricula, because doing this will promote and transform nursing knowledge, skills and values (Chan & Chan 2009:225; Morris & Faulk 2007:451; Rhodes, Schutt, Langham & Bilotta 2012:27). The macro curriculum, which is usually designed by experts, provides a broad outline for courses, stating the principles that are prescribed by a registering body (Meyer & Van Niekerk 2008:41). In designing a curriculum, these experts consider various aspects such as regulatory bodies, legislation and the needs of the community (Meyer & Van Niekerk 2008:49; Uys & Gwele 2007:24). In South Africa, the South African Nursing Council (SANC), and Council on Higher Education (CHE), Department of Health (DoH) and the Department of Higher Education (DoHE) regulate the design of a nursing curriculum.

Informal professional socialisation, on the other hand, could be described as the so-called hidden curriculum. The hidden curriculum is the unintended learning that takes place to shape students' attitudes, values, beliefs and associated behaviour (Barania, Azmab, & Seyyedrezaic 2011:1658). Informal socialisation occurs incidentally, by for instance the student nurse observing the behaviour of a professional nurse giving patient care, having discussions on patient issues and in general, and absorbing the culture of nursing (rituals and valued behaviour of the profession) (Chitty & Black 2011:132).

The success of the implementation of a curriculum lies in the quality of planning and design regarding day-to-day teaching and learning activities (Carl 2009:134; Kotzé 2008:176). The importance of a well-designed curriculum is emphasised by Karesth (2004:642): for example, the inclusion of moral issues could promote the development of a moral conscience. However, the influence of the informal curriculum may be more challenging. These teaching and learning activities may include a variety of teaching strategies, utilisation of mentors, preceptors, educators and the creation of a supportive learning environment.

The role of mentors and preceptors has been explored by several studies. The positive influence of the preceptor and mentor enhances the development of knowledge, skills and positive attitudes (Leners, Wilson, Fenton & Connor 2006:653; Sedgwick & Yonge 2008:62; Smedley 2008:190). Regarding the role of the educator, Bourbonnais and Kerr (2007:1548) found that visibility and support of educators complement the fostering of an effective preceptor programme and support professional socialisation. Both the educator and the mentor or preceptor influence the student's socialisation process.

An additional influential factor is the conscious and subconscious effect of role models on the professional socialisation of students (Perry 2009:36). The deliberate modelling of skills, knowledge and attitudes shapes not only students' socialisation, but also their unintentional modelled behaviour (Chan & Chan 2009:225; Donaldson & Carter 2005:353; Licqurish & Seibold 2008:487, Smedley 2008:189). Exemplary role models tend to detail nursing care, relate with ease to students, patients and colleagues and have the ability to affirm the value of other persons (Perry 2009:39–43). In contrast, poor role models are described as unhelpful and generally unsupportive regarding students' learning needs (Licqurish & Seibold 2008:487). Role models, both in the clinical and academic field, who reflect undesirable knowledge, skills and attitudes, create internal conflict within the student regarding explicit and implicit professional values (Andrew, Brainard, Heather & Brislen 2007:[1]).

In addition, the effect of a favourable learning environment that supports the student in the development of the cognitive, affective and psychosocial domains has been acknowledged by several authors (Chan & Ip 2007:677; Kotzé 2008:192). The learning environment, whether clinical or academic in nature, should be humanistic, authentic, supportive and caring to optimise learning in a student (Meyer & Van Niekerk 2008:107;

Smedley 2008:190). In contrast, an unsupportive learning environment contributes to feelings of humiliation, inadequacy and being unwanted (Licqurish & Seibold 2008:487).

Apart from teaching strategies, the influence of a mentor, preceptor, role model and the learning environment, internal factors such as the person's own feelings, beliefs and previous experiences may influence the process of professional socialisation (Price 2009:14). Students' own perception of how a professional nurse should be will influence their professional socialisation (Price 2009:15). The values and beliefs of peers and adults, as well as their influential worldviews, are external influences that will also shape the student to aspire to a specific image of a professional nurse (Price 2009:20).

It is evident from the literature that various factors influence the professional socialisation of students. Despite this wealth of knowledge on professional socialisation, stakeholders are still faced with the challenge of how to teach and facilitate the internalisation of the desirable skills, knowledge, values and beliefs in students, eventually to fulfil their role as competent professional nurses. This challenge is reflected, for example, in the type and number of reported cases of professional misconduct. These include unethical behaviour, administering of wrong medication, inadequate care, sexual harassment and poor competency standards (Holder & Schenthal 2007:26; Hout, Cuperus-Bosma, Hubben & Van der Wal 2005:794). In South Africa, the incidence of professional misconduct is evident from the 491 complaints investigated by the SANC from June 2003 until June 2012. Of the 491 cases, the highest number, namely 179, was reported in the Gauteng Province (SANC 2012a). These complaints included poor basic nursing care, poor nursing attitudes, physical and verbal abuse, fraud, theft, education-related issues and sexual harassment. In addition, studies related to the professional socialisation of students in the South African context reveal that student nurses are exposed to unethical behaviour from their superiors. Students are humiliated, called names and witness uncaring behaviour by their role models (Beukes, Nolte & Arries 2010:[5]; Mabuda, Potgieter & Alberts 2008:24).

The researcher is personally involved in the formal and informal professional socialisation process as a nurse educator. The researcher had similar experiences to those mentioned above: undesirable behaviour was observed in not only students but also professional nurses in the health institutions where students gain their clinical

learning experience. Role models acted unprofessionally and were unsupportive of students' learning needs. Students also reported cases where they witnessed physical abuse of patients, and professional nurses leaving the hospital premises during their shift to do shopping, leaving skeleton staff and students to care for patients. This kind of behaviour has an impact on patient care, as well as on the socialisation experiences of students. Furthermore, the image of the nursing profession in general may suffer from such behaviour.

From the above discussion, it is evident that various factors influence the professional socialisation of students. Despite the abundance of knowledge on these factors, it remains a challenge to support effective professional socialisation in student nurses. Although the concept and phenomenon are well explained in the literature, the gap that was identified is that there are no guidelines to implement the principles of professional socialisation on the operational level. The implication is that professional nurses and nurse educators are not supported to fulfil their responsibilities concerning the professional socialisation of students.

1.3 RESEARCH PROBLEM

Undesirable internalisation of skills, knowledge, values and beliefs of students may result in ineffective professional socialisation. In South Africa, a professional nurse is guided by the Nursing Act (South Africa 2005a:34), Regulation to the Scope of Practice (SANC 1984:R2598), the Regulations on Acts or Omissions (SANC 1985a:R387), *Batho Pele* Principles (South African Government Information 2007:[1]) and the Patient's Rights Charter (Mellish, Oosthuizen & Paton 2010:170). These regulatory measures, the various curricula of universities and colleges and the influence of the informal curriculum direct the professional socialisation of students. Despite these regulations and curricula, student nurses become professional nurses that do not always demonstrate the desirable levels of knowledge and skills or portray the appropriate values and beliefs of the nursing profession. The research question for this study is therefore: *How could the internalisation of skills, knowledge, values and beliefs be guided in student nurses to help them become effectively socialised as professional nurses?*

1.4 RESEARCH PURPOSE

The purpose of this sequential mixed-methods study was to explore and describe the perceptions of professional nurses regarding their role in the professional socialisation of students, and the experiences of students regarding their professional socialisation as members of the nursing profession. Themes generated from the qualitative data (phase I) were developed into items for a questionnaire to determine and describe educators' perceptions on their teaching and facilitation of the professional socialisation of students (phase II). Qualitative and quantitative data were integrated and then used to develop and validate guidelines that could support nurse educators and professional nurses in the professional socialisation of students.

1.5 RESEARCH OBJECTIVES

The objectives of this study were to

- explore and describe the perceptions of professional nurses regarding their role in the professional socialisation of students in an academic hospital in Gauteng
- explore and describe the experiences of students regarding their socialisation as members into the nursing profession in an academic hospital in Gauteng
- determine and describe the perceptions of nurse educators on the teaching and facilitation of the professional socialisation of students registered for the four-year integrated nursing programme in Gauteng
- develop and validate guidelines to support nurse educators and professional nurses in the professional socialisation of students

1.6 SIGNIFICANCE OF THE STUDY

Reports of patients receiving poor nursing care as well as unethical treatment by nurses seem to be common (Makhubu 2011:4; Myburg 2007:133; Oosthuizen 2012:58). This type of behaviour leads not only to disciplinary hearings, as reported by SANC, but also to a decline in health care in South Africa, which has an effect on the country's economy and the image of the nursing profession. The notion has been reflected in the words of President J Zuma, when he stated that nurses should change their approach to caring

for patients or clients. He called upon nurses to improve healthcare through nursing practice, training, development, management, leadership and research (Zuma 2011).

The development of a professional conscience is rooted in the professional identity of a nurse. The development of professional identity or professional socialisation seems to be influenced by diverse factors; the nurse educator and professional nurse form an integral part of this process. It is therefore important that students are supported in the development of a professional identity that will reflect those qualities needed to provide quality patient or client care and will uphold the image of the nursing profession. This research endeavoured to provide the educator and professional nurse with a guide that would support this process of effective professional socialisation of students.

Furthermore, applied knowledge of the professional socialisation of student nurses was developed. Firstly, the study explored and described the perceptions of professional nurses and the experiences of student nurses related to the professional socialisation of students. Secondly, it examined nurse educators' teaching and facilitation of the professional socialisation of student nurses in the Gauteng province. This evidence resulted in the development of guidelines to support nurse educators and professional nurses in the professional socialisation of student nurses.

1.7 DEFINITIONS OF THE KEY CONCEPTS

• Professional socialisation

Chitty and Black (2011:131) describe professional socialisation as a process through which a person acquires the knowledge, skills, values and ethical standards to form a professional identity. For the purpose of this study, professional socialisation is viewed as the internalisation of knowledge, skills, values and beliefs to form a professional identity.

• Nurse educator

According to the regulations (SANC 1987, R118, para 1(i)), a nurse educator is a person who has undergone a programme of education at an approved education institution and who is registered for an additional qualification in nurse education. In this

study, a nurse educator is defined as a person who teaches and facilitates student nurses following the four-year integrated nursing programme to become competent professional nurses. The nurse educator will hereafter be referred to as an educator. Furthermore, this study considered certain characteristics of educators, namely being a role model and having the ability to work together with others in a team.

- **Professional nurse**

According to the Nursing Act, No 33 of 2005 (South Africa. 2005a:6) a professional nurse is a person who is registered as such in terms of Section 31 of the Act. In this study, the term professional nurse may also indicate professional midwife. In this study, a professional nurse is a person who practises in a specific clinical environment where students are placed to acquire clinical experience to fulfil the objectives of their nursing programme. The professional nurse's role and responsibility concerning students is to guide and mentor them to become professionally socialised.

- **Student nurse**

A student nurse, according to Kotzé (2008:187), is a person who has successfully completed 12 years of schooling and has met the entrance requirements of an approved nursing school. In the context of this study, a student nurse means a student who is registered for the programme regulated by Regulation 425 of 1985 (SANC 1985b), also referred to as the four-year integrated programme. On completion of this programme, the student will be registered as a professional nurse (general, community and psychiatric) and midwife. In the discussion to follow, the student nurse will be referred to as a student.

- **Perception**

Perception is the way in which a person notices things through their senses, the way a person thinks about something and the natural ability to understand things (Dictionary.com 2012, sv "perception"). In the context of this study, perception entails how educators and professional nurses perceive the process of professional socialisation of students in the nursing educational and clinical environment.

- **Experience**

Experience is knowledge gained of something a person has seen or encountered (Dictionary.com 2012, sv "experience"). Experience in the setting of this study implies the encounters students have while being exposed to the clinical and educational environment.

- **Facilitation**

Facilitation is described as an act of assisting or making easier the progress or improvement of something (Dictionary.com 2012, sv "facilitation"). Facilitation in nursing education is viewed as a process followed to enhance the development of students in their professional socialisation.

- **Teach**

To teach a student means to impart knowledge or skill to a person (Dictionary.com 2010, sv "teach"). For the purpose of this study, teaching means to equip a student with the appropriate knowledge, skills, values and beliefs to become a professional nurse.

- **Guideline**

A guideline is defined as a principle put forward to set standards or determine a course of action (Falex 2013, sv "guideline"). In this context, guidelines mean directions on supporting a student in the process of professional socialisation.

- **Clinical learning experiences**

Clinical learning experiences are described as those unplanned experiences in the clinical field through which students learn the skills, knowledge, values and beliefs to nurse real patients (Billings & Halstead 2009:285; Ransie & Grealish 2007:172). Clinical learning experiences in this study refer to the learning experiences that will occur while student nurses are placed in a clinical environment where they actively take part in

caring for patients. Students may or may not receive remuneration while caring for patients and obtaining their clinical learning experiences.

- **Clinical environment**

The clinical environment is described as a place where students learn to apply in practice their synthesised theoretical knowledge (Billings & Halstead 2009: 286). The clinical environment in this study refers to an environment where various health care professionals care for patients or clients.

- **Values and beliefs**

Values are learned and originate from experiences; they are reflected in behavioural patterns and moral judgement, while a belief is described as an intellectual orientation or conviction on whether something is true or false (Chitty & Black 2011:292; Rassin 2008:615). In this study, values and beliefs are those values and beliefs manifested in the behaviour patterns of educators, professional nurses and students.

- **Cultural awareness**

Cultural awareness is described as a person's awareness regarding his or her own cultural assumptions and preferences (Hawala-Druy & Hill 2012:777). Cultural awareness is described in this context as the sensitivity educators, professional nurses and students have regarding their own and others' cultural orientation.

1.8 FOUNDATION OF THE STUDY

The foundation of the study will be discussed in terms of the philosophical paradigm and theoretical framework.

1.8.1 Philosophical paradigm

A paradigm refers to one's general worldview on the complexities of the real world (Polit & Beck 2008:14). There are mainly four broad paradigms, namely the naturalistic (constructivism), post-positivistic, participatory and pragmatic paradigms (Creswell &

Plano Clark 2011:41). This study was approached from a pragmatic point of view. A pragmatic paradigm will approach a research problem from different angles, which underpin the belief of both a constructivism and post-positivism paradigm (Creswell 2003:6; Polit & Beck 2008:310). A pragmatic view focuses on obtaining the best possible answer to a problem (Creswell & Plano Clark 2011:41). The search to understand the internalisation of knowledge, skills, values and beliefs in students guided the research approach that resulted in using a constructivist (phase I) and post-positivist (phase II) approach in this study. The researcher considered both single and multiple perspectives during this study.

A constructivist paradigm consists of multiple realities, namely subjectivity, individuality and the context where the research is conducted (Polit & Beck 2008:15). The perceptions of professional nurses and experiences of students regarding the phenomenon *professional socialisation* (naturalistic paradigm) are subjective and may be influenced by various events. The natural environment in this study was the one in which the professional nurses and students perform their daily activities. This setting allowed the researcher to gain an understanding of the phenomenon of *professional socialisation*. Conversely, the underlying belief of the post-positivistic paradigm is that observable facts and events occur as a result of antecedents; it is characterised by reductionism, detailed measurements of variables and testing of theories (Creswell & Plano Clark 2011:415). The views on the teaching and facilitating of educators concerning the professional socialisation of students were obtained through numbers and facts in an objective manner. Therefore, both these paradigms guided the approach to addressing the research problem.

In addition, the underlying philosophical assumptions guide the departure point of a paradigm. Assumptions are accepted truths that are not scientifically tested (Brink, Van der Walt & Van Rensburg 2012:27). These assumptions are usually described in terms of ontological, epistemological, axiological, methodological and rhetorical assumptions, which will be discussed below.

1.8.2 Ontology

Ontology refers to reality, meaning that the real world is determined by natural causes (Polit & Beck 2008:14). Both single and multiple realities may influence the research

evidence. In this study, it was assumed that the perceptions of professional nurses regarding their role in the professional socialisation of students, and the experiences of students regarding their professional socialisation, were unique and authentic. In addition, the manner in which the educators teach and facilitate professional socialisation to students may have an influence on their professional socialisation. Thus, the perspectives of professional nurses, students and educators regarding the phenomenon *professional socialisation* assisted the researcher to discover and understand realities. The researcher also believed that internalised knowledge, skills, values, and beliefs related to nursing form the foundation of the professional socialisation of students.

1.8.3 Epistemology

Epistemology is described as the theory of knowledge (Holloway & Wheeler 2010:339). Knowledge could be obtained either through objectivity (positivist stance) or subjectivity (naturalist stance) (Maree 2007:31–32). In order to develop and validate comprehensive guidelines for the professional socialisation of students, wide-ranging data were needed. It was therefore assumed that a combination of a subjective and objective perspective would provide the best evidence regarding the *professional socialisation* of students as a phenomenon. This study therefore explored and described subjective perceptions and experiences of professional nurses and students, while objective data from educators' perceptions of their teaching and facilitation of professional socialisation were collected.

1.8.4 Axiology

Axiology addresses the role of values and biases in the research process (Manson 2006:167). It was assumed that values and biases related to both the researcher and the participants would influence the approach to addressing the research question. In phase I (qualitative phase) the perceptions of professional nurses and experiences of students were influenced by the participants' values and biases, as well as the interpretation of the data by the researcher; therefore subjectivity had a great influence. This subjectivity allowed for in-depth data generation. In contrast, in the second quantitative phase, preconceptions were limited, since objective data were collected

from educators. However, the data provided by the educators on how they taught and facilitated professional socialisation were also offered from their perspective.

1.8.5 Methodology

Methodology refers to the selection of the research process that will provide the best evidence (Polit & Beck 2008:14). In combining quantitative and qualitative data, the researcher made the assumption that the best evidence would be generated by mixing the data in order to develop and validate the guidelines. These approaches complement each other's unique characteristics, since the problem is addressed from different perspectives.

1.8.6 Rhetoric

The way an idea or evidence is communicated refers to the rhetoric element (Farlex 2012, sv "rhetoric"). The assumption was made that since the perceptions and experiences of participants were primarily described in words to convey the evidence generated, a description using words would be required. In contrast, evidence from teaching and facilitation practices of educators was described in terms of objective numbers, supported to a more limited extent by a description in words. The evidence used in the development and validation of the guidelines was primarily described in words.

1.8.7 Theoretical basis of the study

This study was a sequential, exploratory, mixed-methods design, with the emphasis on the qualitative component of the design. Holloway and Wheeler (2010:11) suggest using a theory as a framework or general orientation to understand the phenomenon in qualitative research. The model as proposed by Cohen (1981:16) for professional socialisation assisted the researcher to understand the phenomenon *professional socialisation*. This model proposed four stages of the development of professional socialisation, as displayed in table 1.1 (Chitty & Black 2011:134). These stages are termed unilateral-dependence, negative-independence, dependence-mutuality and interdependence. The stages may not necessarily occur in sequence, and the duration of each stage may also vary (Cohen 1981:16, 27).

In stage I, unilateral-dependence, the student nurse relies on authority and control by external sources for guidance. Because of lack of experience and knowledge, students do not question the authorities and rely on guidance. This stage is typically that of a student who first enters the nursing profession. The second stage, the negative-independence stage (II), is characterised by cognitive rebellion, where the student nurse no longer accepts all information as true, but questions concepts and ideas. This stage is crucial, because it develops critical thinking. Debating ideas in order to make judgements and inferences is important (Cohen 1981:17).

During stage III, the dependence-mutuality stage, the student develops empathy and evaluates the environment to develop a more realistic perspective. During this stage, role limits are learned and the student tends to associate with role models that are compatible with his or her professional needs and expectations (Cohen 1981:25). During the final stage (IV), interdependence-mutuality, the student nurse acts autonomously but also consults others in order to act independently. Successful completion of this stage leads to the development of a self-concept associated with the identity of the nursing profession (Chitty & Black 2011:135). Cohen (1981:27) further suggests that if any of these stages does not occur, problems may result, for example total rebellious behaviour, professional attrition and role discrepancies.

TABLE 1.1 OVERVIEW OF COHEN'S MODEL OF PROFESSIONAL SOCIALISATION

Stages	Key behaviours	Application
Stage I Unilateral-dependence	Rely on external limits and control determined by authority figures.	Novice student nurse relies for example on the nurse educator for guidance and will probably not question or critically analyse concepts, owing to lack of experience and background knowledge.
Stage II Negativity-independence	Critical thinking abilities and knowledge expand.	The student nurses start to rely on their own judgment. They will question authority, which Cohen describes as the cognitive rebellion stage.
Stage III Dependence-mutuality	Test concepts and facts.	The student nurse evaluates ideas and starts to demonstrate empathy and commitment to others.
Stage IV Interdependence	Develop the capacity to make decisions in collaboration with others. Self-concept includes role identity.	The student accepts her or his role as a professional nurse and acts after consultation with others.

(Chitty & Black 2011:135)

1.9 RESEARCH DESIGN AND METHOD

A sequential, exploratory, mixed-methods design was followed. Mixed-methods research utilises both qualitative and quantitative research approaches to collect, analyse and report research findings in a single study (Sheperis, Young & Daniels 2010:190). The design consisted of a qualitative component (phase I) that collected data from professional nurses and students regarding their perceptions and experiences on the phenomenon of *professional socialisation*. The study was sequential, because the data obtained in the qualitative phase were used for item generation to collect quantitative (phase II) data from educators' perceptions on their teaching and facilitation of professional socialisation in students. In a sequential mixed-methods design, data collection occurs chronologically and steps depend on one another (Teddlie & Tashakkori 2009:26). Finally, all data were used to develop guidelines for educators and professional nurses to support them in the professional socialisation of students. Table 1.2 presents a summary of the research process.

TABLE 1.2 SUMMARY OF THE RESEARCH PROCESS

	Phase I	Phase II	Guideline development
Research objective	<ul style="list-style-type: none"> To explore and describe the perceptions of professional nurses regarding their role in the professional socialisation of students To explore and describe the experiences of students regarding their socialisation as members into the nursing profession 	To determine and describe the perceptions of educators on their teaching and facilitation of professional socialisation of students registered for the four-year integrated nursing programme in Gauteng	To develop and validate guidelines to support educators and professional nurses in the professional socialisation of students
Approach	Qualitative	Quantitative	Inductive and deductive reasoning
Population	<ul style="list-style-type: none"> Professional nurses working in an academic hospital in Gauteng (Population A) Students registered for the four-year integrated nursing programme (Population B) who were placed at the same academic hospital as the professional nurses from population A for their clinical learning experiences 	All educators involved in the teaching and facilitation of the four-year integrated nursing programme in Gauteng	<ul style="list-style-type: none"> Data from phases I, II and literature Experts in guideline development, nurse managers, educators and professional nurses
Sampling method	Purposive for samples A and B	Census	Purposive
Data collection	Focus groups Field notes	Questionnaire	Validation instrument
Data analysis	Tesch's data analysis approach (1990:142–145)	Descriptive and inferential statistics (SAS, Version 9.2 statistical package)	Inductive and deductive reasoning
Rigour	Credibility, confirmability, dependability, transferability and authenticity	Cronbach alpha testing Testing of instrument Face and content validity	Expert review
Data integration	Sample A and B	Data from phase I and literature for the purpose of item generation	Data from phases I, II and literature

1.10 RESEARCH SETTING

The setting for gathering the first qualitative data (phase I) was an 832-bed academic hospital in Gauteng. The setting was selected because of the accessibility of the hospital and participants. Professional nurses (Sample A) worked in this hospital. Students (Sample B) were registered for the four-year integrated nursing programme and were placed in the same hospital setting for their clinical learning experiences.

The quantitative data (phase II) were collected from all educators involved in the teaching and facilitation of the four-year integrated nursing programme in Gauteng. The research was conducted in the Gauteng province, which covers an area of 16 548

square kilometres and has a population of 11 328 203 (South Africa.Info 2012). South Africa consists of nine provinces, of which Gauteng is one. Nine (9) nursing education institutions, five (5) universities and four (4) nursing colleges provide the four-year integrated nursing programme in this province. The educators employed by these education institutions represented the population. LoBiondo-Wood and Haber (2006:134) state that findings will have meaning in a specific setting. In this case, the data on *professional socialisation* as a phenomenon should be interpreted in the context described above.

1.11 ETHICAL CONSIDERATIONS

The three basic principles a researcher should keep in mind when conducting research are beneficence, respect for human dignity and justice (Brink et al 2012:34). The researcher respected these principles by ensuring that no harm was done to the participants, respondents and related institutions, by providing them with sufficient information before they consented to participate. The confidentiality and anonymity of their participation was also assured. To ensure scientific rigour, the Research and Ethics Committee of the Department of Health Studies at Unisa reviewed the research proposal (Annexure I). A detailed discussion of these ethical considerations will follow in chapter 2, section 2.8.

1.12 SCOPE OF THE STUDY

This study's focus was on providing guidelines for educators and professional nurses to support them in the process of professional socialisation of students. The study was conducted in a South African context, specifically in the Gauteng province. Although it is limited to one province, the principles of professional socialisation of students may also be applied to other provinces with similar circumstances.

1.13 STRUCTURE OF THE THESIS

The discussion of the study is divided into eight (8) chapters.

Chapter 1: Orientation of the study

This chapter introduces the background to the problem and the problem statement. It further describes the research purpose, objectives and significance. Concepts to be used are clarified, the foundation of the study is discussed and a brief overview of the research design, methodology, ethical principles, and scope of the study is provided.

Chapter 2: Research design and methods

Chapter 2 describes the research design and methodology, including the population, sampling, data collection and analysis. In addition, the measures to ensure the trustworthiness, validity and reliability of the study and ethical considerations are discussed.

Chapter 3: Data analysis, presentation and discussion of findings of phase I

This chapter discusses the analysis and interpretation of the data obtained from the focus-group interviews conducted with the professional nurses and students, supported by field notes and a literature control. The data of both sets of samples are integrated to further guide the data collection of phase II.

Chapter 4: Literature review

Chapter 4 discusses additional literature on the phenomenon *professional socialisation* in order to locate and orientate what is already known about this issue. The literature was also used to develop items for the questionnaire to be used for quantitative data collection.

Chapter 5: Data analysis, presentation and discussion of findings of phase II

This section offers a discussion of the analysis and interpretation of the data obtained from the educators who were involved in the teaching and facilitation of the four-year integrated nursing programme, through self-administered questionnaires. Descriptive and inferential statistics were used to analyse the data and the results are presented as composite frequency tables, pie and bar graphs with a supportive discussion.

Chapter 6: Discussion of the integrated data from phases I and II

This chapter (6) presents a discussion on the integrated data from phases I and II that formed a foundation for the guidelines.

Chapter 7: Discussion on the development and validation of guidelines to support educators and professional nurses with the professional socialisation of students

Chapter 7 discusses the development and the validation by field experts and experts in guideline development of the guidelines to support educators and professional nurses in the professional socialisation of students. Each guideline is preceded by concluding statements, followed by a set of recommendations to support educators and professional nurses in the professional socialisation of students.

Chapter 8: Conclusions, recommendations and limitations

This section provides an overview of the study, including the recommendations and limitations of the study.

1.14 CONCLUSION

Chapter 1 introduced the complexities of the professional socialisation of students. It highlighted the effects of undesirable professional socialisation that are reflected in poor nursing care and unethical behaviour. A justification for conducting this study was discussed, together with a clarification of concepts. The chapter then described the study's theoretical foundation and paradigm, as well as giving a brief overview of the research design, methodology and the research setting. A short description of the

relevant ethical principles and scope of the study was followed by a final outline of the thesis.

The next chapter discusses the research design and methods.

CHAPTER 2

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

This chapter offers a detailed discussion on the research design and methods, including the data collection, population and sample, measures to ensure trustworthiness, validity, reliability and ethical considerations.

2.2 RESEARCH OBJECTIVES

The first two objectives of this study were to qualitatively explore and describe the perceptions and experiences of professional nurses and students on the professional socialisation of students. The third objective was to quantitatively determine and describe the perceptions of educators on their teaching and facilitation of professional socialisation to students. The last objective was to develop and validate guidelines to support nurse educators and professional nurses in the professional socialisation of students.

2.3 RESEARCH DESIGN

The research design refers to a plan regarding the process that is followed to solve the research problem (Babbie & Mouton 2011:647). This study was guided by the question: *How could the internalisation of skills, knowledge, values and beliefs be guided in student nurses to help them become effectively socialised as professional nurses?* A sequential, exploratory, mixed-methods design was followed to answer the above question. In mixed-methods research the researcher collects, analyses and integrates data and draws inferences from both qualitative and quantitative research approaches in a single study (Teddlie & Tashakkori 2009:7).

2.3.1 Mixed-methods research

The main reason for using a mixed-methods design was that the combination of a qualitative and quantitative design would address the research problem from different perspectives. The rationale for using mixed-methods research was as follows:

- Using mixed methods means that better understanding of the research problem can be established (Creswell & Plano Clark 2007:8–13). The researcher could obtain a full understanding of the factors influencing professional socialisation from the perspectives of both professional and student nurses. In addition, educators addressed the professional socialisation of student nurses from a teaching perspective.
- The strengths of the qualitative and quantitative methods complement each other, thus generating the best answer to a problem (Connelly 2009:31; Denscombe 2007:109–111). The qualitative approach aims at understanding and obtaining rich in-depth information, where subjectivity and the context in which the data are obtained are important. In contrast, a quantitative approach focuses on objectivity, precise measurements and predictions; however, the knowledge generated using this method alone may be too abstract and general and not directly applicable to situations (Johnson & Onwuegbuzie 2004:19–20). Through exploring and describing the phenomenon of professional socialisation, multiple perspectives that were rich in detail were obtained from professional nurses and students in a natural setting. The setting in which the data were collected was familiar to the participants and they could therefore share their perceptions and experiences with ease. These perspectives could be examined further in the light of the educators' teaching and facilitation of professional socialisation of students on a larger scale, and precise measurements could be employed. This resulted in comprehensive evidence from the perspective of not only professional nurses and students but also the educators.
- The combination of qualitative and quantitative approaches could provide better answers to questions than if a single approach had been adopted (Connelly 2009:31). The perceptions and experiences of participants in phase I provided detailed and personal evidence, which would not have been possible if only a quantitative approach had been adopted. Conversely, the quantitative data generated in phase II were on a larger scale and provided answers that could be

generalised, which would not have been possible with a purely qualitative approach.

- Through combining qualitative and quantitative data, methodological triangulation could be established, which consequently resulted in better understanding of the scope of the research problem (Denscombe 2007:119, 135). In this instance, the combination of the different forms of data resulted in the discovery of contradicting and/or supportive evidence on the phenomenon, which added richness to the study.
- Creswell (2003:11) states that the focus of the research problem is dictated by the philosophical foundation. The research problem encouraged the application of a pragmatic worldview that included both a post-positivist and a constructivist worldview, as discussed in chapter 1.
- Another characteristic of mixed-methods research is that words can give meaning to numbers, while numbers add precision to words (Johnson & Onwuegbuzie 2004:21). In the qualitative component (phase I), words were used to describe the analysis and interpretation of the perceptions and experiences of the participants. However, in the quantitative component (phase II), numbers, descriptive and inferential statistics were used to describe the data pertaining to the teaching and facilitation of students by educators.

The advantages of mixed-methods research are huge. Among others, this approach allows the researcher to gain better understanding of the research problem, address the weaknesses of each approach and apply different worldviews and methodological triangulation. The challenges of mixed-methods research facing the researcher include the cost involved, the time span and the complexity of managing the different approaches. These challenges were addressed in this study through expert guidance from the promoters, careful planning and following the correct methodology to ensure rigour in the research process.

In the selection of a sequential exploratory mixed-methods design, the timing, priority (weighting) and the integration of data (mixing) need to be considered (Creswell & Plano Clark 2007:80; Denscombe 2007:118). This type of mixed-methods research first aims to explore a topic qualitatively, before an attempt is made to measure the phenomenon quantitatively. Regarding the timing of this study, it commenced with the qualitative component (phase I), followed by the quantitative (phase II) component.

Phase I, the qualitative component, received priority over phase II, the quantitative component, since it guided the data collected in phase II. Weight is usually allocated to the first phase in a sequential exploratory mixed-methods design (Tashakkori & Teddlie 2003:227). The mixing of data occurred in two ways. First, the qualitative data (phase I) of samples A and B were integrated; this formed the basis for the instrument designed to collect data in the quantitative phase. Secondly, after the collection of the phase II data, both sets of qualitative and quantitative data were integrated to guide the development of guidelines.

2.3.2 Exploration

When little is known about a phenomenon, exploration is done with an intention to understand its full nature (Polit & Beck 2008:21; Schmidt & Brown 2009:149). To understand the influences on the internalisation of skills, knowledge, values and beliefs of students, *professional socialisation* as a phenomenon was explored, firstly in terms of the perceptions of professional nurses regarding their role as professional nurses, and secondly the way in which students experienced their professional socialisation as members of the nursing profession. This information was essential, as it guided the information to be collected from educators on the teaching and facilitation of students' professional socialisation.

2.3.3 Description

The purpose of description is to communicate accurately the magnitude, variations and significance of a situation regarding the phenomenon being studied (Polit & Beck 2008:19; Schmidt & Brown 2009:12). In order to create a representation of the phenomenon *professional socialisation*, a detailed and accurate description of the perspectives of professional nurses and students was provided. Furthermore, the way in which educators perceived their teaching and facilitation of professional socialisation to students was described, together with the prevalence and the nature of particular practices. According to Schmidt and Brown (2009:149), a descriptive design allows the researcher to recognise and document the characteristics of the phenomenon. In addition, a description was provided of the integrated evidence of the two phases, to develop and validate the guidelines intended to support educators and professional nurses in the professional socialisation of students.

2.3.4 Contextual

Terre Blanche, Durrheim and Painter (2007:287) state that to make sense of research findings, it is important to study the phenomenon in the setting where it occurs. Therefore, the influence of the research setting, namely an academic hospital in Gauteng, where professional nurses work and students gain clinical learning experience, was recognised. In addition, the teaching and facilitation of educators in relation to professional socialisation of students were interpreted in the context of all nursing colleges and universities that provide the four-year nursing programme in Gauteng.

2.4 STUDY SETTING

The first phase of the study occurred in an 832-bed academic hospital in Gauteng. This hospital serves as a training hospital for not only nurses, but also other health professionals, such as doctors, physiotherapists, occupational therapists and others. Various nursing education institutions place their students in this hospital for clinical learning experience. The students involved in this study were from three nursing education institutions, two universities and one nursing college. These institutions provide the four-year integrated nursing programme. While students are placed to gain clinical learning experience, they are under the direct supervision of professional nurses, as they actively take part in patient care. The data were collected from these students and from the professional nurses who supervise and coach them.

In the second phase of the study, data were collected in all nursing education institutions in Gauteng that provide the four-year integrated nursing programme. The Gauteng province has maintained the highest output of the four-year integrated nursing programme in South Africa since 2003. The latest figures for 2012 indicate that 757 (23.5%) of the 23 225 students who completed the four-year integrated nursing programme were from the Gauteng province (SANC 2012c). Nine nursing education institutions, five universities and four nursing colleges generated this student output. These educational institutions are situated in the Pretoria and Johannesburg vicinity, as illustrated in figure 2.1. Data were collected from all educators employed by these institutions.

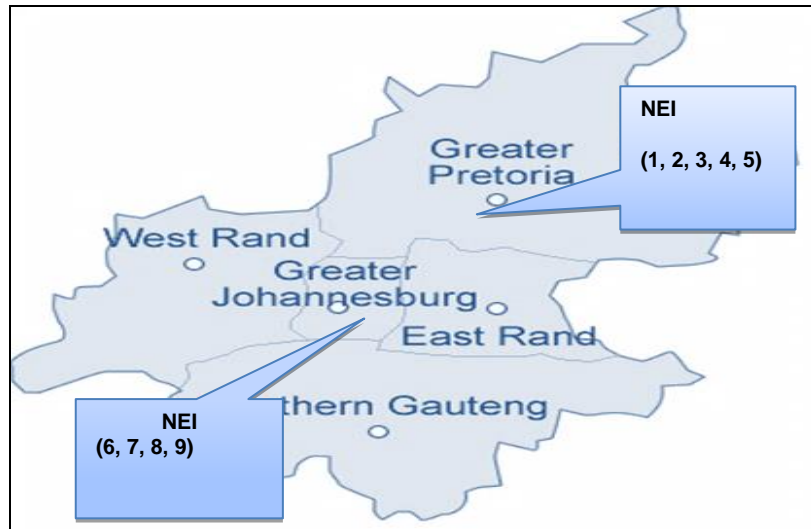


Figure 2.1 Nursing education institutions that provide the four-year integrated nursing programme in Gauteng
(NEI = Nursing education institution)

2.5 RESEARCH METHODOLOGY

Research methodology refers to the procedures and techniques followed to collect data (Babbie & Mouton 2011:75; Polit & Beck 2008:765). Figure 2.2 illustrates an overview of this process.

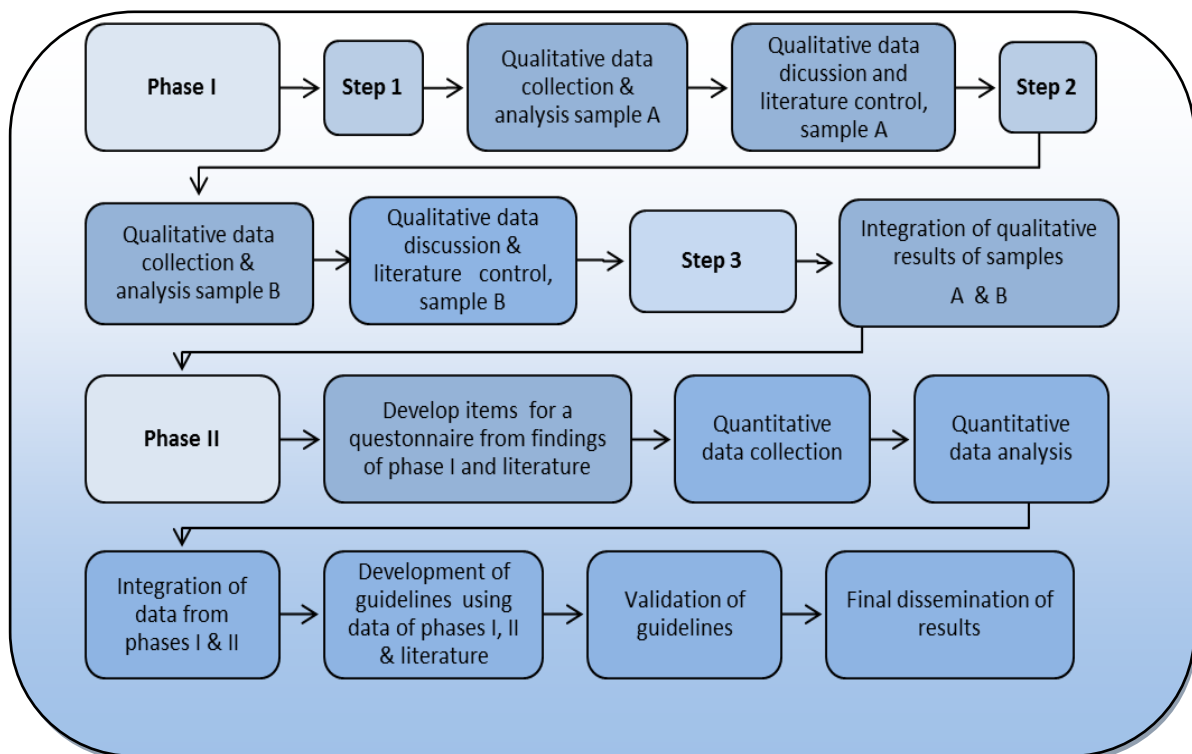


Figure 2.2 Visual outline of the research process

To maintain a clear distinction, the two phases of the study will be discussed separately.

2.5.1 Qualitative phase I

A qualitative design attempts to understand human experiences based on multiple perspectives, through exploring and describing systematically the underlying meaning in a natural setting (Botma, Greef & Mulaudzi 2010:182; Streubert Speziale & Carpenter 2007:21). The decision to use a qualitative research approach for phase I was based on the relevant characteristics as outlined by Polit and Beck (2008:219) and Streubert Speziale and Carpenter (2007:21). These characteristics include the following:

- Qualitative research is typically characterised by various truths. This was evident in this study, since the worlds of the professional nurses as participants, who worked an academic hospital in Gauteng, were diverse. Their level of experience as professional nurses ranged from eight months to 17 years, and revealed perceptions that were varied and information rich. In addition, the students as participants represented four different levels as regards their educational progress. Although similar themes emerged on each level during the data analysis, the unique characteristic of each level were reflected in their experiences. For example, the second level's ability to reason and question issues was more advanced than that of the first level.
- The importance of discovering the participants' emic perspective is important in qualitative research (Brink et al 2012:121). The researcher was interested in the unique thoughts and experiences of the participants regarding this phenomenon. Commitment to the participants' views is another aspect typical of qualitative research (Brink et al 2012:10). This principle was respected by the researcher's providing a detailed account of the perceptions and experiences of the participants.
- Another characteristic of a qualitative approach is that the researcher is a key instrument in the data collection (Lichtman 2006:12). The researcher filled the role of an interviewer during data collection, as well as an interpreter in the data analysis. The researcher's own preconceptions and worldview influenced how the data were analysed. As a result, subjectivity was accepted, which added richness to the data.

- Typically, a literary style with thick descriptions is used to report qualitative data (Lichtman 2006:14). A detailed description of the data obtained from phase I has been provided.

2.5.1.1 Population

A population is described as an entire group of elements, persons or objects that meets the study criteria (Schmidt & Brown 2009:213). The study population of phase I consisted of two populations, namely population A, which comprised professional nurses working in an academic hospital, and population B, comprising students who were registered for the four-year integrated nursing programme. The accessible population A were all professional nurses in a specific academic hospital in Gauteng, who worked in the wards where students who were registered for this nursing programme had been placed for their clinical learning experience. The accessible population B were all students who were registered for the four-year integrated nursing programme from the first to the fourth year and did their clinical learning in the academic hospital where the professional nurses worked.

2.5.1.2 Sample

A sample represents a subset of a larger set, selected by the researcher to participate in a study (Brink et al 2012:217). To maintain a clear distinction, the two samples, A and B, are discussed separately.

- **Sample A**

Sample A was purposively selected. Purposive sampling is usually based on inclusion criteria specified by the researcher regarding the information the participants have about the phenomenon concerned. This type of sample tends to provide complete and rich information (Denscombe 2007:17; Streubert Speziale & Carpenter 2007:29). The inclusion criteria were related to the experience of the participants in guiding the students of this specific nursing programme in their clinical learning experiences. The inclusion criteria for sample A were as follows:

Inclusion criteria of sample A

The professional nurses must have

- had experience in clinical supervision of students who were registered for the four-year integrated nursing programme
- worked as a professional nurse in a ward in the specific academic hospital in Gauteng where the four-year integrated nursing students were placed for their clinical learning experiences

Sample A's participants consisted of willing and available professional nurses who met the criteria. An information leaflet on informed consent was provided (Annexure VI). Before the participants were approached for their consent, the approval of the unit managers of the appropriate wards was obtained. The participants' contact details were taken so that the researcher could inform them later of the exact date, time and venue of the data collection. The Gauteng Department of Health (Annexure II) and the academic hospital (Annexure III) granted the researcher permission to conduct the study.

Size of sample A

In qualitative research, the sample size is functional for the purpose of the investigation and the size is determined at the point where data saturation occurs (Burns & Grove 2007:348; Schmidt & Brown 2009:161). Holloway and Wheeler (2010:341) describe data saturation as a state where no new information that is relevant to the study emerges. Carlsen and Glenton (2011:2) explain that the richness and thick descriptions of data could justify a smaller sample size. Data became saturated when there was evidence that the themes pertaining to the participants' role in the professional socialisation of students occurred repeatedly. At this stage, two focus-group interviews with seven participants in each group had been conducted.

- **Sample B**

Sample B consisted of students who were registered for the four-year integrated nursing programme from first- to fourth-year level who had been placed for their clinical learning

experience in the same academic hospital in Gauteng where the participants in sample A worked. Sample B consisted of a homogeneous purposive sample. The participants of sample B were purposively selected because they would be able to provide detailed information on their professional socialisation experiences. Krueger and Casey (2009:65) state that the composition of a focus group is determined mainly by the purpose of the information needed and the homogeneity of the group. A homogeneous sample includes individuals that have similar characteristics regarding a specific aspect, and thus allows for free-flowing conversations (Krueger & Casey 2009:66; Liamputtong & Ezzy 2005:82). Homogeneity was established through the participants' related level of training, which implied that each focus group comprised only a specific year group, for example first-year students (participants) were interviewed together. The rationale for this decision was that they would feel more comfortable in sharing their experiences with participants with the same level of training. Sample B's inclusion criteria were as follows:

Inclusion criteria of Sample B

The students must have been

- registered at a nursing education institution for the four-year integrated nursing programme
- placed at the selected academic hospital to gain experience in clinical learning

The participants were approached via their respective nursing education institutions. Both the institution and the participants themselves consented to participation in the study, after an information leaflet and an informed consent form were provided (Annexures VI and IV). Liamputtong and Ezzy (2005:86) state that very often time and the available budget may limit the number of focus-group interviews that are conducted, but the main objective would be to determine when the research question had been reliably answered. In this instance, a repetition of the themes related to the experiences of students regarding their professional socialisation experiences occurred after five focus group interviews had been conducted. The number of participants taking part in the focus-group interviews ranged from seven to ten per group, as indicated in tables 2.1 and 2.2 (discussed in section on the size and composition of the focus groups).

2.5.1.3 Data collection

The principles of data collection from samples A and B were the same; therefore, both are discussed together. Data were collected from November 2010 to March 2011 by means of focus-group interviews, which were supported by field notes.

- **Focus-group interviews**

Focus-group interviews are used to ascertain perceptions, attitudes, and opinions in a non-threatening and non-judgemental environment on a focused topic (Gray 2009:233; Krueger & Casey 2009:xiii; Polit & Beck 2008:394). The way in which professional nurses perceived their role in the professional socialisation of students (sample A) and students (sample B) experienced their professional socialisation as members of the profession was described and explored in this way.

Lichtman (2006:128–129) describes three approaches to conducting focus-group interviews, namely self-managed, structured and semi-structured focus-group interviews. The focus-group interviews in this study were conducted as self-managed focus-group interviews. In a self-managed focus-group interview, the moderator introduces the topic to the group to discuss and allows them to interact. If the group loses focus, the moderator will guide the discussion to maintain the focus and may introduce supportive probing questions. This approach elicits data that are rich and varied (Lichtman 2006:128). One central question was posed to the participants of each sample. A set of probing questions was kept at hand in case probing was needed (Annexures VII and VIII).

The researcher, who acted as moderator, piloted a focus-group interview to establish her ability in this regard, and to try out the use of one central question while keeping probing questions ready. This approach appeared to be a workable option. The pilot interview will be discussed later on.

The rationale for using focus-group interviews was as follows:

- The underlying motives and different viewpoints of the participants can be assessed in a short time (Denscombe 2007:180; Polit & Beck 2008:295). In this

study, focus-group interviews enabled the researcher to discover how the participants thought and felt about this phenomenon.

- Data collected through this method are contextual and rich in information (Greeff 2005:301). In this study, data that were generated had meaning in the context of this academic hospital, as the participants worked as professional nurses and gained clinical learning experience as students.
- Group dynamics can be applied to encourage participants to clarify viewpoints, which would be difficult in a one-to-one interview (Burns & Grove 2007:379). The difference between a group and an individual interview is that the synergetic effect of the participants' interaction can be used to probe the discussion and generate information (Lichtman 2006:126; VanderStoep & Johnston 2009:235).
- The data obtained through focus-group interviews can be used to generate items for inclusion in a questionnaire (Burns & Grove 2007:379; Denscombe 2007:180). In this case, items were generated for a questionnaire to determine the educators' teaching and facilitation of professional socialisation to students (phase II).
- A moderate amount of time is required to conduct the actual focus-group interview (Gorman & Clayton 2005:147). The researcher found, however, that although it appeared to be a quick method of data collection, the application of this method required a considerable amount of time and planning.
- This method fosters an atmosphere in which common topics of interest can be discussed. Holloway and Wheeler (2010:133) mention that group interaction empowers participants, because they can freely express their views. This interaction was experienced particularly among the participants from sample B (students).

Apart from the benefits of focus-group interviews, their limitations were also considered:

- The moderator should be careful of power dynamics ("groupthink"), meaning that some participants could dominate or reroute the discussion (Marshall & Rossman 2006:115; Streubert Speziale & Carpenter 2007:39). During the focus-group interviews, the moderator experienced this phenomenon, but did not want to disrupt the flow of the discussion and found it difficult at times to manage the

power dynamics of the group. This challenge was addressed by inviting every participant to share his or her perceptions or experiences.

- The logistics of focus-group interviews may be very complicated and they may be hard to assemble (Marshall & Rossman 2006:115). In this study, careful planning counteracted this problem, by the researcher's using, for example, a checklist to assist with the logistics. Problems with recruitment were experienced, which will be discussed later in the study.
- Transcription of data may be challenging because the distance of the microphone from the participants could make voices less audible (Holloway & Wheeler 2010:134). This obstacle was addressed by using two voice recorders to enhance the clarity of the recordings.

Piloting

Siedman (1998), as cited in Greeff (2005:294), suggests a pilot focus-group interview with a small number of participants. This group will assist the researcher to deal with practical issues and to determine the researcher's own ability to facilitate a focus-group interview. A focus-group interview was therefore conducted with seven professional nurses to establish the ability of the researcher to conduct such an interview, as well as the feasibility of using one central question. This focus group was also included in sample A, as valuable information was obtained during this group interview. Greeff (2005:309) states that the first focus-group interview could be regarded as a pilot test of a focus-group interview.

The recruitment of the participants was challenging, because the pilot focus-group interview was conducted during a general strike in the public sector. Although the participants initially agreed to participate, not all of them could participate, which compelled the researcher to recruit new participants the morning before the focus-group interview. A valuable lesson was learnt: sufficient time should be allocated prior to conducting a focus-group interview in case something unforeseen happens. The venue and process followed were as planned. Initially the researcher was unsure of her moderating skills, but the conversation flowed easily and very little probing was necessary. The pilot focus group was very valuable, because it gave the researcher confidence to proceed with the rest of the data collection.

Recruitment of the participants

Possible and willing participants who met the selected criteria were approached beforehand via the unit manager of the ward. They were given an invitation letter and phoned the day before the scheduled date of the focus-group interview. Despite these steps being taken, as suggested by Krueger and Casey (2009:75–76), the researcher needed to re-recruit participants in both samples A and B. The reasons offered for not participating were that the ward was too busy, the participants were not on duty and some were not interested at all. (The focus groups were conducted during lunchtime to minimise infringement on the wards' daily activities and patient care.) As had been learnt from the pilot focus-group interview, sufficient time was scheduled on the day of the focus-group interview to approach the unit manager and possible participants for re-recruitment. When re-recruitment was necessary, the participants were approached personally. This seemed to yield the best results.

Size and composition of the focus groups

The size of groups taking part in the focus-group interviews ranged from seven to ten participants per interview. The size and composition of sample A and B were as follows:

Sample A

Two focus-group interviews were held with sample A. The groups consisted of seven participants ranging in years of experience as professional nurse from less than one year to 17 years, while the second focus-group interview also consisted of seven participants. Their level of experience ranged from eight months to eight years. It was assumed that experience as a professional nurse in the clinical field would benefit the student nurse's professional socialisation, therefore the information regarding their level of experience was noted. A summary of the participants' attributes in sample A is presented in table 2.1.

TABLE 2.1 SAMPLE A COMPOSITION

Focus group 1	Years of experience as a professional nurse	Number of participants
	< 1	0
	1	3
	2	3
	3	0
	8	0
	17	1
Total	1	7
Focus group 2	Years of experience as a professional nurse	Number of participants
	< 1	2
	1	0
	2	3
	3	1
	8	1
	17	0
Total	1	7
Total of all focus groups	2	14

Sample B

As table 2.2 indicates, there were five (5) focus group interviews, consisting of 48 students who participated. As previously discussed, the participants were grouped according to their level of training in order to encourage them to share their experiences freely. One focus-group interview involved third- and fourth-year students (participants), as both groups arrived to participate. It was decided to continue with this focus-group interview, but also to conduct another focus-group interview. This situation resulted in another focus-group interview being held involving 10 participants in their third year.

TABLE 2.2 SAMPLE B COMPOSITION

Number of focus groups	Number of participants	Level of training
1	10	1
1	10	2
1	11	3
1	7	3 rd and 4 th
1	10	4
Total:	5	48

Conducting the focus-group interviews

Prior to the interviews, the researcher did some preparation, as suggested by Greeff (2005:293). This preparation included visiting the venue and checking the voice recorders to avoid possible failure. In order for a focus-group interview to be successful, the environment must be relaxed and quiet (Polit & Beck 2008:400). It is

also advisable to commence with items such as informing the participants about the confidentiality and anonymity that are guaranteed and having a general introduction (Marshall & Rossman 2006:114). In this study, the focus-group interviews were conducted in a quiet seminar room, and prior to the discussion refreshments were served to allow the participants to interact with one another, which fostered a relaxed atmosphere. The participants were asked to introduce themselves. After the first participant had shared some ideas, the atmosphere became relaxed and the discussion began to flow.

Regarding sample A, the central question posed was: "Please share your views on your role as a professional nurse in the professional socialisation of students who are registered for the four-year integrated nursing programme." Probing topics that related to being a role model, mentor and preceptor, skills, knowledge, values, attitudes and the learning environment were kept on hand (Annexure VII). The central question for discussion in sample B was, "Please describe your experiences related to your professional socialisation as a student nurse." Possible probing topics that related to role models, mentors, preceptors, skills, knowledge, values, and attitudes, the workload, the learning environment, financial issues and personal issues were kept on hand (Annexure VIII).

Apart from the above-mentioned considerations, the moderator should ensure that all members participate and that the discussion flows, but should guard against being judgemental (Polit & Beck 2008:395). Care was taken not to give an opinion, but rather to rephrase the comments, in order to allow the participants to share their views, as suggested by Descombe (2007:180).

Length and venue of the focus-group interview

There is no specific length for a focus-group interview, but in general, it should not take longer than two hours (Descombe 2007:181). In this study, the average length of the focus-group interviews was an hour and thirty-five minutes. In some instances, the participants wanted to extend the discussion, but the researcher needed to terminate the interview because of some participants' responsibilities. The remaining participants were, however, given additional time for discussion, as it was obvious that they wanted to discuss their concerns. This discussion did not form part of the results, but rather

served as a form of debriefing. Liamputtong and Ezzy (2005:82) suggest that there may be several reasons why a discussion should not be too lengthy; for example, the participants might find it difficult to concentrate and need to attend to other responsibilities, as happened in this instance.

Voice recording and transcription

It is important to transcribe the voice recordings accurately in order to capture all the information and nuances. Holloway and Wheeler (2010:282) indicate that transcription is a long and frustrating process. The researcher can support this statement; however, it allowed prolonged engagement with the transcriptions. In addition, the confidentiality and anonymity of transcriptions were ensured by replacing the names of the participants with pseudonyms, as suggested by Denscombe (2007:183).

- **Field notes**

In addition to the focus-group interviews, field notes were taken to support the data of the interviews. Field notes are unstructured observations that are made directly after the interviews in order to understand and support the data (Polit & Beck 2008:405, 745). Gorman and Clayton (2005:185) describe field notes as what the researcher observes, hears, experiences and thinks when collecting data. Botma et al (2010:217) advise researchers to include notes on non-verbal communication, the atmosphere during the discussion, seating arrangements and the order in which the participants speak, to assist with voice recognition. The field notes that were taken included information on the venue, seating arrangements, the participants' behaviour, the way they spoke, any incidents that occurred and the researcher's reflective thoughts (Annexure XI) . These notes were made directly after each focus-group interview. The data provided better understanding during the analysis of the data obtained during the interviews. An aspect the researcher initially found challenging was the interpretation of non-verbal communication, since the focus was on the content of the discussions; however, as the researcher gained confidence, this skill became easier to apply.

2.5.1.4 Data analysis

Analysis of qualitative data aims to organise the data and provide structure to them in order to give meaning to them (Polit & Beck 2008:508). A systematic process, together with continuous reflection about the data, was followed in the analysis, as suggested by Creswell (2009:184), and Krueger and Casey (2009:114). Tesch's (1990:142-145) method of data analysis was used as follows:

Although the data of sample A and sample B were initially analysed separately, the process of data analysis described below applies to both samples. The transcripts were numbered from one to seven to identify in which transcript certain topics emerged. Documents one and two represented the transcripts of sample A, while documents three to seven represented those of sample B.

The transcripts were read attentively to get a sense of what they were all about. Each document was read to identify which information was related to a topic, for example factors related to the learning environment. Thoughts related to the topics were then written down in the margin adjacent to the topic. This task was repeated with all the interviews. A list of all the topics was compiled and similar topics were clustered together and grouped accordingly. The topics were arranged into three columns. The first column consisted of the major topics that were related to the purpose of the study. The second column reflected unique topics that did not occur very frequently, but were relevant to the study. In the third column were grouped topics that were mentioned but did not appear to be relevant to the study (Annexure IX).

The list was reviewed again using the transcripts, which were then abbreviated as codes. During this process, new topics were identified and simultaneously it was determined how well the topics described the data. This was followed by an appropriate description of the topics that emerged as categories. Each category was then finally abbreviated. During this step, attention was paid to the actual content of the data. Commonalities, uniqueness, confusions, contradictions and possible missing information regarding the data related to the research question guided this step. Annexure X displays an example of the final categorised data that emerged as themes, categories and subcategories.

Four cognitive processes, namely comprehension, synthesising, theorising and re-contextualising, were used during qualitative data analysis, as described by Loiselle, Profetto-McGrath, Polit and Beck (2010:320). These processes assisted the researcher to understand and to identify the interrelated concepts of professional socialisation as these were revealed in the data. In addition, attention was paid to how and why these concepts were linked, in order to put *professional socialisation* of students into context.

2.5.1.5 Integration of results from sample A and B and literature control

In this phase of the study, the data from samples A and B were integrated. Prior to this process, the themes, categories and subcategories that emerged from each sample were analysed and discussed separately, supported by literature control. The aim of literature control is to support or contradict findings of the current study in comparison with previous studies (Creswell 2003:32). The integrated data were presented as themes, which emerged with respect to important issues in student professional socialisation. During the integration of the data, professional nurses' perceptions were compared with the experiences of students. Better understanding of each sample's view regarding professional socialisation was thus obtained.

2.5.1.6 Trustworthiness

Trustworthiness was established according to the criteria suggested by Lincoln and Guba (1981), as quoted in Polit and Beck (2008:539). The main aim of rigour in qualitative data is to represent the participants' information as accurately as possible (Streubert Speziale & Carpenter 2007:49). The criteria are described in terms of credibility, confirmability, dependability, transferability and authenticity (Denscombe 2007:297–302; Polit & Beck 2012:585–586). Table 2.3 provides a summary of these criteria applied to this study.

TABLE 2.3 STRATEGIES TO ENSURE TRUSTWORTHINESS

Criteria	Strategies to ensure trustworthiness	Application
Credibility A true reflection and an accurate description of the data (Polit & Beck 2008:539)	Prolonged engagement	<ul style="list-style-type: none"> Adequate time was spent with the verbatim transcripts.
	Reflexivity	<ul style="list-style-type: none"> Field notes of data collection process and researcher's own feelings and thoughts during the data collection process were kept.
	Triangulation	<ul style="list-style-type: none"> Triangulation: focus-group interviews with different groups of participants and field notes were used.
	Member checking	<ul style="list-style-type: none"> The transcribed data were confirmed with the participants. Only two participants responded indicating that the transcribed data were a true reflection of the focus-group interviews.
	Peer examination	<ul style="list-style-type: none"> Discussion of the research process and findings was held with experienced promoters. Consensus discussion between the researcher and an independent qualitative researcher regarding the development of the themes, categories and subcategories occurred.
Researcher credibility	<ul style="list-style-type: none"> Researcher has done previous qualitative research. 	
Confirmability Objectivity of the presented data (Denscombe 2007:300)	Reflexivity	<ul style="list-style-type: none"> Reflective notes were kept.
	Audit trail	<ul style="list-style-type: none"> The unprocessed data (voice recordings), field notes, the documents related to the themes, development of categories and subcategories, consensus and promoters' discussions were kept as evidence in case an audit needed to be conducted.
Dependability Consistency of data over time (Polit & Beck 2008:539)	Coexistence with credibility	<ul style="list-style-type: none"> The same criteria as for credibility were also applicable to dependability.
	Thick description	<ul style="list-style-type: none"> A detailed description of the research process followed was provided.
Transferability Application of the research in similar circumstances (Denscombe 2007:299)	Accurate description	<ul style="list-style-type: none"> A dense description of the research process and results of the study was provided. Purposive sampling of professional nurses and students was done.
Authenticity The extent to which the realities of the participants are described (Polit & Beck 2012:585)	Detailed description	<ul style="list-style-type: none"> An emic perspective of the participants was provided.

2.5.2 Quantitative phase II

The following quantitative phase discusses the procedures followed to collect data from the educators. Quantitative research is described as systematic, objective and formal, with strict control of possible influences; the findings can be generalised (Burns & Grove 2007:24). This quantitative component was non-experimental and descriptive in nature, which implied that no manipulation of the variable: professional socialisation of students occurred. Brink et al (2012:112) state that a non-experimental design describes the phenomenon, and explores and explains the relationships between the variables. This type of design could obtain opinions, attitudes, needs or facts regarding a phenomenon (Brink et al 2012:114). The objective in this study was to determine and describe the perceptions of educators on their teaching and facilitation of professional socialisation of students.

Some of the characteristics of quantitative research have already been discussed in subsection 2.3.1, in relation to the rationale for using mixed-methods research. The following additional characteristics of a quantitative approach were considered:

- In quantitative research, the researcher does not actively participate in the activities related to the phenomenon being investigated, as in qualitative research. This method uses structured procedures and formal instruments to collect data (Botma et al 2010:82; Brink et al 2012:11). In this phase, a structured process was followed in administering the data collection instrument, and the researcher maintained distance from the collected data.
- Quantitative research focuses on a small number of concepts and has preconceived ideas regarding these concepts (Brink et al 2012:11). In this study, composite constructs, originating from the themes of the qualitative phase, were described in terms of the educators' perceived facilitation and teaching of professional socialisation to students.
- Quantitative research focuses on statistical analysis to analyse data (Botma et al 2010:83). In this study, descriptive and inferential statistics were used to analyse the data of this phase.

2.5.2.1 Census

In view of the manageable size of the population, it was decided to include the entire population (census) of 277 possible respondents. A census includes all members of a population that meet the inclusion criteria (Polit & Beck 2008:749; Welman, Kruger & Mitchell 2009:101). The inclusion criteria for the unit of analysis of this population were that the educator should

- have taught and facilitated students who were registered for the four-year integrated nursing programme
- be employed by a nursing education institution, situated in the Gauteng province

In order to create a source list (sample frame), each nursing education institution in Gauteng was approached to provide a list of all possible respondents who met the study criteria, which resulted in 277 eligible respondents.

2.5.2.2 Data collection

Data collection is a precise and systematic process to address the research purpose of a study (Botma et al 2010:131). This section discusses the data collection plan, instrument, validity and reliability. Brink et al (2012:147) suggest several questions to be asked during the planning of the data collection process. The questions that were considered in this study resulted in collecting data from respondents who met the study criteria. The type of information to be collected was primarily guided by the data pertaining to professional socialisation of students obtained in the qualitative phase I and the literature. The data were collected by means of a self-administered questionnaire completed by all willing and available respondents at the nine educational institutions in Gauteng. The distribution process commenced after the instrument was tested. This will be discussed below.

Although the process of obtaining consent was challenging, all nursing education institutions gave permission to collect data and provided a contact person with whom the researcher communicated regarding the distribution and collection of the questionnaires (Annexure XII). This contact person was responsible for distributing the questionnaires with the information leaflet, which included clear instructions and an

informed-consent form (Annexure XIII). Some nursing education institutions requested that an information session be arranged with the heads of department, which was done by the researcher. In addition, other institutions preferred the respondents not to sign the written consent form, as it was argued that respondents who completed the questionnaire had tacitly given the researcher permission to use the data, therefore the completion of the questionnaire implied consent. The completed questionnaires could be posted in a sealed box left at each nursing education institution. An average of two weeks was given to complete the questionnaires, which the researcher then collected. Despite this period provided, the researcher went back several times to some institutions, because they requested additional time to complete the questionnaire. The data collection occurred during May 2012 and June 2012. Of the 277 questionnaires issued, 128 (46%) completed questionnaires were received.

2.5.2.3 Data collection instrument

A questionnaire is a structured self-report instrument that is inexpensive; its use is a technique to generate numerical data from a large number of respondents in a short period (Schmidt & Brown 2009:190). This type of instrument is also used to obtain information on experiences regarding how respondents feel about, believe and value a phenomenon (Polit & Beck 2008:369). The focus of phase II was on obtaining information about educators' teaching and facilitation of the professional socialisation of students. A questionnaire was used to investigate the themes that had emerged from phase I and the literature, to obtain the perspectives of educators on a larger scale on the phenomenon *professional socialisation* (Annexure XIV). This approach to data collection is typical of a sequential mixed-methods study, as one set of data builds on the other (Creswell & Plano Clark 2007:121).

Despite the advantages of this type of data collection, disadvantages such as a low response rate, provision of socially acceptable answers and misinterpretation of questions should be considered when using a questionnaire (Brink et al 2012:153). In fact, the researcher experienced some of these challenges, such as a low response rate of 46% (N=128). The researcher implemented various strategies, such as phoning, emailing and revisiting the nursing education institutions, to try to increase the response rate.

- **Development of structured questionnaire**

During the construction of a questionnaire, the compiler should consider the research objectives and the collection of complete and accurate information (Brink et al 2012:154). Here the questionnaire development was guided by the objective of phase II, the themes that emerged from qualitative phase I, Cohen's (1981) model of professional socialisation and the literature. Items that addressed Cohen (1981) stages of professional socialisation were included as student behaviour.

In the design of the questionnaire, the researcher paid special attention to the wording, making it for example easily understandable and unambiguous, avoiding leading questions and stating the questions in a positive style. Some of the questions were further explored by asking open-ended questions to obtain richer information. Apart from considering these design issues, the researcher found that expert advice from the promoters and a statistician (Annexure XVIII), as well as the pre-testing of the instrument, assisted in the design of the questionnaire.

- **Pre-testing of the instrument**

Pre-testing of an instrument is essential, as possible errors regarding aspects such as the wording and time limits can be identified (Brink et al 2012:175). The instrument was pre-tested by distributing it to 24 respondents from a nursing education institution that was not situated in Gauteng and thus did not form part of the population. This institution also offered the four-year integrated nursing programme. Eight (33%) respondents responded to the pre-testing. As a result, some changes to the wording were implemented to improve the clarity of statements; other than that, no further changes were made.

- **Content of the structured questionnaire**

The questionnaire consisted of five sections of mainly closed questions or statements with supported open-ended questions on socialisation (Annexure XV). The items in the questionnaire consisted of positively orientated statements or questions that needed to be rated on a 7-point Likert scale, where one (1) equalled 'strongly disagree or never' (most negative rating), and seven (7) equalled 'strongly agree or always' (most positive

rating). In certain items, for example item 26 (Annexure XIV), more than one option could be selected.

- **Composition of the questionnaire**

Table 2.4 displays a summary of the composition of the questionnaire.

TABLE 2.4 COMPOSITION OF THE QUESTIONNAIRE

Sections	Addressed items
Section A Items 1-6	Biographical data Age, gender, mother tongue, highest qualification, duration of involvement in the four-year integrated programme and the type of institution that employed the respondent
Section B Items 7-36	Educator as role model <ul style="list-style-type: none"> • Concept of professional socialisation • The teaching and facilitation strategies used in student professional socialisation • Educator as role model (work ethic, teamwork and cultural awareness) • Support provided to students
Section C Items 37-51	Educator facilitation of educational strategies <ul style="list-style-type: none"> • Nursing curriculum philosophy • The teaching of skills, knowledge, values and beliefs • A student- versus educator-centred teaching approach • Accommodation of students' different learning orientations and scheduling of tests and assignments • Cultural awareness • Institutional support to students • Clinical support to students
Section D Items 52-64	Educator and the clinical environment <ul style="list-style-type: none"> • Minimum prescribed hours by SANC • Communication between the nursing education institution and the clinical field as well as within the clinical field • Educator's clinical competencies • Clinical support to students
Section E Item 65-85	Student <ul style="list-style-type: none"> • Selecting candidates for nursing • Preparation for the first exposure in the clinical field • Theory-practical experiences • Student behaviour and support • Cultural awareness • Cohen's stages of professional socialisation
Section F Item 86	Additional comments

2.5.2.4 Data analysis

Brink et al (2012:177) state that data analysis involves categorising, ordering, manipulating, summarising and describing the data in understandable terms. In this study the unprocessed data were coded and entered into a Microsoft (MS) Excel (Windows 2010) spreadsheet, which a statistician (Annexure XVIII) analysed, using the

SAS Version 9.2 statistical package. The analysis included descriptive and inferential statistics. Descriptive statistics describe and summarise data, while inferential statistics draw inferences about the study population (Brink et al 2012:179.) The data were presented by means of composite frequencies tables, pie and bar graphs; these are discussed in chapter 5.

The composite frequency tables were presented on the subsets of the questionnaire items that described the perceptions on six professional socialisation constructs. For each composite frequency table, the Chi-square test, evaluated against Fisher's exact probabilities, was included to determine whether the response patterns to all questionnaire items within a subset of items followed the same trend. A Chi-square test is usually used to test the significance between the observed and expected values in a contingency table (Botma et al 2010:172). Furthermore, a Fisher exact test was done to determine the level of statistical significance in sparsely populated frequency tables (Boslaugh & Watters 2008:196). The statistically significant dependency between the response patterns of the items within a subset of the questionnaire items was determined. For example, some response patterns exhibited a negative or neutral response, while others exhibited a generally positive perception trend.

In addition, two-way frequency tables were calculated to determine whether the perceptions of the respondents were influenced by their biographical attributes. Frequencies of the categories of a set of construct scores (1–7) were cross-referenced with a biographical attribute and Fisher's exact chi-square tests. The biographical properties included were age, years of involvement in the nursing programme, qualifications and type of institution. Two attributes, namely gender and mother tongue speaking, proved to be unbalanced with respect to the frequencies in their categories, and were not investigated, since these attributes would not have provided reliable results. (A very small portion of the sample's mother tongue was English and only five respondents were males.)

2.5.2.5 Validity and reliability

In order to conclude that the findings of a study are true and accurate, strategies of validity and reliability should be implemented. The collected data will only be valid and reliable if the measurement procedures and data collection instruments are at

acceptable levels of reliability and validity (Delpont 2005:160). Wrong inferences could be a threat to the validity and reliability of a study.

- **Validity**

Validity refers to how accurate the inferences of the study results are concluded to be (Polit & Beck 2008:286). This study's validity was enhanced through methodological triangulation, because both qualitative and quantitative research approaches were applied to study the phenomenon *professional socialisation*. A study's validity is strengthened if two or more research methods are used in the same study (Burns & Grove 2005:225).

Since this study was non-experimental in nature, threats of internal validity did not apply to it; however, external validity was considered. External validity refers to the extent to which the results could be generalised to other settings (Polit & Beck 2008:753). The entire population of eligible respondents in Gauteng was used, which allowed generalisation of findings, thereby supporting the study's external validity.

Instrument validity is concerned with whether the instrument measures what it is supposed to measure (Brink et al 2012:165). Instrument validity is discussed in terms of content, face and construct validity and influential factors related to measurement errors. *Content validity* addresses the extent to which all the major elements of the concept are being measured (Polit & Beck 2008:458). Content validity was established by using themes from the qualitative phase for item generation, while the literature and Cohen's (1981) stages of professional socialisation were investigated. This validity was further enhanced through consultation and discussions with the promoters and a statistician. In addition, the instrument was pre-tested, as suggested by Brink et al (2012:166).

Face validity is the judgement on the appearance of the instrument regarding the extent to which it measures what it is supposed to measure (Brink et al 2012:166). Although this is considered a weak validity strategy, the same individuals who assessed the instrument for content validity also judged its appearance and outline.

Construct validity deals with the degree to which the instrument measures abstract concepts (Gray 2009:157). Various tests, such as factor analysis and analysis of variance (ANOVA), could be conducted to establish construct validity; however, in this study only conceptual and operational definitions were considered to clarify the constructs, as suggested by Burns and Grove (2005:216).

Although validity factors such as environmental factors or the respondents' physical and emotional status may have an influence, as suggested by Brink et al (2012:165), these could not be controlled, since it was a self-administered questionnaire.

- **Reliability**

Reliability deals primarily with how well the phenomenon is measured and whether the same results will be obtained with repeated measurements (Delpont 2005:16; LoBiondo-Wood & Haber 2006:345). Six constructs were composed from items that measured aspects of professional socialisation, for example cultural awareness. These composite constructs obtained a Cronbach alpha value of from 0.7 to 0.87, except for the construct: the educator and the clinical field, which obtained a Cronbach alpha value of 0.68. Therefore, the Cronbach alpha test indicated that the measurement of five composite constructs was reliable. This type of reliability testing refers to internal consistency, which estimates to what extent the items in the composite construct measure the same attribute (Polit & Beck 2008:471). Usually a level of 0.7 or higher is an accepted level of measurement (Tavakol & Dennick 2011:54).

Reliability is further enhanced through clear conceptualisation of constructs, a precise level of measurement and pre-testing of an instrument (Delpont 2005:163). Instrument reliability was strengthened by clarifying the constructs with clear definitions, using a 7-point Likert scale to increase the sensitivity of measurement, and pre-testing the instrument.

2.6 INTEGRATION OF DATA FROM THE QUANTITATIVE AND QUALITATIVE PHASE

The stage in which qualitative and quantitative data are integrated, also known as the point of interface, is described as when the researcher implements the independent or

interactive relationship of a mixed-method study (Creswell & Plano Clark 2011:66). The data obtained from phase I (qualitative data) and phase II (quantitative data) were integrated at this stage, which is discussed in chapter 6. In some instances the results were supported by both phases; however, in other instances the one phase's data contradicted the other phase's data. Integration of data from a mixed-methods study implies merging results that may contradict or support each other (Bergman 2008:115). From the integrated data, concluding statements were formulated that formed the basis of the guidelines. Experts in guideline development, a manager of a nursing education institution, nurse managers, educators and professional nurses, validated the guidelines.

2.7 APPROACH FOLLOWED IN GUIDELINE DEVELOPMENT

The last objective, namely to develop and validate guidelines for educators and professional nurses to support students in their professional socialisation, is discussed in this section. Guidelines are described as a systematic development of statements to assist nurse practitioners and patients in the decision-making process about the best health care in a specific clinical situation (Newell & Burnard 2006:236; Scottish Intercollegiate Guideline Network 2008:2). Various strategies, such as systematic reviews, case studies, expert opinions and meta-analyses, may be used to develop guidelines (Leech, Van Wyk & Uys 2007:104; Miller & Kearney 2004:815; Polit & Beck 2008:32). Whichever method is used to develop guidelines, it must be founded on research evidence (Leech et al 2007:106; Miller & Kearney 2004:815). This study's guidelines were developed by drawing evidence from the integrated qualitative and quantitative data, using logical reasoning processes.

2.7.1 The reasoning process followed during guideline development

According to Polit and Beck (2008:13), experience, intellectual ability and thought processes are utilised in the process of logical reasoning. Two processes, inductive and deductive reasoning, are involved in logical reasoning. Inductive reasoning proceeds from a particular point of departure to a general conclusion, while deductive reasoning moves from general or various findings to a particular conclusion (Polit & Beck 2008:13; Schmidt & Brown 2009:14). Deductive reasoning was applied during the formulation process of the guidelines by using evidence from phases I and II, and the

literature. Each category included a summary of related concluding statements. From these statements, one guideline for each category was formulated. Inductive reasoning was applied when recommendations for implementation were proposed from the summarised concluding statements of each category.

2.7.2 Validation of the guidelines

There appears to be a variation in how guidelines are validated. Best-practice guidelines seemed to be the most vigorous in their validation methodology (AGREE Research Trust II 2009). Other validation strategies of guidelines included asking subject experts to evaluate the guidelines and requesting interest groups to comment on the proposed guidelines (Coetzee 2006:101; Mkhonta 2008:151).

Proposed attributes suggested for guidelines to be valid are credibility, applicability, clarity, completeness, reliability, comprehensiveness and cost-effectiveness (Adams & McCarthy 2007:132; Leech et al 2007:110, Miller & Kearney 2004:816). In this study, field experts, including guideline experts, a manager of a nursing education institution, educators, nurse managers and professional nurses, assessed the guidelines with an instrument that was adapted from studies by Leech et al (2007:110) and Maree (2007:218). A combination of these attributes was used as criteria for validation. The participants who assessed the guidelines were:

- Educators who had previously developed guidelines
- Educators involved in teaching students
- Nurse managers dealing with students
- Professional nurses involved in guiding students in their clinical learning

The participants were provided with a hard/electronic copy of a summary of the proposed guidelines that needed to be assessed against a set of criteria together with a letter that provided relevant information and requested consent from the participants (Annexures XVI and XVII). An agreement on the timespan was reached to allow them to familiarise themselves with the guidelines and give feedback. After their feedback had been received, the necessary changes were made. Finally, the guidelines were disseminated through describing the research findings in a thesis. Further

dissemination of these guidelines by means of an article and the implementation thereof in nursing education institutions and in the clinical field is envisaged.

2.8 ETHICAL CONSIDERATIONS

The three basic principles that guided the research process were beneficence, respect for human dignity and justice. The following procedures, as suggested by Polit and Beck (2008:174), were introduced to adhere to these principles:

2.8.1 Beneficence

The principle of beneficence requires minimum harm and maximum benefit to participants (Polit & Beck 2008:170). This principle was satisfied by doing a risk versus benefit assessment, as suggested by Denscombe (2007:143) and Polit and Beck (2008:174). The advantages were that the participants and respondents could benefit, as they contributed to the development of guidelines for the professional socialisation of students, thus contributing not only to the guidelines, but also to nursing as a profession. They could also discuss and share burning issues regarding student professional socialisation in a comfortable and safe atmosphere. On the other hand, the risks of participating in this study were that the participants and respondents needed to sacrifice their time. In sharing their views, especially during the qualitative phase, possible emotional harm, such as exposure to previous uncomfortable encounters, could have been experienced. Had such emotional harm become evident, the researcher would have referred the participants for counselling. However, the researcher found that the participants enjoyed the focus-group interviews and showed no signs of emotional harm.

2.8.2 Respect

Informed consent addresses the principle of respect for human dignity, which includes the right to self-determination and full disclosure (Brink et al 2012:34; Polit & Beck 2008:170–171). According to Polit and Beck (2008:176–178), informed consent should address three aspects, namely the content, comprehension and documentation of the informed consent. Aspects such as the research objectives, procedures, commitment, potential risk/benefits, compensation, confidentiality, anonymity and the right to

withdraw were included in the request for informed consent. A written informed consent form was made available to the participants in phase I (Annexures V and VI), the respondents of phase II (Annexure XIII) and the field and guideline experts during the validation of the guidelines (Annexure XVI). In addition, the related educational institutions (Annexure XII) also gave ethical approval to conduct this study, as well as the Gauteng Department of Health (Annexure II), the academic hospital (Annexure III) and the nursing education institutions' Research and Ethics Committees (Annexure XII). One education institution proposed changes to the data collection instrument. Since the distribution of the instrument to other institutions was already at an advanced stage, these suggestions were acknowledged but not implemented.

2.8.3 Justice

The last principle refers to justice, which includes the right to privacy and fair treatment (Polit & Beck 2008:173-174). The principle of justice was addressed by protecting the anonymity and confidentiality of the participants, respondents and institutions. Through replacing names of participants, respondents and institutions with pseudonyms and numbers during the transcription, entering and reporting of the data, their privacy and anonymity were respected. Furthermore, all data were stored in a secure place to ensure confidentiality.

Regarding fair treatment, purposive sampling was used in the qualitative phase (I) and the validation of the guidelines, therefore not all possible participants were included. However, that is typical of qualitative research. In contrast, all respondents who participated in the quantitative phase (II) had an equal chance of being included, since a census was used.

2.8.4 Scientific integrity

The research evidence should display sound scientific knowledge (Burns & Grove 2005:203). Evidence generated during this research was not manipulated, fabricated or plagiarised. Experienced promoters in the research process ensured that this study was performed according to acceptable ethical principles. Credit was given to previous scientific publications through referring to the sources, as well as careful paraphrasing of published work.

2.8.5 External review

Researchers might be biased when doing a risk-benefit assessment, therefore an institutional review of the research proposal for applicability is imperative (Burns & Grove 2005:199). The Research and Ethics Committee of the Department of Health Studies at Unisa reviewed this study for ethical approval, which protected the researcher, participants, respondents and institutions involved in this study (Annexure I).

2.9 CONCLUSION

In this chapter the research purpose, objectives, research design and methods of each phase were discussed. This was followed by a discussion on the integration of the data, the development and validation of the guidelines for educators and professional nurses to support the professional socialisation of students, and adherence to ethical principles.

Chapter 3 discusses the data analysis of the qualitative phase I, supported by the literature.

CHAPTER 3

DATA ANALYSIS, PRESENTATION, DISCUSSION AND LITERATURE CONTROL OF PHASE I'S FINDINGS

3.1 INTRODUCTION

This chapter discusses and presents the data analysis and literature control of the qualitative phase (phase I). The first discussion and findings obtained from the focus group interviews and field notes refer to sample A (professional nurses), followed by sample B (students) and finally the integration of the data of samples A and B. A table indicating the theme, categories and subcategories related to the relevant sample will precede the discussion of each theme's categories and subcategories. The discussion will be supported by in-text reference to the relevant units and related literature. Following the discussion of samples A and B, an integration of these findings will be presented.

3.2 DATA ANALYSIS

Tesch's method of data analysis (Tesch 1990), as cited in Creswell (2009:1860), was used to analyse the data of phase I. This process commenced with the researcher's becoming familiar with the data, differentiating between a topic and content and then listing the topics into major, unique and leftover headings. The relationships between the categories were then established, followed by the assigning of abbreviated codes. The data were subsequently sorted, bearing in mind the commonalities, uniqueness and contradictions of the content. Finally, recoding was done where necessary. A detailed description of the methodology used in this phase was presented in chapter 2, section 2.5.1.4. The main themes that emerged from samples A and B are indicated in table 3.1.

TABLE 3.1 THEMES FROM SAMPLES A (PROFESSIONAL NURSES) AND B (STUDENTS)

Sample A: Professional nurses	Sample B: Students
Theme 1: Professional nurses' views of their role in the professional socialisation of students	Theme 1: Factors related to a clinical learning environment
Theme 2: Professional nurses' perceptions of the values and beliefs of students	Theme 2: Experiences related to the attitudes of professional nurses and students
Theme 3: Professional nurses' experiences related to the attitudes of students	Theme 3: Values and beliefs orientation

3.3 ANALYSIS, DISCUSSION AND LITERATURE CONTROL OF SAMPLE A (PROFESSIONAL NURSES)

The data from sample A (professional nurses) were collected from two focus group interviews, involving professional nurses who work at an academic hospital in Gauteng. The participants shared typical information on the professional socialisation of students, since they were closely involved with the supervision of students' clinical learning. Table 3.2 indicates the biographical profile of sample A's participants, the professional nurses. It was assumed that the participants' years of experience in working with students would provide more in-depth knowledge, hence this information.

TABLE 3.2 BIOGRAPHICAL PROFILE OF SAMPLE A

Characteristic	Value	Frequency	Percentage
Gender	Male	0	0
	Female	14	100
Experience in years	<1	2	14
	1	3	22
	2	6	42
	3	1	7
	4-5	1	7
	6-17	1	7
Total number of focus-group interviews	-	2	-

All 14 participants from sample A were female and their years of experience as a professional nurse ranged from less than one year up to 17 years. Most of the participants: six (42%) had two years of experience. During the recruitment of participants for the focus group interviews, the researcher noticed that the older professional nurses were not interested in participating.

Three themes and nine categories with their subcategories emerged from sample A’s data analysis. The three themes that emerged during the data analysis of sample A were:

- Theme 1: Professional nurses' views of their role in the professional socialisation of students
- Theme 2: Professional nurses' perceptions of values and beliefs of students
- Theme 3: Professional nurses’ experiences related to the attitudes of students

3.3.1 Theme 1: Professional nurses’ views of their role in the professional socialisation of students

In Theme 1: Professional nurses’ views of their role in the professional socialisation of students, three categories emerged, namely the professional nurse as a role model with certain attributes, as clinical supervisor; and as a creator of the learning environment. The participants perceived these aspects as influential in the professional socialisation of a student. Table 3.3 indicates theme 1’s categories and subcategories.

TABLE 3.3 THEME 1: PROFESSIONAL NURSES’ VIEWS OF THEIR ROLE IN THE PROFESSIONAL SOCIALISATION OF STUDENTS

Theme	Category	Subcategory
Theme 1: Professional nurses’ views of their role in the professional socialisation of students	Role model	<ul style="list-style-type: none"> • Positive attitude • Approachability
	Clinical supervisor	<ul style="list-style-type: none"> • Knowledgeableness • Theory-practice gap • Acknowledgement of students
	Creator of a learning environment	<ul style="list-style-type: none"> • Workload • Teamwork • Continuous support • Mentor • Scarce resources • Discipline • Orientation • Learning opportunities • Communication between educators and the clinical field

3.3.1.1 *Category: Role model*

In the category 'role model', the subcategories that were associated with a role model were the professional nurse's portraying a *positive attitude* and being *approachable*. In this study the participants stated that the professional nurse should be a role model by setting an example, as is evident from the following statement:

"I think to set an example to the student, because it is important, the student need to see how a sister must be. Ja ... an example." D1

The above view is been supported by the literature, as a role model is described as a professional nurse whose observed behaviour and attitudes are imitated by students (Grealish & Ranse 2009:87; Perry 2009:37). Brammer (2006:371) emphasises the importance of a role model, because the extent to which professional nurses view themselves as role models may either enhance or inhibit the degree to which the student will develop into a competent professional nurse.

In the subcategory *positive attitude*, the participants emphasised that the professional nurse should portray a positive attitude to students. It was described as follows:

"I think behaviour and attitude from us as professional nurses, if we don't behave professionally then they would take from us the attitudes that we are promoting, let us promote an attitude that everyone can account on, and say that this sister has a nice attitude for me, then I think in that way we will create a work environment where everyone will be happy at the end of the day." D2

"The way you behave and the way you talk to them as a professional nurse is the way you can create that, it depends on you as a professional nurse, how you talk to the students." D2

Beukes et al (2010:[4]) support the importance of professional nurses' awareness of their attitudes and actions when interacting with students. However, a negative attitude creates a hostile environment that is not conducive to students' learning (Mabuda et al 2008:24).

Regarding the subcategory *approachability*, the participants felt that students should have the courage to ask questions of the professional nurse when placed in the clinical

field for their clinical learning experiences. The following quotations relate to this finding:

“Ye, whereby everyone can feel free to talk about these things so that the students can ..., it goes back to approachability. They can approach you to ask something.” D1

“So what you are saying is right. We must be approachable ...” D1

The above statement also illustrates the synergetic effect of a focus group interview, where the participants could interact and support one another's views. Perry (2009:39) states that exemplary role models have the ability to have good relationships with individuals. Therefore the professional nurses should be open-minded and be aware of the students' needs in order to support them.

3.3.1.2 Category: Clinical supervisor

In the category 'clinical supervisor', the professional nurse who fulfils this role was described as a person who assists and guides students with their clinical learning. A participant explained this role as follows:

“Really I noticed with all the fall outs of last year, really that started as staff nurses this year until now you still have to assist them and guide them and take the hands and make sure that they do the correct things and know what medication to give.” D2

Carlson, Pilhammar and Wann-Hansson (2010:438) confirm that, apart from the professional nurse's duty of caring for patients, support to students is essential for students' learning. In addition, the Clinical Model for Education and Training of SA endorses this supportive role of the professional nurse in relation to student learning (Nursing Education Stakeholders of SA 2011:3). The role of the professional nurse as clinical supervisor also gave rise to subcategories: *knowledgeableness*, *theory-practice gap* and *acknowledgement of students*.

In the subcategory *knowledgeableness*, the participants voiced their views on the level of knowledge and skills of a professional nurse in this way:

“I can say the other thing as a professional nurse, we can lead our students to professional growth by me, as a professional nurse to be knowledgeable and skilled and have a way to deliver the knowledge to the student.” D2

The value of the professional nurse being knowledgeable is highlighted by Magobe, Beukes and Müller (2010:[6]), who found that lack of the appropriate skills and knowledge in the professional nurse is reflected in students’ poor clinical competencies.

The subcategory *theory-practice gap* emerged as a display of the discrepancies between the theory and practice, and was described as follows:

“They do have the knowledge, they just don’t know how to put it forward or how to make use of it in practice” D2

The theory-practice gap could be described as the difference between the theory taught and what is practised in the clinical setting. This phenomenon has been a concern for other authors as well (Dlamini 2011:85; Nxumalo 2011:292). Another participant explained how one could assist students to integrate theory with practice:

“... Say for instance her diagnosis; she must do the pathophysiology or something. At least the student will learn in that ward and then they discuss it maybe the next day. It is better than sitting there next to the patient doing nothing and I think, how can I say, it’s give the student, how can say...also motivate the student back to her book and link theory with practicals.” D1

The participants realised the need to support students in integrating theory with practice. Other strategies to integrate theory with practice, such as continuous clinical supervision and including students as team members, have also been suggested in the literature (Evans 2009:24).

Participants were of the opinion that the professional nurse needed to acknowledge students’ progress instead of focusing only on their mistakes. In the subcategory *acknowledgement of students*, a participant stated that professional nurses were only visible when students had done something wrong, but did not acknowledge achievements. It was said:

“We coming back to feedback again, they just leave the students that they can go on, if you do something wrong then you will see the sister a lot in the day but if you do stuff right then they will say okay well she is working.” D2

The study by Carlson, Kotzé and Van Rooyen (2005:71) on final-year nursing students' experiences regarding their preparedness to become a professional nurse found that students in their study indicated that the feedback that professional nurses give is mostly negative. Another participant suggested that a technique to give recognition was to allow students to include their own ideas:

“And again, for motivation, just give them a chance to bring their own ideas, if they have an idea, give them a chance so that they can use their own ideas.” D2

Acknowledgement of competencies that have been achieved enhances the learning process as well as the student's self-esteem and motivation (Clynes & Raftery 2008:406).

3.3.1.3 Category: Creator of a learning environment

In the category 'creator of a learning environment', the subcategories *workload, teamwork, continuous support, mentor, scarce resources, discipline, orientation, learning opportunities* and *communication between educators and the clinical field* emerged. The participants felt that these aspects were important influential factors in the creation of a favourable learning environment. A participant voiced her opinion on the learning environment as follows:

“No with regards to this teaching. I think we should create an environment or atmosphere which is conducive to learning.” D1

The clinical setting is characterised by a variety of learning opportunities, which are uncontrolled (Koontz, Mallory, Burns & Chapman 2010:240). Unlike in a classroom setting, the educator, or in this instance the professional nurse, cannot control the attitudes, work ethics, patients, family members, supplies and equipment, which results in an unpredictable learning environment. The participants were well aware of the unpredictability of the clinical setting, which was evident from the discussion on the different subcategories.

Regarding the subcategory *workload* the participants voiced their concern about their unavailability to support students in their learning needs because of the amount of work. A participant said:

“Because most of the time we are busy in the ward and we utilise the student as a workforce, we then forget that they are here to learn.” D2

Similar results were found in other South African studies, which indicated that where students were used as a workforce, it interfered with their learning objectives (Carlson et al 2005:70; Magobe et al 2010:[4]). In South Africa, students are part of the workforce and are not supernumerary. This situation is not unique to South Africa. Students in the UK experienced being ‘used’, which had a detrimental effect on their studies when they had to share the workload (McGowan 2006:1103–1104). On the other hand, where students have supernumerary status, it widens the gap between theory and practice, thus interfering with the learning outcomes (Allan, Smith & O’Driscoll 2011:853).

Another issue that emerged was the professional nurses’ inability to work in a team. In the subcategory *teamwork* the participants explained that there was often not enough support among team members, especially when students needed to be disciplined. Professional nurses did not want to be labelled as the ‘bad’ nurse, and thus failed to support colleagues when unpleasant decisions needed to be made. A participant reported as follows:

“We must come together. If they do something wrong we must discipline them. I cannot be the nice sister and she becomes the bad sister, because she is always calling them, you, what that in charge [Meaning the professional nurse in charge of a unit].” D1

In situations where double messages are portrayed, students become confused and consequently the learning process is hindered. Waterson, Harms, Qupe, Martitz, Manning, Makobe and Chabeli (2006:73) report that one of the factors that may contribute to the poor performance of students is educators working in isolation and not as a team. The same principle concerning educators could be applied to professional nurses’ teamwork. It is important that professional nurses support each other in portraying the same message to students.

In the subcategory *continuous support*, the participants expressed the view that students were often exposed to clinical situations that they were not fully prepared to handle. They suggested continuous support, especially emotional support, during exposure to the clinical field. A participant stated the following:

“Nurses are just thrown in there, they must just work and do things and go on and I think from an emotional level that is difficult for them as well.” D2

Support to students is important; Chesser-Smyth (2005:324) states that students experience anxiety, particularly during their first placement in the clinical field. However, Grealish and Ranse (2007:176) found that although challenging situations may cause feelings of anxiety, they are seen as significant learning opportunities.

Being a *mentor* emerged as subcategory which implied guiding students in their learning, as is evident from the following two statements:

“... because they look at us because as their mentors in the wards, so we must teach them wherever they don't understand them and answer their questions so they need something.” D1

‘I think it's better to use the mentors, so the student can learn fast because sometimes as sisters we are busy, we don't have time to teach the student, that is the problem, so the mentors because they are there, they are going to teach the students.’ D2

The participants' understanding of the person responsible for acting as mentor was different. The first statement described a mentor as a professional nurse who acted as a mentor, while the second participant was of the opinion that a mentor was a dedicated staff member who fulfilled the role of a mentor as part of his/her daily activities. Despite this difference in opinion, the value of mentoring was appreciated.

The participants stated that *scarce resources* were barriers to learning; however, the problem could be overcome as long as a clear explanation was provided to the student on why certain procedures were performed in a specific way. The following was said:

“We didn’t have this equipment, so in order for us to get here we did this. Because you looking at the outcome. But the student must know why you did that.” D1

“Most of the units there’s no Mims in the ward.” D2

This finding was also evident in other studies where professional nurses are faced with challenges such as limited resources with regard to human resources and equipment (Mabuda et al 2008:22; Mntambo 2009:148). Although limited resources are viewed as a barrier to learning, Hathorn, Machtmes and Tillman (2009:237) state that staff shortages could be seen as an opportunity to include the student in active patient care and could therefore enhance students’ learning experiences.

In creating a learning environment the participants believed that there should be order and *discipline*, which emerged as a subcategory. Students should report on time for work and be corrected when they failed to adhere to the basic rules of the ward. They expressed themselves as follows:

“The other thing is discipline, knowing that they have to report to work on time, to report whenever they go out or they are attending at school, so that’s something that we can teach them so that they can be responsible at the end of the day.” D2

Waterson et al (2006:72) maintain that students lack respect for their superiors and do not exhibit disciplined behaviour. In order for students to become professionally socialised, they should learn the professional conduct of nursing. The participants felt they should coach students to be accountable for their behaviour. The Registered Nurses’ Association of Ontario (2007:32) states that the key factor in being professional is accountability, which implies acceptance of responsibility for one’s actions.

The participants agreed that *orientating* students on their first day in a ward was important. However, it might not always be possible, owing to work pressure. They shared their views as follows:

“Sorry, what I have ... also wanted to say, it also starts with orientating the pa ... ag the patients, the students when they enter the ward for the first time.” D1

”Personally I ... there are days that is so busy in the morning ... you really cannot orientate the student at that time. You, you want to settle the ward, because

before am here for a student, I here for a patient. So let's see that the patients are settled then I'll take you around and show you the unit." D1

It appears that the participants are aware of the needs of the students, but because of the demands of the daily activities of the ward, it is not always possible to orientate students as they wish to. The value of orientation is confirmed; as Levett-Jones, Lathlean, Higgins and McMillan (2009:320) state, when students are well orientated they experience less anxiety, have an increased feeling of self-worth and are positive about learning.

In the subcategory *learning opportunities*, the participants were well aware of students' need for learning opportunities. However, it appeared that it was not always possible to allow students to do all the procedures because the students behaved irresponsibly. A participant stated her view on this as follows:

"So and sometimes you will see that some sisters will give students not that opportunities. It's not that ... you ask this. In my ward if you are a student we will not be allowed to get an RP (radical prostatectomy) patient from theatre. And there is nothing special about that patient. It is just that they have been open in their abdomen and we know that you will just come and dump your patient there."
D1

A challenge regarding learning opportunities was that students should clearly understand what was expected of them, especially when learning opportunities were provided. Other reported challenges were to provide meaningful learning opportunities to students; however, limited placement in the different disciplines and ineffective communication regarding students' learning needs complicated this objective (Beukes et al 2010:[5]; Hathorn et al 2009:237; Mabuda et al 2008:23–24).

The participants expressed their concern about lack of *communication between educators and professional nurses*. The students exploited this lack of communication to their own advantage and also undermined the professional nurses' authority, as is evident from the following:

"When you ask them, 'no, my lecturer said so and so'. So that's why I said it's a triangle and it could only function when everyone brings their part." D1

"If their lecturers, they will come follow them up. I don't know what school. I also think there is also no relationship between the, those lecturers and the, the

sisters. Because sometimes they will just come and greet you and pass and they can't even ask you that how are my students or what's happening." D1

Poor communication between professional nurses in the clinical area and educators is not unique to the institution where the study was done. Similar evidence was found in Mabuda et al's study (2008:23-24), which suggested that there should be better cooperation between professional nurses, preceptors and educators to ensure that the learning needs of students are appropriately addressed.

3.3.2 Theme 2: Professional nurses' perceptions of values and beliefs of students

This theme describes how professional nurses perceived the values and beliefs as displayed by students. This display emerged as the categories 'disciplined behaviour', 'career choice' and 'image'. Table 3.4 displays the categories and subcategories related to the theme 'professional nurses' perceptions of values and beliefs of students'

TABLE 3.4 THEME 2: PROFESSIONAL NURSES' PERCEPTIONS OF VALUES AND BELIEFS OF STUDENTS

Theme	Category	Subcategory
Theme 2: Professional nurses' perceptions of values and beliefs of students	Disciplined behaviour	<ul style="list-style-type: none"> • Maintaining discipline • Respect
	Career choice	<ul style="list-style-type: none"> • Career choice
	Image	<ul style="list-style-type: none"> • Appearance • Perceptions of the profession

3.3.2.1 Category: Disciplined behaviour

In the category 'disciplined behaviour', the subcategories *maintaining discipline* and *respect* emerged as patterns of behaviour from students. Students lack discipline. This finding was previously discussed in the category 'creator of a learning environment'. Participants expressed concern about ill-disciplined students. They argued that students should be disciplined because the values typical of the nursing profession should be respected. The following statements explain their views:

“... must come together. If they do something wrong we must discipline them.” D1

“So if you work at a certain level or are professionalism and you can enforce that to others even if they don't like it they won't do it because that's just the way it is because those are the values of ward of the hospital or the company that you work for.” D2

Subedar (2008:102) states that professional behaviour is fundamental to all nurses and students should learn the rules and norms of nursing.

In the subcategory *respect*, the participants perceived students as disrespectful towards patients and senior persons. The following quotation illustrates their views:

“But being professional and respectful. When, when one of the matrons or senior persons come you will stand, go to your patient even if you just go and say hello.”
D1

The participants perceived students as disrespectful when they did not rise from their chairs when a senior person entered a room, or when they wore their nails long when nursing patients. Students not greeting a person, and students leaving the ward without permission were also reported as disrespectful behaviour in Klerk's (2010:29) study. Disrespectfulness is not unique to South Africa, as student disruptive behaviour related to the academic environment was also found in the United States of America (US) (Clark, Farnsworth & Springer 2008:261-262). Gallagher (2007:370) states that respect involves acknowledgment and an appreciation of other persons' uniqueness.

3.3.2.2 Category: Career choice

In the category career choice, the participants were concerned about the kind of students who chose nursing as a profession, as is evident from the following statement:

“It is not a calling to them, then they won't be professional, and they won't respect anything else because they are not happy with what they are doing; they just doing it to get a salary and you have to love what you are doing.” D2

Furthermore, the participants felt that the students entered the profession without passion. They voiced this as follows:

“But I also think it is also a problem that most of the students do not want to be nurses anymore. Ummm ... if you ask them, I think almost 70% will tell you didn't want to be a nurse.” D1

The participants believed that students pursued nursing as a career for the wrong reasons; as one participant said:

“Yes, I think they still have to have the passion of nursing, they mustn't take nursing as just ordinary work, they must have a passion for it and they must enjoy it, the more they have passion.” D2

Reasons for choosing nursing as a career could be influenced by factors such as an experience of a family member being ill or internal motivational issues (Chitty & Black 2011:131). A South African study indicated that students selected nursing as a career because they could earn a salary while studying (Breier, Wildschut & Mgqolozana 2009:[3]). This reason was also found to be true in this study.

3.3.2.3 Category: Image

In the category 'image', the subcategories *appearance* and *perceptions of the profession* emerged. The participants were concerned about the image that students and professional nurses portrayed. They shared their experiences in terms of physical appearance and their perceptions regarding nursing as a profession. The participants expressed the opinion that the appearance of students and professional nurses did not portray the desired image of the profession. The following statements illustrate their views:

“The way we are dressed, it doesn't show professionalism; even sisters you will really wonder what went wrong; the way I will dress it doesn't show professionalism.” D2

Another participant said:

“... image somebody is working in labour. How do you do your PV (vaginal examination). How do you PV your patient with those nails?.” D2

“Long hair and long nails and ... Miniskirts ...” D2

Nursing as a profession has a certain dress code, for example wearing distinguishing devices with the appropriate uniform and short nails to protect the patient from injuries. The dress code has changed over the years, from a white starched linen uniform to a more comfortable dark coloured uniform. Nurses feel very strongly about a dress code. The issue of wearing a white uniform sparked a debate during a Nursing Summit in April 2011. This debate resulted in a request that all stakeholders should advocate the wearing of a white uniform (NEA Newsflash 2011:1). This signifies that the current practices regarding the dress code do not portray the desired image of the nursing profession.

A poor public image of nursing is a matter of concern. The participants described incidents in which they encountered negative attitudes from the public about the fact that they chose nursing as career. One participant stated that when she told someone she was a nurse, the reply was:

“Oh, no. Isn’t there anything else that you could have done?” D2

Not only the public but also the participants themselves were of the opinion that nursing has a negative image.

“I think our profession has got very negative connotations to it.” D2

Nursing as a profession seems therefore to be faced with not only internal challenges, but also public perceptions of the profession. Meiring (2010:108) states that the media contribute to this negative perception.

3.3.3 Theme 3: Professional nurses’ experiences related to the attitude of students

The theme ‘professional nurses’ experiences related to the attitude of students’ describes how professional nurses experienced students in the clinical area. Two categories emerged, namely ‘gender’ and ‘attitude’. Table 3.5 displays the categories and subcategories that will be discussed related to theme 3.

TABLE 3.5 THEME 3: PROFESSIONAL NURSES' EXPERIENCES RELATED TO THE ATTITUDE OF STUDENTS

Theme	Category	Subcategory
Theme 3: Professional nurses' experiences related to the attitudes of students	Gender	<ul style="list-style-type: none"> • Male
	Attitude	<ul style="list-style-type: none"> • Negative attitudes • Positive attitudes

3.3.3.1 Category: Gender

In the category 'gender', the participants described male students as uncaring and undisciplined. The following quotations explain their view:

“Ja but the male students are ... He was sitting there not caring. But when she asked him and his getting away with everything.” D1

Another participant just put it simply:

“Ja, male students!” D1

Gender-related issues in nursing focus on the shortage of men in the profession and the barriers they are faced with, such as the public perception of men in nursing (Roth & Coleman 2008:151). In contrast, this study's data on gender issues were related to negative experiences female professional nurses had with male students.

3.3.3.2 Category: Attitude

In the category 'attitude', two subcategories, namely *positive attitudes* and *negative attitudes* are discussed. The participants maintained that people's background and the way in which they had been raised would determine students' attitude to the nursing profession and their caring attitude to patients. One participant held the following view:

“I think also your upbringing influences the way you at work. The nu... the sisters and also the students; it goes back to attitude, I think. Also the way you handle you parents, the way your parents handle you, I think it also have an influence.”
D2

An attitude is described as a complex mental state involving beliefs, feelings and values and dispositions that cause persons to act in a certain way (WordWeb Online 2009. Sv “attitude”). The participants were pleased with those students who portrayed a positive attitude, which is evident from the following statements:

“Very impressed I even say to myself these students are very hard working people. Really first year!” D1

“B group that 3rd year group they are really such a nice group and they are the smartest group, they are always willing to learn, they are always punctual and so they become a group of sisters who are also that calibre and if you can do that with every year group then you grow ... a good profession again.” D2

The data suggest that professional nurses are more willing to work with students who have positive attitudes than with students who are not serious about their studies. The following statement was made about a negative attitude:

“... The attitude from the student’s side is also important, because I find I can work with students ..., she doesn’t have to be the smartest student but at least she is willing to learn and she comes and ask me questions, I will explain to her everything, but the other ones who think they are too clever or the other ones who is just lazy and they don’t know anything and don’t want to do anything, I cannot work with them.” D2

Professional nurses’ willingness to help students may be influenced by other factors, such as legal implications. This implication contributes to professional nurses feeling that students are a nuisance at times (Hathorn et al 2009:241; Levett-Jones et al 2008:320). In this study the participants felt that as long as students had the appropriate attitude, they would help them. A participant described her view as follows:

“But the negative side that I have seen from students this day is that that don’t want to learn. The less they can do the better for them. So you will always find that they are sitting around and when you approach then they became angry. But the ones that I notice in my unit, okay there is ... may I must say mmm. Less that 50% are like that ne.” D1

Some students were not serious about their education and had an apathetic attitude. Similar findings were recorded in a South African study on the attitudes and values of educators and students (Waterson et al 2006:72).

3.4 ANALYSIS, DISCUSSION AND LITERATURE CONTROL OF SAMPLE B (STUDENTS)

The data from sample B (students) were collected from five focus-group interviews involving students. The focus groups were conducted according to the students' levels of training, in order to ensure an open discussion.

The biographical profile of the participants, including gender and training level of the participants, is indicated in table 3.6. There were 48 participants in this sample, of which four (8.3%) participants were males, while 44 (91.7%) were females. Five focus-group interviews, grouped according to the level of training, were conducted. One interview included third- and fourth-year level participants, as both groups turned up. It was decided to continue; an additional interview, involving only third-year level participants, was conducted. The data demonstrated no difference between the themes that emerged from the focus groups that included only third-year level participants and the group that included third- and fourth-year level participants.

TABLE 3.6 BIOGRAPHICAL PROFILE OF SAMPLE B

Characteristic	Value	Frequency	Percentage
Gender	Male	4	8.3
	Female	44	91.7
Total number of participants		48	100
Level of training	1	10	20.8
	2	10	20.8
	3	11	22.9
	3 & 4	7	14.6
	4	10	20.8
Total number of participants		48	100
Total number of focus groups		5	

As regards the first-year level students, Cohen (1981:16) describes the first stage as the unilateral-dependence stage, which is when the students rely on an external authority to guide them. The first-year level students were initially not particularly explicit in sharing their experiences; however, when they became more relaxed, they shared their experiences freely. This observation fits into the first stage of Cohen's (1981) model, in that first-year students would at first be reserved, because of their dependency level.

It was noticed that the second-year level participants needed more time to share their experiences. They were allowed additional debriefing time to verbalise their experiences after the interview was terminated. The second-year students were disillusioned in what they experienced and were questioning practices. This phenomenon fits into Cohen's (1981:17) second stage of professional socialisation, the negative-independence stage. This stage is characterised by rebellion and questioning of current practices.

In the third stage of Cohen's (1981:17) model, which is called the dependence-mutuality stage, the student learns his or her role limits and tends to associate with role models. Interestingly, the third-year level students expressed their disapproval of some behaviour of professional nurses in no uncertain terms.

The final stage, according to Cohen (1981:17), is when the student acts independently, called interdependence. In this study, the fourth-year level participants still had issues with which they were dissatisfied, and were still in a stage where they had to act under the supervision of a professional nurse. It thus appears that the first three stages of Cohen's model were reflected in the participants' level of training. The findings of these data will subsequently be discussed.

Three themes and 11 categories with their subcategories emerged from sample B's data analysis. The three themes that emerged during the data analysis from sample B were:

- Theme 1: Factors related to the clinical learning environment
- Theme 2: Experiences related to the attitudes of professional and student nurses
- Theme 3: Values and beliefs orientation

3.4.1 Theme 1: Factors related to a learning environment

In theme 1, factors related to a clinical learning environment, four categories emerged, namely 'teaching and learning', 'daily activities in a nursing unit', 'health and safety risks' and 'communication between the clinical field and nursing educational institutions'. The categories and subcategories are displayed in table 3.7.

TABLE 3.7 THEME 1: FACTORS RELATED TO A CLINICAL LEARNING ENVIRONMENT

Theme 1: Factors related to a learning environment		
Theme	Category	Subcategory
Theme 1: Factors related to a learning environment	Teaching and learning	<ul style="list-style-type: none"> • Positive/negative learning environment • Learning opportunities • Professional nurse as clinical supervisor • Level of the professional nurse's knowledge • Theory-practice gap • Teamwork • Mentor • Educator
	Daily activities in a nursing unit	<ul style="list-style-type: none"> • Orientation • Work schedule • Workload • Resources
	Health and safety risks	
	Communication between clinical field and nursing educational institutions	

3.4.1.1 Category: Teaching and learning

The subcategories related to the category ‘teaching and learning’ were *positive versus negative environment, learning opportunities, professional nurse as clinical supervisor, level of knowledge of the professional nurse, theory-practice gap, teamwork, mentor and educator*. The participants stated that the learning environment should be characterised by acceptance of a student who is not perfect but needs to learn. The following was said:

“... if you go to a hospital or if you are in an environment where you are accommodated and accepted as a student with your faults and because you are there to learn, we are not perfect, we are there to learn but I just hate coming to a ward where I know I won't be accepted, I really hate it.” D7

Meyer and Van Niekerk (2008:107) support the above-mentioned statement, stating that students should be respected for their uniqueness and their abilities that need to develop.

The subcategory *positive versus negative learning environment* dealt with the influence of the environment on student's learning. When the professional nurse is willing to teach and support students, a *positive learning environment* is created. The following statement illustrates this view:

"... and in G, I worked in ward 6, there's one sister, we even asked her to come and work as a teacher, she said she will be frustrated by us, she has this thing diabetes DKA (Diabetes Ketoacidosis) – She was always willing to teach us, even during tea time and lunch time." D3

In contrast, a negative learning environment caused students to become demotivated and reluctant to come to work. The participants shared their thoughts as follows:

"I'd like to say something that is very negative. When I started nursing, I started four years ago with like ..., I loved it, I really loved it, ... When I came to this part of nursing, I hated ..., I'm sorry to say that, I come to work not because I hate giving patient care, I hate coming to work because of the units that I work in ..."
D7

Participants believed that if the professional nurse was willing to teach and accept them as students who were not yet competent, a positive learning environment would be created, whereas the opposite would create a situation where students disliked nursing. Koontz et al (2010:244) state that professional nurses need to take cognisance of the influence they have on students' learning experiences, an observation which seemed to be relevant for this study.

Learning opportunities as subcategory emerged as an important influential determinant in the professional socialisation of students. The participants expressed frustration because they were not given adequate opportunities to learn. They were assigned to perform fragmented routine tasks, which did not form part of a holistic care plan for a specific patient. This situation led to boredom and frustration. The following was said:

"... that I feel like I know everything, from what to what, so all you do is just push the machine (blood pressure machine) until you are tired, until you can't push it anymore, you are so frustrated, the whole day, the machine, I was asking them what is going to be new in second year." D3

Several studies confirm that students are not provided with meaningful learning opportunities (Beukes et al 2010:[5]; Hathorn et al 2009:228; Mabuda et al 2008:23).

Apart from learning opportunities, students expressed a need to be supervised by a professional nurse; however, students complained that the professional nurses did not have time to fulfil this function. They were even scared to ask questions of professional nurses. A participant said the following:

“So you are scared to go and ask questions, you are just scared to ask “can I do that” or .., you are...” D6

If students are afraid to approach the professional nurse this could be risky, as they may perform nursing interventions without supervision. Mabuda et al (2008:23) also found that students were left alone to do the procedures without supervision. According to Baxter (2007:104), clinical supervision allows the student to improve his or her clinical skills, develop relationships with experienced practitioners, socialise into the clinical setting, apply theory to practice and ultimately provide safe patient care. If a situation is created where the student is afraid to approach the professional nurse, then obviously learning will be hindered. Thus the professional nurse as *clinical supervisor* was identified as an important agent in the socialisation of students.

Not only did the participants want the professional nurse to be a clinical supervisor, but also felt that they needed to demonstrate a certain *level of knowledge*. The participants were disappointed in the professional nurses' level of knowledge, because they did not know patients' diagnoses and were unable to answer questions. They said the following:

“... if you go and ask they would say go to Ward so-and-so behind the door. There is this pamphlet, you can read it and then you will find the answer. I mean this person has been working in this ward for ages, for years, but they still can't explain to a student in simple terms what is wrong with a patient.” D3

Koontz et al (2010:244) argue that staff nurses (professional nurses) feel insecure when challenged with situations they do not know. Magobe et al (2010:[4]) found that a lack of appropriate qualifications of professional nurses contributed to poor clinical competencies in students. The above findings might provide some reasons for professional nurses lacking relevant knowledge.

In the next subcategory: *theory-practice gap*, professional nurses in sample B share similar perceptions to those of the participants in sample A regarding the gap between theory and practice, as is evident from the following statement:

“The things that I am learning in theory they are so different, I can’t apply most of them in practice.” D5

Similar findings were found in other studies done in South Africa and Iran (Mabuda et al 2008:23; Sharif & Masoumi 2005:[4]). Another participant said that when educators helped them to reflect on their practice they were able to integrate theory with practice. The following was said:

“I experienced it very positive because all the academics that we learn in our classes really reflect when you go into the ward to do the procedures.” D4

Reflective practice is one of the strategies suggested by Duffy (2009:166) to enhance theory-practice integration, which seems to have occurred in this case, to judge by the above statement.

The ability of professional nurses to demonstrate *teamwork* was experienced as another influential factor in professional socialisation of students. The participants were of the opinion that professional nurses could not work together as a team. However, in situations where the participants felt part of a team, they felt appreciated and were motivated to go into the clinical field. The following was shared:

“The one thing that nurses cannot do themselves is to work as a team, you find they don’t care even if there are students, they just shout at each other like that, they lack professionalism if I can put it that way.” D5

“... but for me when I feel more involved in the work and when I feel more accommodated, It makes it easier for me to go to work, I look forward to going to work, I even enjoy working because I know what I’m doing ...” D7

Including students as team members was also found to have a beneficial effect in studies done in the UK, Australia and Japan, which indicated that when students are included as team members, learning is enhanced (Condon & Sharts-Hopko 2010:169; Grealish & Ranse 2009:9).

In the subcategory *role of the mentor*, the participants viewed peers or junior qualified professional nurses in their community-year service as mentors. The positive impact of a mentor was reported, since students would easily ask a mentor for assistance instead of the professional nurse. The following statement illustrates the role of a mentor:

“When they came it was so nice because I would go to them and say “the sister just said ...” you know for example an abbreviation that you don’t know and you’re scared to ask, “what’s that?” and then you just go to them and you go, “the sister wants this and that” so if they can get the third years to be like mentors to the first years ...” D7

The positive role of a mentor was also highlighted in Magobe et al’s (2010:[4]) study, which found a positive relationship between the competencies of students and the quality of mentors.

Apart from the influence the professional nurse could have on the students’ professional socialisation experiences, the participants reported the *educator* as being knowledgeable, open and approachable, which in turn motivated students. The participants reported their views as follows:

“Then we were helped by our tutors, we asked everything that we wanted to know so that it gave me a positive motivation to continue because they came to the wards ...” D5

This finding contradicts the findings of Mabuda et al (2008:22) and Waterson et al (2006:72), which state that the educator was only seen during assessments, which had a negative impact on the learning of students.

In the category ‘teaching and learning’, various factors were found to influence students’ professional socialisation.

3.4.1.2 Category: Daily activities in a nursing unit

The category ‘daily activities in a nursing unit’ was divided into the subcategories *orientation*, *off-duty*, *workload* and *resources*. This category describes the daily activities that occur when working in a ward and the challenges students face when dealing with these activities.

Orientation is a basic activity that is usually done when students enter a new unit. All the participants reported that they did not receive any orientation when starting to work in a new unit. One participant even indicated that her first encounter with the clinical field was an unpleasant experience, since she was never orientated. She described it as follows:

“Okay I had a very bad experience because my first week at the hospital they didn’t orientate me at all and I was told that I’m going to do the bed pans only and it was so traumatising, because it was my first year and I didn’t know what to expect exactly as a first year student.” D4

In addition, the participants described the emotions they experienced, especially in their first year when they were not orientated. One participant said:

“And first year students are so emotional, from home and they are very emotional so they do not tend to remember anything that you tell them.” D4

Various studies highlight the importance of orientation. When students are orientated their ability to learn increases and they feel good about themselves (Chesser-Smyth 2005:325; Happel 2009:373; Levett-Jones et al 2009:319). The data in this study indicated that students were left alone, which obviously had a negative impact on learning outcomes.

In the subcategory *work schedule*, the students who took part in this study needed to complete a minimum of 4 000 hours training during their four years of study to be registered with the SANC (SANC 1985b:par.2.3). These hours are divided into prescribed disciplines and are scheduled considering the needs of a unit and the prescribed hours. Students in this setting were not supernumerary. The participants reported unfair practices regarding permanent staff getting preference in terms of personal needs. If the participants asked to schedule their clinical learning experiences in such a way that they would have time available to prepare for a test, it was not granted. In some instances they had to work from 7:00 to 19:00 and write a test the following day. One participant described it as follows:

“Ja I can seconded that because they usually say they are short of staff on weekends and you must work” ... Whereas the same permanent staff will request my son is sick or just not feeling well and they will get off, whereas when I’m writing a test tomorrow and I’m allocated for the 7 to 7 shift the day before and I request maybe 7 to 1 or a day off and I work later on, I am not granted that opportunity.” D5

On the other hand, students may also be guilty of not adhering to the scheduled working hours. Mntambo (2009:135) reports on pupil-enrolled students who are not willing to work during weekends.

The *workload* of the ward affected the participants. They reported that they were frustrated and even emotionally affected when the professional nurses were too busy, mostly with administrative work, to assist them. They voiced their frustration as follows:

“... you ask and she says “no I haven’t got time, I’m busy” ... they are always busy with administration, always administration.” D4

“... it’s so busy you don’t even smile because it’s like in my case I’m so emotional in such a way that if I feel I have to do something, the one who is supposed to do it and he doesn’t do it, I feel like grabbing this person and make them do what they are supposed to do.” D3

Pearcey and Draper (2008:600) confirm that professional nurses give priority to administrative duties, which causes students to become frustrated. Although Lehasa (2008:87) supports this finding, stating that professional nurses have an increased workload, Mongwe (2001:106) found the opposite in her study. She found that professional nurses said that they were busy, but when they were observed this was not always the situation.

Apart from an increased workload, inadequate *resources* contributed to the challenges of nursing care, as well as the teaching and learning of students. The participants complained of not having enough basic supplies, such as gloves. It appears that this situation may be due to lack of proper planning, since supplies were then borrowed from an adjacent ward. The participants explained it as follows:

“When we tell them the gloves are big they say there’s nothing we can do, you have to wash with those gloves, either put two gloves, try something else, but you have to wash the patients with those gloves.” D3

“The other thing that plays a big role is the management of the ward, if there is enough stock and you are able to do without going to another ward for an injection or something like that ...” D6

Magobe et al (2010:[4]) found similar evidence of lack of equipment, which hindered students’ learning outcomes.

It is evident that the participants were faced with various challenges during placement in the clinical field, such as a lack of orientation, strict scheduling of hours, professional nurses’ workload and inadequate resources.

3.4.1.3 Category: Health and safety risks

According to the Occupational Health and Safety Act no 85 of 1993 (South Africa 2005b), employers are obliged to protect their employees against occupational health and safety risks, such as possible infectious diseases. The participants reported that they were allocated to care for patients with infectious diseases without being informed of the risks involved. When the participants showed signs and symptoms of encephalitis, they were not provided with the necessary support. Their concerns were as follows:

“I think there was about 9 of our students are having encephalitis now; before that, a lot of us were ... and we all had the same symptoms, terrible headaches, stiff neck, fever, but we are not allowed to get medication, you have to go and see your own doctor or, so you don’t get protected.” D3

In this situation the basic need of being safe was not satisfied. Similar situations were found in another study, where students reported that they were forced to work with patients with communicable diseases without the necessary protection (Mntambo 2009:123).

3.4.1.4 Category: Communication between the clinical field and nursing educational institutions

Communication between the clinical field and nursing educational institutions is important to ensure that both stakeholders' needs are addressed. The participants described experiencing a lack of communication between these two stakeholders regarding the students' work schedule on public holidays. In certain instances students were not supposed to work on public holidays as they needed to receive extra remuneration, which is not included in the students' budget. The following was said:

“We have that meeting, the unit managers seem to understand that and then when they have the meeting their staff, I don't know where it goes wrong, do they give out a message” D7

When clear communication between the nursing education institution and the clinical field occurs, learning is enhanced, for example about the learning objectives students need to complete (Hathorn et al 2009:242).

Theme 1 addressed the challenges experienced by the participants in relation to the environment where they needed to learn and receive support. The issues that seemed to be important included teaching and learning, the daily activities in a nursing unit, health and safety support, and communication between the clinical field and nursing educational institutions.

3.4.2 Theme 2: Experiences related to the attitudes of professional nurses and students

In the second theme, namely experiences related to the attitudes of professional nurses and students, the categories 'attitudes', 'favouritism' and 'attitudes of professional nurses to other members of the multi-disciplinary team' are discussed. Table 3.8 displays the categories and subcategories of this theme. In sample A (professional nurses) the same category, attitude, was discussed, with the difference that it was described from the viewpoint of professional nurses.

TABLE 3.8: THEME 2: EXPERIENCES RELATED TO THE ATTITUDES OF PROFESSIONAL NURSES AND STUDENTS

Theme	Category	Subcategory
Theme 2: Experiences related to the attitudes of professional nurses and students	Attitude	<ul style="list-style-type: none"> • Positive • Negative
	Favouritism	
	Attitude of professional nurses to other members of multidisciplinary team	

3.4.2.1 Category: Attitude

In the category ‘attitude’ the subcategories *positive* and *negative attitude* as experienced by students emerged. In the subcategory *positive attitude*, the participants shared positive experiences related to professional nurses who would teach them. The following was reported:

“... say “call your colleagues so that I tell you together.” I’ve had good experience with the sisters.” D3

Hathorn et al (2009:229) are of the opinion that when a positive learning environment is created where students are treated with dignity and respect, they will internalise the appropriate behaviour.

In contrast, the participants related that they had negative experiences in relation to the *negative attitudes* of professional nurses during their clinical learning experiences. They accused the professional nurses of hostility and stereotyping them. They said, for example:

“I don’t know what to say, a lot of sisters, they hate students, they say that, ja, some of them, they say that we think that we are superior or something, they just have this, ja some of the sisters have this attitude towards us.” D3

“It’s not fair you get to a ward they stereotype, they label you, they give names, they don’t treat you fairly because they don’t even know you.” D7

Mabuda et al (2008:24) found similar evidence in Limpopo, where students complained of the negative attitude of professional nurses and stereotyping. The participants in the current study went further and said the professional nurses were the reason they became delinquent. They described it as follows:

“... has a major impact on why students are delinquent, because if you coming into a ward and the sister understands you’re a student, you are a human being first of all, you going to have problems along the way and she’s actually giving you that space to have you problems, then you going to make sure you come early to work, when I’m delegated for a task.” D6

From the statements it is clear that much of the relationship between the professional and student nurses was dysfunctional. Levett-Jones et al (2009:323) state that learning is influenced by the quality of the relationships students have with staff members.

Apart from the accusation that the professional nurses had a negative attitude, the students among themselves experienced unsatisfactory relationships. The following was said:

“Then you get a student, let’s say from Y but I think they were 4th years, ‘god’ knows they were so rude. You couldn’t ask them anything, actually if you ask something they will make you their guinea pig.” D4

It thus appears that when the participants experienced positive attitudes from professional nurses and their peers, relationships were favourable and learning was enhanced, whereas when a negative attitude was experienced it contributed to students’ delinquency.

3.4.2.2 Category: Favouritism

The students who took part in this study were from three different nursing education institutions. All three institutions were represented during the focus group interviews. During the interviews it became clear that the participants perceived that students registered at certain education institutions received preferential treatment. The following statements illustrate their views:

“... this rivalry thing going on between the three institutions because we feel at “X” the “U” students think they are better than us and then “T” we really don’t know them ...” D7

“Anyway they are being bias and favouring which students, I never thought they hated “X” students, I never thought they don’t like “T” students because where

ever we go is “U” students, “U” students, and it’s like, we’ve heard enough”

D3

Khatri and Tsang (2003:289) describe favouritism as the special relationship between superiors and subordinates, which they call cronyism. They argue that in an organisational context where cronyism exists, certain subordinates will easily be promoted and get a salary increase. Although the participants in the current study felt that there was favouritism, they were surprised, when they shared their views in the same group, to find that other students from other nursing education institutions felt the same. These findings demonstrate how easily perceptions are formed that might not always be true.

3.4.2.3 Category: Attitudes of professional nurses to other members of the multidisciplinary team

In the category ‘attitudes of professional nurses to other members of the multidisciplinary team’, it was the participants’ perception that professional nurses treated students differently from medical students and doctors. The participants perceived professional nurses’ attitude to doctors as that of trying to please them, whereas students were treated as though they were inferior. They said the following:

“Okay, one thing that I hated about nurses is that it seems as if they can’t be independent, most of the time they want to please doctors, it’s all about doctors.”

D5

“... why do you treat me as a student, why do you treat me different than you treat that assistant medical student? She could not answer me.” D4

The participants were disappointed in professional nurses not being able to act as independent practitioners. It seems that professional nurses still do not have a clear understanding of their role with regard to medical doctors. The Van Wyk versus Lewis (1924) case clearly indicated that professional nurses have their own profession and are in no way the servant of a doctor. They should therefore claim their professional status and practice (Searle, Human & Mogotlane 2009:111). Furthermore, treating students differently could be seen as a form of humiliation. Students are not always sufficiently equipped to deal with such behaviour as bullying and humiliation (RNAO 2009:41).

As discussed in theme 2, students mostly experienced negative attitudes from professional nurses, which could hinder their professional socialisation. Furthermore, students perceived themselves as being compared with one another and treated with less respect than medical students.

3.4.3 Theme 3: Values and beliefs orientation

In theme 3, ‘values and beliefs orientation’, the categories ‘professional nurses’, ‘disregard of culture and gender’, ‘role model’ and ‘perceptions of the nursing profession’ emerged. In theme 2 of sample A, perceptions of the values and beliefs of professional nurses were described in terms of the views of professional nurses. Theme 3, ‘values and beliefs orientation’ emerged from the students’ perspective. Table 3.9 displays the categories and subcategories of theme 3, values and beliefs orientation.

TABLE 3.9 THEME 3: VALUES AND BELIEFS ORIENTATION

Theme	Category	Subcategory
Theme 3: Values and beliefs orientation	Professional nurses	<ul style="list-style-type: none"> • Work ethic • Respect
	Disregard of culture and gender	<ul style="list-style-type: none"> • Language • Race • Gender
	Role model	
	Perceptions of the nursing profession	<ul style="list-style-type: none"> • Career choice • Image

3.4.3.1 Category: Professional nurses

In the category ‘professional nurses’ the subcategories *work ethic* and *respect* emerged. Regarding the subcategory *work ethic*, the participants observed that the conduct of some professional nurses was unethical and breached the rules and regulations. Participants reported that professional nurses physically abused patients by hitting them with a ruler, clamping them with forceps or stuffing a pillowcase into a patient’s mouth to force the patient to deliver a baby. The following statements were made:

“Women are hit with rulers; women are clamped with forceps just because they’re trying to give birth! I almost ... it was a shock of my life, this woman, a primigravida who couldn’t bear down appropriately, what are you supposed to do as a nurse? Teach her how to, and do everything possible, technically, scientifically, to get this baby out. You clamp this woman with pair of forceps for not being able to push out her own child.” D5

“Or they stuff a pillowcase into her mouth or they do whatever, it brought tears to my eyes, because how is this woman supposed to feel, that she’s an incapable mother. Now all these things and then you complain, no [wonder] women enter depression after they give birth.” D5

The participants stated that they did not want to be part of such practices. One said:

“... when they start doing all these things I will go out of the way because I don’t want to be part of all these things. I feel for the patient, I know it’s painful so I can’t do that. I walk out.” D5

This evidence speaks of grave disrespect for human dignity. Furthermore, if students witness this behaviour, the question arises, will they imitate this behaviour? Unethical behaviour of nurses is not limited to the institution where the study was conducted. Oosthuizen (2012:58) found that newspaper reports of instances of abuse and humiliation of patients by nurses are common in South Africa. Nursing is guided by various guidelines to ensure sound ethical behaviour. Some of these guidelines are RNAO’s (2007:42) best-practice guidelines on professionalism in nursing and the International Council of Nurses’ Code of Ethics (2006:5). South African nurses’ professional conduct is guided by various acts, regulations and ethical codes.

The participants, furthermore, made serious allegations that some professional nurses steal, and exploit students’ goodwill, as the following quotes show:

“... the registered nurses, the permanent staff, all levels, the permanent staff can’t wait for the food to be dished out because if there’s anything left over suddenly I have no lunch box and I’m just loading it, apples, eggs, milk, bread, whatever. The patients don’t ever get boiled eggs.” D6

“Not only on the weekends, they’ll ask you, “are you here with your car today?” “yes” “okay will you drive me to Spar?” or KFC or wherever, and then you have to drive them with my petrol money that I don’t even have, you’ll drive them wherever.” D6

Although students reported the alleged negative behaviour to educators, participants stated that educators did not address their concerns, as is evident from the following statement:

“We talk to our tutors about it, they will say they will follow it up but we see nothing is being done about this.” D3

This reported unethical behaviour is a cause of serious concern, not only for student professional socialisation, but also for nursing as a profession.

The next subcategory that emerged is closely related to the values and beliefs of a person, namely *respect*. The participants reported that the professional nurses insulted and humiliated them by calling them “hazards” and making rude and discriminating remarks in front of patients. The following was said:

“The first day when we get there, they call us hazards, meaning that they are going to keep strict monitoring on us.” D7

“... I was doing, she didn't do anything but she was in front of a patient, full of rude and discriminating remarks which wasn't good for me because one of the patients asked me, am I professional wound care assistant, I said no I'm a student.” D4

These findings concur with the findings of Mabuda et al (2008:24) and Mntambo (2009:127), who described similar disrespectful behaviour. Beukes et al (2010:[4]) also found that community nurses were disrespectful to students and basically ignored them. RNAO (2007:43) states that one of the strategies for success in creating sound ethics is to respect the values and decisions of others.

3.4.3.2 Category: Disregard of culture and gender

In the category ‘disregard of culture and gender’, the subcategories *language*, *race* and *gender* emerged. In the subcategory *language*, the participants complained that professional nurses did not use English as the official language when discussing patient-related issues. When asked to explain the reporting of a patient's condition in English, they just ignored the request, as is evident from the following statements:

“When I ask them please speak English so I can understand you they just ignore and its really hampering, so the language thing is also a problem for me.” D5

This behaviour may have serious consequences, since the students might be misinformed about the patients’ needs. Another participant explained how discouraged she got when she could not understand the communication. She said the following:

“Then you get so *moedeloos* [discouraged] which is like okay, just go with the flow.” D4

Klerk (2010:49, 79) also reported that professional nurses experienced language as a barrier, especially foreign students. Inability to understand the different languages also caused stress in Bruneian students when they needed to care for patients (Burnard, Binti, Rahim, Hayes & Edwards 2007:812). Inability to communicate effectively could influence not only patient care, but also the learning process of students.

In the subcategory *race*, the participants reported racial discrimination. They described the unwillingness of white students to help black patients, and how a black student physically attacked a white student. The following statements were made:

“... the minute a black person rings a bell or something they will call you and say “can you go and speak to that patient, I can’t hear what he is saying.” D3

“... because I saw in the wards that a white ‘Y’ [student from a certain education institution ‘Y’] student was strangled by one of the ‘X’[student from another education institution ‘X’] students, and she was grabbed around the neck because of a dispute and all the X friends stood by that perpetrator ...” D4

Racial tension seems not to be unique to South Africa, as a study done in a predominantly white nursing environment revealed that African American students felt unsupported and alienated (Coleman 2008:10). Despite this negative report on racial tensions, positive experiences were also shared. A participant described an incident as follows:

“You find nice ones, they don’t even mind, they don’t mind what the skin colour the patient is, they help them the best way they can.” D3

The data signify a very volatile learning environment, which should be handled with great care.

In the subcategory *gender*, the participants primarily described male students' experiences and their interaction with female professional nurses. The male participants reported that some female professional nurses did not assign nursing delegations directly to them, because of their cultural beliefs regarding gender. A participant described it as follows:

“For me some cultures is that they [men] are mainly superior, so they don't want to ask me something because they sometimes it happens then they will ask someone else to ask me because they don't want to speak directly to me because in their culture they don't speak directly to males.” D6

This situation may have consequences, for example some of the details of a message might get lost because no direct communication occurs with male students. The perceptions regarding males were further highlighted by one participant:

“... normally they will say male nurses get away with everything in the wards, I've noticed that.” D6

The data also illustrate the role of cultural beliefs and the need to be culturally sensitive not only to patients but also regarding student learning. Nurses should be aware of others' cultural differences with regard to race, ethnicity and gender orientation, which implies cultural competence (Maier-Lorentz 2008:38, 40).

3.4.3.3 Category: Role model

In the category 'role model', the participants shared their experiences regarding the absence of exemplary role modelling by professional nurses. They were disillusioned with the profession because of what they experienced in terms of nurses cheating and taking short cuts and not being exemplary role models. In addition, they stated that the only role models were those in higher positions. They shared the following:

“You know I always tell people that I will never, I don’t ever want to be a ward sister ever in my life because of the experiences I’ve had ...” D3

“The role models they show us how to cheat, how to take shortcuts, how not to do it, how to cover up everything and I personally, that’s why I think he said the high level people are more our role models.” D5

The literature supports the findings of less admirable role models in the clinical learning environment (Carlson et al 2005:71; Klerk 2010:82; Mabuda et al 2008:22; Mntambo 2009:122). The influence of professional nurses acting as positive role models in the professional socialisation of students is emphasised in several studies (Koontz et al 2010:244; Perry 2009:43).

3.4.3.4 Category: Perceptions of the nursing profession

The next section describes the participants’ perceptions and experiences regarding *career choice* and the *image* of nursing. In the subcategory *career choice* the participants confessed that nursing was not their first career choice. One participant said:

“I came to nursing because I wanted to go into medicine but I ended in B Cur.”
D4

O’Brien, Mooney and Glacken (2008:1846) reported similar findings in that students indicated that they would have preferred alternative health-related professions. In addition, Wright and Maree (2007:606) found that prospective students did not have a clear understanding of what the nursing profession entailed. Selecting the right career is not always straightforward. A meta-study by Price (2009:11) indicates that various factors influence nurses to pursue nursing as a career. Historical and stereotypical understanding of nursing, and other considerations such as job security and earning a salary, seem to influence nurses in their career choice (Price 2011:iii).

In the subcategory *image*, the participants were critical of the image their peers portrayed and described it as unprofessional. Some behaviour by students, such as chewing bubble gum and walking with earphones in their ears while caring for patients, were judged to be unprofessional, as illustrated by the following quote:

3.4.5.1 Theme 1: Characteristics of a professional nurse

The data from samples A and B indicated that the professional nurse should have certain characteristics to be able to influence a student positively in the professional socialisation process. The characteristics of the professional nurse were identified as those of a person who acts as a role model and clinical supervisor. She or he should be knowledgeable, approachable, portray a positive attitude and be aware of her or his own behaviour. Although these characteristics were identified as important, the students did not observe these characteristics being displayed. In fact, they reported that the professional nurses were not knowledgeable, displayed negative attitudes, were unable to function as independent practitioners but were also unable to work together in a team.

As clinical supervisor, it was suggested that the professional nurse should facilitate the integration of theory with practice, acknowledge students' accomplishments, discipline students and include students in the multidisciplinary team. However, students experienced very little clinical supervision behaviour. They were scared to ask for support, as professional nurses were insensitive and perceived as always busy. They also struggled to link the learned theory to practice, as the students were afraid to ask questions of the professional nurse. Furthermore, professional nurses displayed unethical behaviour, such as the physical abuse of patients and exploitation of students' goodwill. Students did not consider the professional nurse to be an exemplary role model. Nevertheless, in some cases students reported admirable role models and the professional nurse being able to act as clinical supervisor.

3.4.5.2 Theme 2: The clinical learning environment

The students reported on various factors that influenced their socialisation experiences in the clinical field. These influential factors were communication between the clinical facility and educator, the theory-practice gap, continuous support, challenges of the clinical environment and attitudes of professional nurses.

In order for students to reach their learning objectives, adequate communication between the clinical facility and the educator is essential. Professional nurses seemed not to be aware of students' learning objectives, while students did not display the

necessary dedication when such opportunities occurred. Professional nurses assigned fragmented tasks to students, which resulted in their not understanding comprehensive patient care. Furthermore, students complained of limited learning opportunities. On the other hand, professional nurses were unwilling to assign certain learning opportunities to students, because of their irresponsibility related to these learning opportunities.

Both professional and student nurses were of the opinion that students struggled to integrate theory with practice. The clinical environment was characterised by a lack of equipment, and discrepancies between the theory that was taught and what was practised widened this gap further. Professional nurses suggested some methods, such as giving students homework and explaining why certain procedures were performed in a certain way, in order to integrate theory with practice.

The support students needed was described as mentoring, orientation, fair scheduling of hours related to their clinical learning, and health and safety precautionary measures. Mentoring was identified as an important support structure by both students and professional nurses; however, their understanding of the person who should fulfil this role was diverse. A mentor was regarded as a peer or a professional nurse. The professional nurses indicated that support in terms of orientation was important, but students reported that they had never received orientation, not even on their first day of nursing. The professional nurses in turn indicated that orientation became difficult when a unit was busy. Furthermore, students described professional nurses as being unsupportive regarding their requests for certain work schedules, especially when they were writing tests. Unfair practices in the scheduling of work hours were reported. Students also reported not being supported in relation to health and safety risks when they needed to work with high-risk patients.

Apart from support, various challenges affected students in the clinical field, for example professional nurses' inability to work together as a team. Students reported professional nurses shouting at each other. Professional nurses confirmed this inability themselves. Other challenges identified were the workload of professional nurses and scarce resources. Both professional and student nurses agreed that the professional nurse's workload was huge, which meant less time for student support. The students perceived the professional nurse's workload as mostly related to administrative tasks. Adding to this workload was the challenge of scarce resources, such as inadequate

equipment. Professional nurses stated that they were performing procedures differently but agreed that students should be provided with a clear explanation for this action. Students indicated that basic equipment was not available and that they often needed to borrow equipment from other units.

Although professional nurses suggested interventions that would support students in the clinical learning environment, students did not experience this support. The clinical learning environment was characterised by various challenges that influenced students' socialisation experiences.

3.4.5.3 Theme 3: Values and beliefs related to nursing as a profession

The data suggested that the values and beliefs of professional nurses and students as exhibited in terms of attitudes and behaviour did not reflect the values of the nursing profession. Students described incidents in which professional nurses exhibited behaviour that demonstrated severe violation of human rights, and where patients were treated inhumanely. Apart from this unethical treatment of patients, students experienced being exploited by being forced to do favours for professional nurses, just because they owned cars. On the other hand, professional nurses accused students of poor time management and absenteeism from the clinical field. Professional nurses were of the opinion that students should be disciplined in a constructive manner in order for them to learn the professional conduct of nursing.

Both professional nurses and students stated that they experienced negative attitudes from each other. Students accused professional nurses of hostility and favouritism towards them, while professional nurses accused students of not being interested in learning and just sitting around doing nothing. Despite these claims of negative attitudes, both samples' participants acknowledged that there were dedicated students and professional nurses.

Regarding the decision to pursue nursing as a profession, professional nurses believed that students chose nursing for other reasons, such as the financial benefit of receiving a salary and studying at the same time. Some of the students confessed that they would rather have studied medicine than nursing. Furthermore, both professional nurses and students were concerned about the nursing image that was portrayed by

some nurses' behaviour and dress code. Both professional nurses and students displayed unprofessional behaviour. Concerns were raised about the dress code of students and professional nurses. Adding to this situation, professional nurses reported that they experienced the public's viewing nursing as a less acceptable career to follow.

Despite the fact that the findings revealed that professional nurses and students did not reflect the core values of the nursing profession, the data revealed that some students and professional nurses did uphold the values and image of the profession.

3.4.5.4 *Theme 4: The educator*

Comments regarding educators were positive, in respect of their knowledge and support to students. However, professional nurses felt that there should be a closer relationship between them and educators to address issues that concern the students. In addition, students perceived educators as not addressing grossly unethical behaviour by professional nurses when this was reported to them.

3.4.5.5 *Theme 5: Cultural and gender orientation*

Although cultural and gender orientation seemed not to be explicitly mentioned in the literature regarding professional socialisation, the data of this study revealed it to be an influential aspect. In relation to gender, both professional nurses and students were of the opinion that male students were treated differently. They were granted privileges female students did not enjoy, because of professional nurses' cultural beliefs. In addition, racial tension seemed to occur among the students; however, this issue was not mentioned by professional nurses. Students reported on racial tension of such intensity that they could physically attack each other. However, professional nurses did not share any aspect related to racial issues. Students were also concerned when other languages were used instead of English to communicate patient-related issues. This situation excluded certain students from learning opportunities. Both professional nurses and students were less sensitive regarding cultural and gender orientation when communicating with others.

Professional socialisation of students as perceived by professional nurses and experienced by students is complex and various socialisation agents influenced this process.

3.5 CONCLUSION

This chapter analysed, presented and discussed the qualitative data of phase I, which reflected the perceptions of professional nurses and the experiences of students. A literature control was done, which indicated similarities to and differences from previous studies. It was found that multiple factors influenced the professional socialisation of students. The data were mainly applicable to the clinical setting where the students gained clinical learning experience. The second phase of this study's focus was on the educators' teaching and facilitation of the professional socialisation of students. This evidence will be discussed in chapter 5. The next chapter discusses relevant literature on the professional socialisation of student nurses.

CHAPTER 4

LITERATURE REVIEW

4.1 INTRODUCTION

A literature review aims to provide the researcher with in-depth understanding of the subject concerned (Botma et al 2010:63). Creswell (2009:45) states that the use of literature will depend on the weight of the design of a particular mixed-methods design. In this mixed-methods design, the emphasis was on the qualitative phase; a literature control was conducted in chapter 3. This chapter discusses additional literature consulted on the phenomenon *professional socialisation* of students in order to design an instrument to be used in the second phase of this study. The themes that emerged in the qualitative phase (phase I) guided this literature review. The topics that will be discussed are a clarification of the concept *professional socialisation*, theories or models related to professional socialisation and the influential factors that the participants of phase I identified as relevant in the professional socialisation of students.

4.2 PROFESSIONAL SOCIALISATION

Professional socialisation, previously described as the internalisation of knowledge, skills, attitudes, behaviours, values and ethical standards, forms part of an individual's professional identity (Chitty & Black 2011:131). Frankland (2010:83) states that professional identity deals with the questions: "Who am I?" and "Where do I belong?" The development of a professional identity appears to be a transitional process influenced by practice and theory. This process leads to the internalisation of the values and norms of a group into an individual's own behaviour (Maxwell, Brigham, Logan & Smith 2011:428; Worthington, Salamonson, Weaver & Cleary 2012:[2]). Apart from external influences on a professional identity, a person enters into a profession with a set of values and beliefs that will also influence his or her behaviour. The degree to which a person will transform to fit into a profession is closely related to an individual's self-concept and those values of the profession that the person regards as important (Seada & Sleem 2012:679).

Professional socialisation is described as acceptance of the behaviour patterns of the surrounding culture, in this instance the nursing culture, for example learning the language typical of a profession (Chitty & Black 2011:132). Professional socialisation of students is a complex issue. Various authors have attempted to describe the process in terms of stages or phases, which will be discussed in the following section.

4.3 THEORIES OR MODELS RELATED TO PROFESSIONAL SOCIALISATION

A number of models or theories have been developed to describe the professional socialisation process. However, the focus of this discussion will be on models related to professional socialisation of undergraduate nursing students, due to the study's focus on undergraduate students.

4.3.1 Hinshaw-Davis model of basic student socialisation (1976)

According to Day, Field, Campbell and Reutter (2005:367), the Hinshaw-Davis model proposes six stages of professional socialisation for students. Stage one consists of the students' entering the nursing profession with innocence and with idealistic images of the profession. Typical images students have are those of kindness and helping patients to get better. The second stage is characterised by dissonance, discovering that nursing has various challenges and that it does not fit into their initial expectations. During the third and fourth stage, role models are identified, which they believe they can imitate, and they then attempt to act according to these role models' demands. The fifth stage consists of holding onto the old ideas and images, while recognising new ones (Chitty 2005:203). The final stage consists of internalising the professional model, but still continuously learning new values and beliefs. The findings of Day et al (2005:643) on the four-year baccalaureate programme indicate that students move from a lay image to a professional one, similar to the stages of the Hinshaw-Davis model, with the exception that the stages do not occur in sequence.

4.3.2 Bandura's concept of modelling (1977)

Bandura's model stipulates that students consciously learn by modelling a competent role model (MacPhee 2011:44). Bandura identifies four processes, namely attention, retention, motor reproduction and motivation. Firstly the student learns by observing the

characteristics of the model, for example the characteristic of caring. This process is followed by remembering the modelled behaviour. The third process consists of performing the observed behaviour. The final process involves the internalisation of the behaviour, provided that the person who imitates the modelled behaviour attaches value to it, by means of self-reinforcement or external rewards (McEwen & Wills 2007:395). Role models held in high esteem will most likely be imitated by the novice nurse (Perry 2009:43). Bandura's model emphasises the importance of the role model in the professional socialisation process, since exemplary role models may have a positive influence on the socialisation of students.

4.3.3 Cohen's model (1981)

This study was guided by Cohen's (1981) model of professional socialisation, which has already been discussed in Chapter 1, therefore only a summary of this model is offered here. This model is based on the cognitive development of a student and proposes four stages of development, namely unilateral-dependence, negative-independence, dependence-mutuality and interdependence (Cohen 1981:16). During stage I, unilateral-dependence, the students depend on external measures. For example, a first-year student needs a great deal of guidance regarding the programme expectations. Stage II, the negative-independence stage, is characterised by questioning authorities and is known as the cognitive rebellion stage. During this stage students have limited knowledge of the nursing profession and start to question the manner in which things are done. In the third stage, dependence-mutuality stage, the students demonstrate empathy and commitment to others. They develop a more realistic view of the environment and are able to think critically. In the last stage, the interdependence stage, students learn from others and are able to make independent judgements (Cohen 1981:16–17).

Various researchers have used this model as a basis for their research; for example Cornelissen (2006:166), who studied the professional socialisation of students in the ecology and consumer business, using Cohen's model. In addition, McCain (1985:185) developed a test to examine the professional socialisation of baccalaureate nursing students based on Cohen's (1981) model, but concluded that Cohen's (1981) model needs to be tested further. Although further testing is recommended, it remains a

valuable contribution to the understanding of the professional socialisation process of students.

4.3.4 Benner's stages of nursing proficiency (1984)

Benner's model describes how the novice moves through five stages to become an expert practitioner (Altmann 2007:115). During the first stage, a student has no knowledge and skills, therefore relies on rules and limitations from others. The second stage is called the advanced beginner, and involves a person who has experience and can apply theory, but needs support (Chitty & Black 2011:135). The third stage (competent stage) is characterised by competence and efficiency. This nurse is able to prioritise, make decisions, plan and coordinate patient care. During the next stage, the proficient practitioner has a holistic view and can easily recognise the priorities of nursing care. The final stage is called the expert stage. During this stage nursing interventions are done on intuition and the person has years of experience (Chitty & Black 2011:136). It is obvious that a student will not progress through all five stages of Benner's model. Benner's model seems to be applicable in areas such as the preparation of mentors and as a tool to assess the professional growth of the advanced professional nurse (Butts & Rich 2011:486). This model focuses not only on the development of a student, but also on the qualified nurse who progresses through her or his nursing career to become an expert.

From the models discussed above, it is clear that the student moves through a series of changes to develop his or her own identity in the profession. Various aspects, such as the degree to which the nurse masters the skill to make independent decisions, the effect of a role model and the changes in level of competency to become an expert, contribute to the professional socialisation of a student.

4.3.5 Overview of the philosophies related to professional socialisation

There are two main schools of thought regarding *professional socialisation* as a phenomenon. Earlier studies viewed professional socialisation from a structural functionalist perspective, which means that professional socialisation is the learning of social roles in a society, consisting of structures with specific functions. The process of socialisation is viewed as conforming to the values, norms and roles of a specific

homogeneous group (Miller 2010:927). Behaviour that does not fit into the norms of the profession, such as questioning current practices, is considered as an exception (Barretti 2004:258).

The second school of thought, the symbolic interactionism approach, views professional socialisation as an on-going process of adjustment to the context where work or training occurs (Barretti 2004:260). Individuals will selectively respond to and interpret the environment and the behaviour of other professionals. Their response is based on their own understanding of the setting and not upon the actual behaviour to which they are exposed (Day et al 2005:637; Miller 2010:927). The degree to which students will conform to the values and norms of a setting is greatly determined by their motivation, self-image and their commitment to the situation (Miller 2010:927). Miller (2010:928) points out that a setting consists of various groups and persons who have different goals and interests, and will probably convey diverse messages to students.

Other studies done on professional socialisation were related to the already qualified professional nurse. These studies focused on aspects of the professional nurse re-entering into a student's role, facing problems such as role strain, time constraints, lack of nursing education institutional support and adaptation to a student's role (Chitty 2005:208). In addition, professional socialisation continues after completion of training as a professional nurse. Methods such as a self-assessment and using a consumer's guide were designed as tools to assist the professional nurse in this process of determining the degree of professional socialisation that has occurred (Chitty & Black 2011:139–140). Other aspects, such as biculturalism, reality shock, preceptors and mentors related to professional socialisation, are also issues that have been addressed in other research studies (Duchscher 2009:1103; Ihlenfeld 2005:176).

4.4 COMPONENTS OF PROFESSIONAL SOCIALISATION

As is evident from the previous discussion, the process of professional socialisation is influenced by various determinants. These determinants are often referred to as socialisation determinants. The discussion below will focus on the components as socialisation agents of professional socialisation.

4.4.1 Curriculum

A curriculum is the blueprint for the educator's teaching and facilitation strategies. Few studies relate in explicit terms to professional socialisation in the curriculum. Nevertheless, Howkins and Ewens (1999:47–48) state that the philosophy of a curriculum may influence the professional socialisation of students. They conclude that if a person is viewed as unique, valued and respected, favourable professional socialisation will occur.

In order to become a professional nurse who will be competent to deal with the ever-changing health care system, it is important to ensure that the appropriate knowledge, skills and attitudes are taught and facilitated (Billings & Halstead 2009:138). In the design of a curriculum, consideration of the learning outcomes of skills and knowledge seems to be less complicated than that of the outcomes related to attitudes, behaviours and ethical standards. All students have their own values and beliefs, which guide their behaviour and consequently their attitudes (Chitty & Black 2011:292). An attempt by Botha (2006:426) to facilitate a professional identity in nurses resulted in a proposed framework for teaching ethos and professional practice. This framework identifies influential factors such as the educator, the student's learning style, age, culture, emotional intelligence, level of professional socialisation and teaching strategies as relevant to the facilitation of a professional identity (Botha 2006:441). Therefore educators need to be aware of these influential factors and diverse learning orientations of students when designing a curriculum and adjust their teaching approach accordingly. Billings and Halstead (2009:23) state that active student participation is of great importance when dealing with the diverse needs and learning styles of students. Chiang, Chapman and Elder (2010:819) emphasise that teaching approaches should rather be student-centred than teacher-centred. It is therefore vital to know and understand the diverse needs of the students when designing a curriculum.

Apart from the formal curriculum, the informal or hidden curriculum, also referred to as the null curriculum, is difficult to control (Uys & Gwele 2007:1). The influence of the hidden curriculum is described as a powerful determinant in shaping students' behaviours, attitudes, values and beliefs (Thiedke, Blue, Chessmen, Keller & Mallin 2004:312). Mooney (2007:79–80) emphasises the influence of ward culture and beliefs on newly qualified nurses. It was concluded that although these nurses feel they want

to change the culture of strict routines and task-oriented nursing care, they are unable to accomplish this goal. Instead, they become frustrated and eventually conform to the unspoken values and ward culture.

4.4.2 Learning environment

The learning environment as a component of professional socialisation comprises mainly two areas: the nursing education institution (faculty or academia) environment; and the clinical environment where the student gains practical experience.

4.4.2.1 *Environment related to the nursing education institution*

The environment related to the nursing education institution consists mostly of the formal content taught to students, while the practical environment involves the field where the students apply the contents that they have been taught in a community or hospital setting. These two environments are different but closely linked.

Previously, nursing education occurred mainly in a hospital setting. At present, the greater part of education in nursing happens at a college or university of which the core function is teaching and learning (Kotzé 2008:119). Although this educational change allows focused nursing education, it has resulted to some extent in a division between the academic and clinical environment (Baxter 2007:104). Academia strives to teach the student according to the best evidence on nursing practices; however, once in the clinical environment the student is confronted with various challenges, such as a lack of equipment and understaffing (Mabuda et al 2008:24). In addition, students become disillusioned when they are placed in the clinical environment (Newton & McKenna 2007:1231; Pearcey & Draper 2008:600). Students' initial preconceptions of what the clinical environment will be like are misleading, and it turns out to be not what they expected (Chan & Ip 2007:677). It thus appears that educators need to prepare students for the challenges of the clinical environment.

An additional challenge academia and the clinical environment are faced with is lack of communication. Lack of communication, specifically related to the learning objectives of students, was identified in several studies conducted in the UK, US and South Africa (Andrews, Brodie, Andrews, Hillan, Thomas, Wong & Rixon 2006:866; Hathorn et al

2009:238; Mabuda et al 2008:23). Andrews et al (2006:866, 869) state that the factors that contribute to a positive learning environment are communication, planning, effective preparation of the student for the clinical practice, approachability of qualified staff and the attitudes of the different role models. In order to address the communication gap between academia and the clinical setting, Andrews et al (2006:866) propose a clinical placement model, while Baxter (2007:106) proposes a culture care model for clinical supervision. Both these models identify communication and collaboration between these two environments as essential to maximising the learning experiences of students. A South African model, the Model for Clinical Nursing Education and Training in South Africa, also proposes better collaboration between the nursing educational institution and the clinical field, with the aim of up scaling the clinical competencies of students (Nursing Education Stakeholders of SA 2011:3). This model suggests the appointment of clinical preceptors and clinical placement coordinators by the nursing education institution. It also proposes that the nurse educator should remain clinically competent and should therefore be part of the clinical preceptor team. In addition, the professional nurse in practice should take joint responsibility for the students' learning outcomes.

The environment related to the educational institution has support systems to assist students with the challenges they face. These support systems may include educators having consultation hours and a student support service that provides assistance, for example with study methods, personal problems and financial problems (Kotzé 2008:123). In higher education institutions, support is legislated and financed by the Department of Higher Education, while nursing colleges are financed by the Department of Health (Kotzé 2008:120, 126). However, nursing students are not only students, but are also used as a workforce and need to work a minimum of prescribed hours for clinical experience (SANC 1985:par. 2.3). This situation may create challenges for students, who have to balance their academic and practical responsibilities. A South African study highlighted this aspect, as inflexible library hours offered students limited access, which contributed to their poor academic performance (Waterson et al 2006:69).

Other support strategies that relate to the educational environment are peer and staff mentorship. Del Prato, Bankert, Grust and Joseph (2011:112) suggest that nursing education institutions are in a favourable position to provide a caring and supportive

learning environment to students to enable them to manage their stress better. Strategies suggested are peer mentorship and a caring learning environment, where the educator acknowledges the feelings of stress and anxiety of students. The use of reflective practice, social support systems, mindfulness and proactive learning were additional strategies suggested for creating a supportive learning environment (Del Prato et al 2011:112-114). It seems that the educational environment poses unique challenges, but also has various support structures to enable students to learn and become socialised into the profession.

4.4.2.2 *Clinical learning environment*

The clinical learning environment is the environment where the student is exposed to learning opportunities where safe nursing care to real patients occurs (Carlson et al 2005:67). The learning environment is characterised by various challenges, but students are exposed to a variety of learning opportunities (Papastavrou, Lambrinou, Tsangari, Saarikoski, & Leino-Kilpi 2010:18). To ensure positive learning experiences, students need a learning environment that is characterised by support, nurturing, respect and dignity (Hathorn et al 2009:229). However, MacKenzie's (2010:264) findings regarding the learning environment in a primary health care setting indicated that most of the students experienced lack of support, which disadvantaged their learning outcomes. The importance of a positive learning environment is further highlighted by the proposed Model for Clinical Nursing Education and Training South Africa, as one of its objectives is to create positive practice environments (PPEs) for students to gain clinical learning experience (Nursing Education Stakeholders of SA 2011:8). The criteria for such an environment are based on the South African government's core domains and subdomains, which are patients' rights and safety, clinical support, leadership, operational management, facilities and infrastructure.

Although the clinical environment is complex, Stuart (2007:212,225) suggests that learning experiences and opportunities should be planned and coordinated to ensure that maximum learning occurs. The importance of this suggestion should be emphasised, as students report that they have inadequate exposure to learning opportunities (Koontz et al 2010:43). Apart from lack of planning, a South African study reports that overcrowded clinical facilities (by students) offer limited learning opportunities, and students are often given menial and routine tasks to do, without

taking into consideration their learning objectives (Mabuda et al 2008:23). In addition, there seems to be a need for clear communication on the learning objectives of students to ensure that these objectives are met (Hathorn et al 2010:242; MacKenzie 2010:265). Students also want to be given responsibilities and do not want to be passive observers. Giving students specific nursing care responsibilities helps them to feel part of the team, which consequently maximises their learning and increases their self-confidence (Grealish & Carl 2009:91; Levett-Jones et al 2009:321).

Another important factor related to the clinical learning environment is clinical supervision. This educational task is a process through which the professional nurse/preceptor/educator or mentor guides and supports the student to reach clinical competency (Gaberson & Oermann 2010:60). During this process a relationship between the supervisor and supervisee is established, where questions can be raised and assessments done to ensure theory-practice integration. The aim is to provide safe patient care and at the same time to develop a professional identity in the student (Baxter 2007:106; Klerk 2010:10; Severinsson & Sand 2010:670).

Important role players such as the preceptor, educator, mentor and professional nurse seem to be significant determinants in clinical supervision. Mabuda et al (2008:22) found that professional nurses do not view clinical supervision as part of their function, but rather see it as the educator's responsibility, while the nursing education institution relies heavily on the professional nurse to supervise the student. This situation has resulted in students carrying out procedures by themselves without supervision. Similar findings regarding educators not giving adequate support were found by Waterson et al (2006:69). Other reasons cited for lack of clinical supervision are financial constraints, and inadequate staff and equipment (Klerk 2010:78; Mabuda et al 2008:23).

Another challenge students are faced with is the diverse and changing learning environments where they are placed to gain clinical experience. Students need to adapt to different hospitals and community settings. This means they are constantly exposed to unfamiliar environments, which obviously creates anxiety that influences the learning process (MacKenzie 2010:138). Students could easily feel that they are a burden on the practice if they are not familiarised with their surroundings. This situation causes them to feel vulnerable (Levett-Jones et al 2009:319). Conversely, if students are welcomed and supported in their new learning environment, they have positive

learning experiences (Ranse & Grealish 2007:174). Nicklin (2008:145) states that one of the key issues in creating an environment conducive to learning is orientation to unfamiliar situations.

Another influential factor related to the clinical environment is the theory-practice gap. Students experience a difference between the theory taught in academia and what is practised in the clinical field (Koontz et al 2010:244; Mabuda et al 2008:23). Literature related to the theory-practice gap proposes some reasons for its existence. The reasons are related to the unpredictability of the clinical environment, and nursing education in Australia moving to higher education (Ranse & Grealish 2007:178; Tiwari, Lam, Yuen, Chan, Fung & Chan 2005:299). Other reasons proposed are the supernumerary status of students and the different persons responsible for supervision (Carson & Carnwell 2007:221). Mabuda et al (2008:24) state that without adequate supervision to reinforce principles taught, students tend to conform to undesirable practices, which further increases the theory-practice gap. Strategies suggested to support the student with theory-practice integration include the use of adequate clinical supervision, reflective practice and evidence-based practice (Baxter 2007:104; Duffy 2009:104).

It is clear that the clinical learning environment poses various challenges that are influential in the professional socialisation process of students. Therefore students need to be cognitively and affectively prepared, especially when they are placed in challenging situations such as rural areas (Sedgwick & Yonge 2008: 625). Despite the different focus and challenges of the clinical and educational institution environments, each environment provides a variety of opportunities for socialising students into the nursing profession. As is evident from the discussion, both environments should collectively attempt to overcome their particular hurdles to enhance the professional socialisation process.

4.4.3 Persons involved in the professional socialisation of student nurses

Apart from the educational and clinical environments that influence student professional socialisation, a variety of persons function within these settings. A central theme that emerged in Price's (2009:17) study on professional socialisation was the persons that act as socialisation agents in the academic and clinical environment. The discussion

that follows focuses on these important role players in the professional socialisation process.

4.4.3.1 Student

Choosing nursing as a career is determined by various factors, such as extrinsic and intrinsic determinants and work values (Hollup 2012:1291). It seems that when students enter the nursing profession they are ill-prepared in terms of their expectations (Waterson et al 2006:71). They have preconceived ideas and images of how the nursing profession should be and are disillusioned when they discover that nursing seems not to be as caring as they expected (Watkins, Roos & Van der Walt 2011:[10]). For example, they are surprised to witness minimal communication between the nurses and patients (Pearcey & Draper 2008:595). On the other hand, some students enter the nursing profession for reasons such as having a “salary” while studying (Breier et al 2009:[3]).

Nursing education institutions have admission criteria for entrance into a nursing programme. Schmidt and MacWilliams (2011:174) completed a systematic review on admission criteria for pre-licensure nursing programmes and found that there were no uniform admission criteria for entering nursing programmes, but they concluded that the best possible candidate should be selected to ensure completion. In South Africa, each university has its own selection criteria, whereas the nursing colleges’ selection is done in conjunction with the Department of Labour. The Department of Labour manages primarily the administrative aspects of the bulk of applicants. A list of candidates who meet the criteria is then sent to nursing colleges to select the candidates (Mildenhall 2012, Telephonic interview, 25 June).

Whatever the reason for the candidate wanting to become a nurse, the process of socialisation into the profession poses challenges. Students, especially first-year students, find the learning process with all its dimensions stressful. They experience a “reality shock” when entering the clinical field for the first time (Nabolsia, Zumob, Wardamc, & Abu-Moghliid, 2012:5853). Students find the clinical environment harsh and uncaring; however, in time they learn to reconstruct their view regarding this setting (Pearcey & Draper 2008:599).

As they progress in the learning programme, they tend to move from a caring attitude toward a competency orientation (Price 2009:15). In the process of socialisation, students were found to experience anxiety and depression, which lowered their self-esteem (Hughes, Romick, Sandor, Phillips, Glaister, Levy & Rock 2003:46). According to Chesser-Smyth (2005:323), students described feeling useless, inadequate and vulnerable. The main stressors identified are the clinical learning environment, with all its challenges, and educators' uncivil behaviour towards students (Del Prato et al 2011:109-112). However, although students may find some situations stressful, these could serve as good learning experiences (Grealish & Ranse 2009:86). To deal with these stressful situations, there is a need for reflective activities in order to make sense of clinical learning experiences (Carlson et al 2005:72; Koontz et al 2010:243).

The literature that was reviewed implies that students have preconceptions of how nursing should be, but what they experience in the clinical area creates disillusionment; however, students who are motivated do succeed, despite challenges (Stomberg & Nilsson 2010: 42; Waterson et al 2006:71).

4.4.3.2 Professional nurse

The professional nurse as a manager plays a key role in the professional socialisation of students (Andrews et al 2006:866). Students continually interact with various individuals in the learning environment, such as the professional nurse as role model. The learning environment is significantly influenced by the way in which relationships are experienced (Levett-Jones et al 2008:322). In Keeling and Templeman's (2012:[5]) study on the effect of positive role models, the professional nurse was mentioned as having a significant influence on students as role model. This notion is supported by Pellegrino (2002:383), who states that a role model is the most powerful force in the professional character formation of a student. A role model is generally seen as a person who has good qualities and is worthy of being imitated (Perry 2009:37). Perry (2009:36) says of role models: "Knowingly or unknowingly, their words and actions become living lessons". Perry's (2009:36) phenomenological research found that exemplary role models have outstanding psychomotor, technical and interpersonal skills, acknowledge other persons and purposively model actions and interventions. Students want to conform to the values, beliefs and behaviour of the nursing culture in order to be accepted (Price 2009:17). However, if neophytes are confronted with

passive-aggressive behaviour and tyranny by senior nurses, they tend to lose self-confidence, which eventually has a detrimental effect on their professional socialisation (Emeghebo 2011:e4).

Unfortunately, studies report on unworthy role models. For example, professional nurses take extended tea and lunch breaks, resulting in neglect of their patients (Carlson et al 2005:71; MacKenzie 2010:158). Mntambo (2009:122) quoted students' reports on professional nurses as follows: "The staff treats us like non-human beings"; "They refuse to teach us in the wards". This evidence is supported by Watkins et al (2011:[4]), who report on the well-being of students at the North-West University. Although role models have been emphasised widely in literature, Grealich and Ranse (2009:90) found evidence that students were able to recognise practices and values they did not want to imitate.

A study that was done in an Australian context (Brammer 2006:968-971) revealed that professional nurses (registered nurses) understood their role regarding students' learning needs, namely being a facilitator, teacher, supervisor, role model, manager, instructor and having an authoritarian role. Though they seemed poorly prepared for the complex demands of this role, it was suggested that they should be given formal recognition. Carlson et al (2005:71) found that professional nurses lack support and receive negative feedback. It was proposed that professional nurses' role as clinical supervisors could be supported by expert nurses, who used best-practice principles and acted as role models (Henderson, Twentyman, Eaton, Creedy, Stapleton & Lloyd 2009:181). It appears that the role of professional nurse is complicated by the various demands of being manager, teacher and caregiver, and these professional nurses should therefore be assisted to manage these demands.

4.4.3.3 Preceptor

There is often confusion about the concepts *preceptor* and *mentor* (Fulton & Lyon 2010:260). A preceptor is seen as a qualified professional nurse who has undergone training to assist students in their professional socialisation (Smedley 2008:185). A preceptor is further described as an experienced nurse or midwife who acts as role model and a resource for the student. This person is attached to the novice for a specific period or experience, with the aim of assisting the student with the professional

socialisation process (Billay & Myrick 2008:259). The Model for Clinical Nursing Education and Training in South Africa describes a preceptor as an experienced and competent professional nurse who is positive about students and herself, who serves as a clinical teacher in the clinical setting and is employed by a higher education institution (Nursing Education Stakeholders SA 2011:7).

Although the concept of a preceptor is not consistently applied in all settings, the qualities required seem to be universal. According to O'Malley, Cunliffe, Hunter and Breeze (2000), as quoted in Smedley (2008:185), the qualities of a good preceptor include experience and expertise in the clinical field, good communication skills, interest in being a preceptor, leadership and assertiveness, being non-judgemental and being able to adapt to meet individual teaching needs, as well as having an interest in personal growth. Rogan (2009:570) states, however, that preceptors are not adequately prepared for their roles and responsibilities, such as assessing student's performances.

Preceptors are also faced with challenges, such as lack of recognition from academia, nursing and administrative staff (Bourbonnais & Kerr 2007:1548). They also have to deal with students who are culturally and linguistically diverse (Smedley 2008:190). Despite the challenges, the value of preceptors is emphasised, as they could ensure positive learning experiences and safe patient care (Bourbonnais & Kerr 2007:1545; Koontz et al 2010:242; Smedley 2008:190). Moreover, the preceptor enhances the professional socialisation of students; as Kim (2007:375) concluded, students' clinical competencies are positively related to preceptorship. Happel (2009:375) supports this statement and adds that the preceptor enhances the inherent values of the nursing practice.

4.4.3.4 Mentor

The concept *mentor* has different meanings, depending on the nursing context. In some countries, for example the UK, a mentor needs to complete a formal course and be registered with the nursing council (Christiansen & Bell 2010:804). In South Africa, no formalised registration is required to be a mentor. Some of the clinical facilities have in-house training, whereas in other cases senior students are nominated to mentor junior students. The Model for Clinical Nursing Education for South Africa does not

clarify the role of a mentor either (Nursing Education Stakeholders SA 2011:17). Despite the lack of a uniform description of the role and responsibilities of a mentor, it appears that a mentor relationship is characterised by a caring and trusting relationship based on mutual interests, with the aim of supporting the novice in the process of professional socialisation. The ideal mentor-mentee relationship is a therapist-client relationship (Potgieter 2008:207).

Andrews et al (2006:866) state that mentors need to be sufficiently prepared for their role. A good mentor should be honest, knowledgeable, experienced, organised, confident and friendly (Potgieter 2008:207). Regardless of whether the mentor has received formal training, the value of mentorship is highlighted because of the positive influence they could have on the professional socialisation of students (Price 2009:127). This finding is supported by Papastavrou et al (2010:181), as students in their study expressed their appreciation for the relationship with a mentor during their clinical supervision.

4.4.3.5 Peers

An additional type of mentoring, namely peer-mentoring, is described as a network of support from peers and higher-level students, who act as mentors to students (Sims-Giddens, Helton & Hope 2010:24). During peer-mentoring, peer learning occurs, which is the acquisition of knowledge and skills through helping one another by students who are more or less on the same level (Topping 2005:631). Very often peer-mentoring occurs in an unstructured manner; however, the effects of peer teaching and learning are found to be beneficial for cognitive and psychomotor development, self-confidence, autonomy, clinical reasoning and leadership skills (Secomb 2008:706). It is also reported that in situations where peer learning was implemented, students could manage the emotional challenges of nursing better (Christiansen & Bell 2010:807).

4.4.3.6 Educator

Different terms are used to describe the concept *educator*. These terms include clinical teacher, faculty, lecturer, lecturer-practitioner, practice-educator, link teacher, clinical facilitator, nurse educator, nurse teacher and tutor (Mkhwanazi 2007:13; Saarikoski, Warne, Kaila & Leino-Kilpi 2009:595). It appears that the weight of the theoretical and

practical content taught is an indication of the educator's main responsibility. In a South African context, an educator is a person who teaches the theoretical component at a university or a college, has an additional educational qualification and is registered with the South African Nursing Council (South Africa 1987:R118).

The value of the educator in different contexts is found to be diverse. The UK makes use of a link-teacher, who is appointed by an educational institution and liaises between the clinical practice and the educational institution. Although the link teacher could be of considerable assistance to students, it was found that the quality of assistance the student will receive depends greatly on the person who offers it (Andrews et al 2006:868). A Finnish study found that characteristics of a good educator, such as good interpersonal and communication skills, excellent clinical knowledge and skills, will enhance the student's learning outcomes (Saarikoski et al 2009:595). In addition, the development of the communication abilities of students is greatly influenced by the educator (Messersmith 2008:130). In 2005, the National League for Nursing published eight core competencies of an educator, of which the development and socialisation of a student is one (Billings & Halstead 2009:12).

In South Africa, studies revealed that educators were not supporting students in their learning needs (Mabuda et al 2008:25; Waterson et al 2006:70). Reasons provided for this lack of support were insufficient staff development, inadequate human resources and inadequate support from management (Mntambo 2009:133). Students also expressed their dissatisfaction with educators who burdened students by giving students unmanageable workloads and assignments or tasks to do as punishment, rather than for educational purposes (Cooper, Walker, Askew, Robinson & McNair 2011:1). The importance of the educator as role model is evident in Altmiller's (2012:15) statement that students justify uncivil behaviour by citing this type of behaviour modelled by educators. Students need to observe and experience educators who demonstrate teamwork, respect and unity among themselves (Altmiller 2012:19). Teamwork and unity are described as having a common goal and being interdependent on one another, but also having a specific role to fulfil (Hughes & Jones 2011:54).

4.4.4 Values and beliefs

The terms *values* and *beliefs*, according to Chitty and Black (2011:293), are often used interchangeably. A belief is described as an intellectual orientation or conviction as to whether something is true or false and is transmitted from one generation to another; it is not easily changed (Chitty & Black 2011:292). Values, on the other hand, are learned and originate from experiences that are eventually manifested as behaviour patterns and moral judgement (Rassin 2008:615). Nursing is guided by professional values. These values are standards of conduct that are upheld by a professional group to provide that profession with a framework to assess professional behaviour (Lin, Wang, Yarbrough, Alfred & Martin 2010:646). Typical standards of action are the American Nurse Association Code for Nurses and the Charter for Nursing Practice in South Africa (International Council of Nurses 2006:4; SANC 2004). These frameworks provide the ethical standards for their members to practise their profession and guide their ethical behaviour (Subedar 2008:108).

The core values that feature consistently in the literature are respect and human dignity (Lin et al 2010:647). Gallagher (2007:360) states that respect is primarily concerned with ethical values. Where respect is demonstrated, meaningful engagement occurs and students experience high levels of satisfaction in the learning environment (Chesser-Smyth 2005:323). In contrast, when a person is treated with disrespect, feelings of humiliation are experienced. Students experience disrespectfulness, for example disregard of language policies and being called “hazards” (Beukes et al 2010:[5]; Mabuda et al 2008:24). In some circumstances students may challenge the situation, but in other instances they will conform to the exhibited values to prevent exclusion from the team (Levett-Jones et al 2009:347). On the other hand, Waterson et al (2006:72) found evidence of students who displayed disrespect towards educators. The students were perceived as disrespectful when they talked loudly and fell asleep during lectures.

Bond (2009:133–134) describes the effect of disrespectfulness in terms of “shame”. *Shame* in Greek literature means wrongdoing. Bond (2009:133) explains that disrespect and an unsafe learning environment lead to shame, which causes low self-esteem and consequently inability to learn. Negative emotions that are associated with shame cause the brain to focus on emotion and not on higher-order complex thinking

patterns (Bond 2009:136). However, Bond (2009:136) further states that shame could be corrected by having trusting relationships, which will lead to a favourable learning environment.

Other studies focus on establishing the professional values of students. Leners, Roehrs and Piccone (2006:504) used Weis and Schank's (2000) professional value instrument to determine the change of values of students studying in Australia from entry to exit level. This study indicated that the results of the item on patient advocacy increased considerably, while those of the item on clinical skills decreased. In addition, a Taiwanese study used the same value instrument as Weis and Schank (2000) to study nursing students and found a significant difference between the entrance and exit level. The values on patients' rights and confidentiality and guidelines for fidelity and respect changed positively towards the exit level (Lin et al 2010:651). This value instrument of Weis and Schank (2000:202) is based on the Nurse Association Code of Ethics for Nurses (1985)

Closely related to respect for human's right is caring behaviour. Murphy, Jones, Edwards, James and Mayer (2009:262) determined the caring behaviour of students from entrance level to third-year level. They concluded that in response to the professional socialisation process during the three years of education, there was a *decrease* in caring behaviour. They postulated that the exposure of students to a clinical environment where there is a demand for rapid throughput of patients and inadequate skill mix contributed to this situation. In addition, the way in which the appropriate values are taught and assessed may also contribute to the internalisation of values (Waterson et al 2006:72).

Values guide an individual's attitude and actions (Rassin 2008:615). To understand individuals' attitudes, one should keep their value orientation in mind. The concept *attitude* is defined as the way a person views something or tends to behave towards it (Wordweb Online 2009. Sv "attitude"). Negative attitudes to students from educators and professional nurses were reported in different studies. One such study of incivility in nursing education revealed that educators portray an attitude of superiority and are disrespectful towards students (Beck 2009:75). Another study reported that students describe feelings of embarrassment, unhappiness, fear, frustration and anger because of the professional nurses' negative attitudes to them (Mabuda et al 2008:24). On the

other hand, professional nurses indicated that they experienced behavioural problems from students, such as coming late for work and displaying disrespectful behaviour (Klerk 2010:29). Hathorn et al (2009:235) state that the negative attitudes of professional nurses may originate from the perception that the quality of nursing care is compromised when students need to be taught.

In conclusion, values and beliefs guide a person's attitude and behaviour. An appreciation of one another's values and beliefs is essential to ensure that constructive relationships are formed, which will eventually influence the way in which students are socialised.

4.4.5 Cultural competence

Another aspect that emerged during the data analysis of phase I was the issue of cultural awareness. Being culturally aware implies consciously examining one's own existence, thoughts and the environment, while considering other people's cultural background (Billings & Halstead 2009:276). South Africa is known for its cultural diversity. An example of such diversity was reports on negative student experiences related to the use of different languages in the learning environment, which caused some students to be excluded from learning (Beukes et al 2010:[5]; MacKenzie 2010:261).

South Africa is not unique in terms of different cultures. Law and Muir (2006:149) report that nursing in the UK is influenced by the changing cultural, political and societal demands. The incorporation of cultural awareness into the nursing curriculum has been suggested to enable students to become culturally competent. The authors further argue that cultural competence is a process that needs to be facilitated (Law & Muir 2006:153).

Maier-Lorentz (2008:42) highlights the fact that students expressed concern about their preparedness to deal with culturally diverse situations. It is suggested that they adopt an attitude of caring, empathy, openness and flexibility to others, since these are the first steps in becoming culturally competent. An additional strategy to increase students' cultural competence is the inclusion of immersion experiences (Larsen 2011:353). Mulaudzi, Libster and Phiri (2009:47-48) advocate that nurses should

practise the *Ubuntu* culture. *Ubuntu* means caring for one another, working as a team, creating a sense of belonging, demonstrating an inclusive leadership style and sharing opportunities, challenges and responsibilities. The importance of cultural beliefs and values was demonstrated when Schaefer (2008:117) used a poem to let students reflect on racism. During this reflection opportunity, students gained new insight into the different cultures, which ultimately restored the broken communication between them.

4.5 CONCLUSION

The discussion on relevant literature on professional socialisation addressed the concept of *professional socialisation*, theories or models of professional socialisation and the different components of professional socialisation. Not all the literature referred to in this review explicitly describes professional socialisation of a student as such. The components discussed as influential socialisation determinants were inferred from the concept description of professional socialisation, as well the data from phase I. The literature review firstly guided the familiarisation of the concept professional socialisation during the phase I of the study and, secondly, the item generation of the data-collection instrument in phase II. This literature review illustrates the fact that the professional socialisation of students is influenced by all encounters and experiences they may have, as well as the beliefs and values they hold when entering the nursing profession.

The next chapter discusses the data obtained from educators' teaching and facilitation of the professional socialisation of students.

CHAPTER 5

DATA ANALYSIS, PRESENTATION AND DISCUSSION OF FINDINGS OF PHASE II

5.1 INTRODUCTION

The purpose of this chapter is to present the data analysis and discuss the data obtained from the educators who completed a self-administered questionnaire in phase II. In this mixed-methods study, the qualitative data of phase I were used to generate items for a self-administered questionnaire to obtain quantitative data from educators (phase II). A total of 128 (46%) out of 277 (100%) respondents who were involved in the four-year integrated nursing programme in Gauteng responded. The findings are presented by discussing the following aspects: the respondents' biographical data, six composite professional socialisation constructs related to the educators' teaching and facilitation strategies, the data obtained from the open-ended questions and questions that were related to the six professional socialisation constructs, the scale reliability of the six composite constructs and the effect of the biographical properties of the respondents on these constructs.

Descriptive statistics (frequencies and percentages) and inferential statistics (Fisher's exact probabilities and Chi-square tests) were used. A detailed discussion on the process followed was provided in chapter 2. The data are presented as composite frequencies in tables, as well as figures, pie and bar graph charts, with supporting descriptions. Literature references are limited because literature control was done in phase I (chapter 3) and a literature review in chapter 4. The data presented were grouped according to the six composite professional socialisation constructs, as explained in chapter 2, and are not in the same sequence as the order of the items in the questionnaire. These constructs were statistically grouped according to their scale reliability and labelled according to the characteristics of the subsets in each construct.

The total percentage of frequencies presented in the tables adds up to 99.9% or 100.1% in some cases, because of rounding to one decimal point. For items to which

not all respondents responded, the frequencies and percentages were calculated according to the number of responses; thus missing values were not included, but were indicated in the tables. The total number of respondents is indicated as 'N', while 'n' has been used to indicate the number of a portion of the respondents. In addition, the total frequencies of the composite constructs are indicated as "nt". Annexure XV displays the tables with frequencies related to the open-ended questions.

5.2 SECTION 1: BIOGRAPHICAL DATA

Section 1 addresses the biographical data, namely the respondent's age, gender, mother tongue, highest qualification, duration of the respondents' involvement in the four-year integrated nursing programme and the type of nursing institution that employed the respondents. The reason for including the biographical data was to determine whether there were any significant relationships between the biographical properties of the respondents and their responses to the professional socialisation constructs.

The biographical data of items 1–6 describe the sample characteristics and are presented in table 5.1. Concerning age, the age of the majority (n=104; 81.9%), of the 127 respondents who responded was above 41 years. The largest portion of the sample consisted of 122 (96.1%) females; only five (3.9%) respondents were males. This characteristic is in line with the total population of the nurse educators registered with the SANC, of which 96.3% (11 395) are females and 3.7% (439) are male educators (SANC 2012d).

Table 5.1 indicates that the mother tongue of the majority (n=105; 84%) of the 125 respondents who responded was not English, while the mother tongue of only 20 (16%) respondents was English. A total of 73 (57.9%) respondents held a bachelor's degree with Nursing Education as specialisation, followed by 33 (26.2%) who had a master's degree and 7 (5.6%) a doctoral degree. This evidence has an implication for nursing colleges, as they aim to become higher education institutions (Bruce 2010:[1]). An educator is required to have a master's degree to teach students who are registered for a bachelor's degree in higher education institutions. In this cohort of 126 respondents, only 40 (31.8%) respondents from universities and colleges held a master's or doctoral degree. This finding implies that 88.3% (n=83) of the respondents need to upgrade

their qualifications to meet this requirement of a higher education institution regarding the offering of a bachelor's degree.

TABLE 5.1 BIOGRAPHICAL DATA (ITEMS 1–6)

Items on biographical data	f	%
Age [Item 1] (N=127)		
21-30	3	2.4
31-40	20	15.8
41-50	44	34.7
51-60	53	41.7
61-65	7	5.5
Gender [Item 2] (N=127)		
Male	5	3.9
Female	122	96.1
Mother tongue [Item 3] (N=125)		
English	20	16
Other	105	84
Highest qualification [Item 4] (N=126)		
Diploma	1	0.8
Diploma & education	6	4.8
B degree	6	4.8
B degree & education as specialisation	73	57.9
Master's degree	33	26.2
Doctoral degree	7	5.6
Duration of involvement in the 4-year integrated nursing programme [Item 5] (N=126)		
1-2 years	31	24.6
3-4 years	20	15.9
5-6 years	15	11.9
7-8 years	16	12.7
9-10 years	13	10.3
> 10 years	31	24.6
Type of institution [Item 6] (N=126)		
College	91	72.2
University	35	27.8

The involvement of 126 respondents in the four-year integrated nursing programme showed that in two categories, 1–2 years and >10 years, the response rate was the same, namely 31 (24.6%). The remainder of the 64 (50.8%) respondents' years of involvement ranged between 3 and 10 years. These findings suggest that the respondents would provide meaningful input, as a variety of information could be obtained from both less experienced and more experienced respondents concerning

this nursing programme. The sample was further characterised by a large number (n=91; 72.2%) of respondents who were employed by nursing colleges, while only 35 (27.8%) of the 126 respondents were employed by universities.

5.3 SECTION 2: THE CONCEPT AND STAGES OF PROFESSIONAL SOCIALIZATION (ITEMS 7, 8, 79–81)

Section 2 provides data on the respondents' understanding of the concept of professional socialisation, as well as the stages of professional socialisation as perceived by the respondents.

5.3.1 Concept of professional socialisation (items 7–8)

The questionnaire commenced with an open-ended question on the description of the concept of professional socialisation (item 7). Most of the 110 respondents who responded were familiar with this concept as described in the literature, which is evident from their responses. As many as 38 (34.5%) respondents stated that professional socialisation was the introduction of a student into the nursing profession, while 25 (22.7%) said it was the acquisition of the knowledge, skills, values and attitudes of the profession, and 22 (20%) indicated that it was the teaching of the conduct of nursing. Other less frequently described categories related to the learning of the norms and values of the workplace (n=13; 11.8%) and being a role model to students (n=11; 10%). Annexure XV presents the tables of all the open-ended responses to items 7 and 8, as well as all other open-ended items that will be discussed as supportive evidence.

In a follow-up question on the concept of professional socialisation (item 8), 115 respondents described how they taught and facilitated professional socialisation to students. The following diverse categories resulted from the responses (Annexure XV). Being a role model as a strategy was indicated by 62 (53.9%) respondents; 47 (40.9%) stated they guided students in the professional conduct of nursing; 19 (16.5%) used different teaching strategies; 16 (13.9%) linked theory with practice, and 7 (6.1%) indicated that they used mentoring as a method. Other less frequent descriptions included creating awareness among students about their role and responsibilities (n=5; 4.3%), the utilisation of case studies (n=3; 2.6%), teaching cultural sensitivity (n=3; 2.6%) and having workshops or going to restaurants with students (n=3; 2.6%).

According to Brown, Stevens and Kermode (2012:1), there is little contemporary research that guides nurse academics and clinicians as to how to support students in their professional socialisation.

The data indicate that most of the respondents understood the concept of professional socialisation. Being a role model and guiding students in professional conduct were the two strategies employed most often to teach and facilitate professional socialisation to students.

5.3.2 Levels of professional socialisation (items 79–81)

Cohen’s (1981) cognitive model (Chitty & Black 2011:135) was used to guide the researcher to understand the concept of professional socialisation. The following data provide information related to this model’s different stages of professional socialisation and the way in which students’ level of training, according to the educators, reflected the characteristics of these stages. Figure 5.1 illustrates the attributes as perceived by the respondents in the different stages of professional socialisation. The attributes of Cohen’s (1981) stages of professional socialisation are described as rebellion (negative-independence stage, II), empathy (dependence-mutuality stage, III), and interdependence (unilateral dependence stage, IV) (Chitty & Black 2011:135).

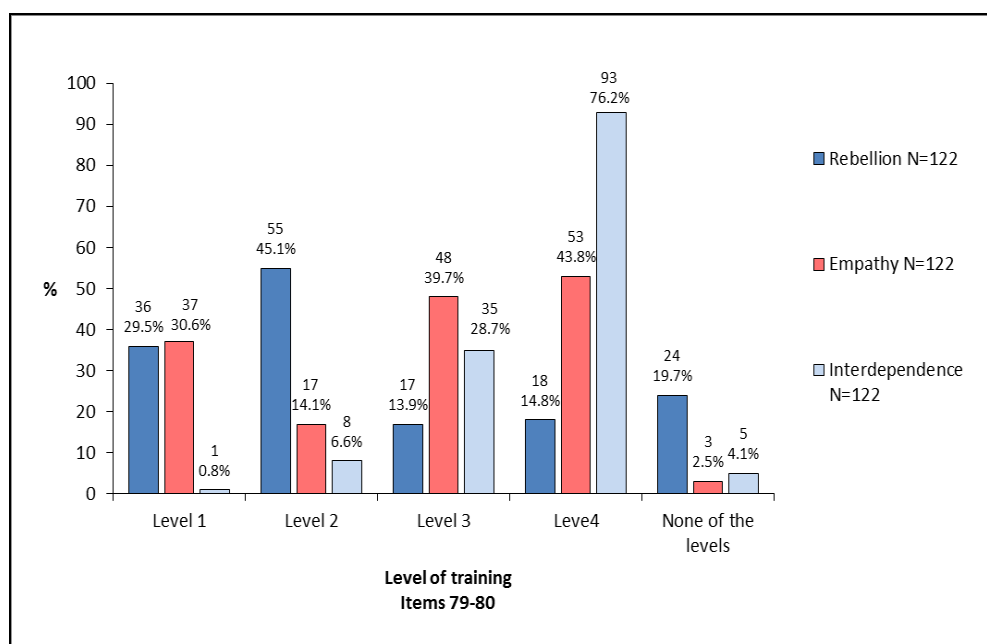


Figure 5.1 Cohen’s (1981) stages of professional socialisation versus level of training (items 79–81)

Of the 122 respondents who responded, 55 (45.1%) perceived students to be most rebellious (stage II) during their second year of study, while 17 (13.9%) respondents indicated students were least rebellious during their third year of study. Empathy (stage III), was mostly exhibited during the fourth year of study (n=53; 43.8%), while a large number (n=93; 76.2%) of the respondents indicated that students reached the final stage being able to exercise independent judgement (stage IV) in the fourth year of study. The final stage is characterised by learning to solve problems through consultation in order to exercise independent judgement (Cornelissen 2006:21).

The data suggest that the progression of students through their study years corresponds to some extent with Cohen's (1981) stages of professional socialisation, especially the negative-independence stage (II), which was said to occur in the second year of study. These findings could support nurse educators and professional nurses by enabling them to anticipate possible rebellious behaviour in the second year. Students could be supported and provided with sufficient opportunities to voice their concerns to address this stage of professional socialisation.

5.4 SECTION 3: THE SIX PROFESSIONAL SOCIALISATION CONSTRUCTS – TEACHING AND FACILITATION OF PROFESSIONAL SOCIALISATION TO STUDENTS

Section 3 describes six professional socialisation constructs that are presented as composite frequency tables with supportive evidence of items of these constructs. Each table indicates the respondents' distributed responses on a perception rating scale from 1 to 7, where '1' indicates the least positive perception and '7' indicates the most positive perception on the listed aspects of the rating spectrum. By including frequencies and percentages in the total column of each table, an indication is obtained of how positive or negative respondents in general felt about the particular aspects of professional socialisation.

5.4.1 Construct 1 (items 9, 11, 13, 15, 17, 31, 33, 35, 57 and 59)

Construct 1, *own rating on the characteristics of an educator*, provided data on the respondents' self-assessed characteristics of an educator, which are indicated in table 5.2. The following characteristics were measured: standards of teaching practice,

interpersonal skills, level of subject knowledge, attitude to nursing education as a career, acknowledgement of others, commitment to teaching students to become competent, feeling comfortable to disagree with colleagues, acceptance of teaching responsibilities, confidence in own clinical competencies and availability of time to stay clinically competent. These characteristics measured certain attributes of a role model and the ability to work together as a team, as described by Grealish and Ranse (2009:87) and Perry (2009:37).

TABLE 5.2 CONSTRUCT 1: OWN RATING ON THE CHARACTERISTICS OF AN EDUCATOR (ITEMS 9, 11, 13, 15, 17, 31, 33, 35, 57 AND 59)

Own rating of the characteristics of an educator								
Frequency Row percentage	Rating negative to positive perceptions: (1 [--] = least positive and 7 [+++] = most positive)							Total N
	1 --	2 -	3 -	4 +-	5 +	6 ++	7 +++	
High standards of teaching practices (self) [Item 9]	0 0.0%	0 0.0%	0 0.0%	3 2.3%	10 7.8%	53 41.4%	62 48.4%	128 100.0%
Rating of own interpersonal skills [Item 11]	0 0.0%	0 0.0%	1 0.8%	1 0.8%	14 10.9%	56 43.75%	56 43.75%	128 100.0%
Rating of own subject knowledge [Item 13]	0 0.0%	0 0.0%	0 0.0%	1 0.8%	14 10.9%	45 35.2%	68 53.1%	128 100.0%
Rating of own positive attitude towards his/her occupation [Item 15]	0 0.0%	2 1.6%	1 0.8%	4 3.1%	9 7.0%	37 28.9%	75 58.6%	128 100.0%
Rating of own acknowledgement to others [Item 17]	0 0.0%	0 0.0%	1 0.8%	1 0.8%	6 4.7%	37 28.9%	83 64.8%	128 100.0%
Nurse educator's commitment to facilitate and teach students to become competent [Item 31]	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 0.8%	21 16.4%	106 82.8%	128 100.0%
Comfortable to disagree with colleagues [Item 33]	2 1.6%	6 4.7%	4 3.2%	7 5.5%	27 21.3%	40 31.5%	41 32.3%	127 100.0%
Accept teaching responsibilities [Item 35]	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 0.8%	27 21.0%	100 78.1%	128 100.0%
Confidence in own clinical competencies [Item 57]	1 0.8%	0 0.0%	0 0.0%	0 0.0%	7 5.6%	38 30.4%	79 63.2%	127 100.0%
Availability of time to stay clinically competent [Item 59]	4 3.2%	4 3.2%	6 4.8%	15 12.1%	30 24.2%	34 27.4%	31 25.0%	124 100.0%
Total	7 0.6%	12 0.9%	13 1.0%	32 2.5%	119 9.4%	388 30.5%	701 55.1%	1272 100.0%
Frequency missing = 8								
Fisher's exact probability (that Chi-square statistic = 324.58) < 0.0001***								

By studying the row of percentages in the totals row in table 5.2, it is observed that the cumulative frequencies and percentages of the rating response categories 5, 6 and 7 (positive rating) add up to 1208 (nt) (95%) responses. This evidence indicates that the respondents' general perceptions regarding the characteristics of an educator were very

positive, since 95% of them selected 'positive' to 'very positive' responses to all questions on this issue. The results indicated that educators perceived themselves as having admirable attributes that reflected exemplary role-model behaviour. These included: maintaining high standards of teaching practices; having good interpersonal skills, sufficient level of subject knowledge and a positive attitude to nursing education as a career; being able to acknowledge others' accomplishments and being committed to teach students to become competent professional nurses. Being a good role model who demonstrates respectable work behaviour and good interpersonal skills enhances student learning (Adelman-Mullally, Mulder, McCarter-Spalding, Hagler, Gaberson, Hanner, Oermann, Speakman, Yoder-Wise & Young 2012:[2]).

In addition, the Fisher's exact probability associated with the Chi-square statistic of 324.58 calculated on the frequencies for table 5.2 is less than 0.0001, which indicates statistical significance on the 0.1% level of significance. The two relevant items that were rated significantly differently from the others were the issues of feeling comfortable to disagree with colleagues (item 33; N=127) and available time to stay clinically competent (item 59; N=124). The cumulative frequencies and percentages for the response categories 5, 6 and 7 of these two items were 108 (85.1%; item 33) and 95 (76.6%; item 59) respectively. This evidence indicates that disagreement with colleagues and availability of time to stay clinically competent were rated less positively than were the other items in this construct. Disagreement with one another has the potential to create conflict, the more so with well-educated, intelligent individuals (Begley 2009:208). This phenomenon may explain why educators indicated that they felt less comfortable in disagreeing with their colleagues. Furthermore, the importance of an educator's clinical competency is valued, as it is suggested that 10% of an educator's time should be allocated to work in the clinical field in order to stay clinically competent (Nursing Education Stakeholders of SA 2011:5). Considering the finding related to clinical competency, the above suggestion of the Nursing Education Stakeholders might be a challenge for some educators.

5.4.2 Construct 2 (items 10, 12, 14, 16, 18, 32, 34 and 36)

The results of construct 2, the *characteristics of an educator* as perceived by colleagues, are presented in table 5.3. This construct described the perceived ratings by respondents of their colleagues' qualities as an educator: standard of teaching

practice, interpersonal skills, subject knowledge, positive attitude to nursing education as a career, acknowledgement of others, commitment to teaching students to become competent, conflict-resolving abilities and acceptance of teaching responsibilities.

Table 5.3 shows that the totals in the row of cumulative frequencies and percentages in the rating response categories 5, 6 and 7 add up to 869 (nt) (85.8%) responses. This percentage (85.8%) signifies that the respondents in general rated their colleagues very positively in terms of the characteristics of an educator.

TABLE 5.3 CONSTRUCT 2: THE CHARACTERISTICS OF AN EDUCATOR AS PERCEIVED BY COLLEAGUES (ITEMS 10, 12, 14, 16, 18, 32, 34 AND 36)

Characteristics of an educator as perceived by colleagues								
	Rating negative to positive perceptions: (1 [--] = least positive and 7 [+++]= most positive)							
Frequency	1	2	3	4	5	6	7	Total N
Row percentage	--	-	-	+-	+	++	+++	
High standard of teaching practices (colleagues) [Item 10]	1 0.8%	0 0.0%	3 2.3%	16 12.5%	25 19.5%	50 39.1%	33 25.8%	128 100.0%
Rating of colleagues' interpersonal skills [Item 12]	0 0.0%	0 0.0%	4 3.2%	17 13.4%	37 29.1%	44 34.6%	25 19.7%	127 100.0%
Rating of colleagues' subject knowledge [Item 14]	0 0.0%	0 0.0%	2 1.6%	6 4.8%	19 15.2%	54 43.2%	44 35.2%	125 100.0%
Rating of colleagues' positivism towards their occupation [Item 16]	1 0.8%	1 0.8%	4 3.1%	8 6.3%	26 20.5%	38 29.9%	49 38.6%	127 100.0%
Rating of colleagues' acknowledgement to others [Item 18]	0 0.0%	1 0.8%	4 3.2%	5 7.1%	32 25.4%	40 31.75%	40 31.75%	126 100.0%
Colleagues' commitment towards facilitating students to become competent professional nurses [Item 32]	0 0.0%	0 0.0%	1 0.8%	3 2.4%	20 15.7%	37 29.1%	66 52.0%	127 100.0%
Perception of conflict resolving abilities between nurse educators [Item 34]	9 7.0%	9 7.0%	11 8.6%	23 17.9%	27 21.1%	30 23.4%	19 14.8%	128 100.0%
Perception of colleagues' responsibility for teaching activities [Item 36]	1 0.8%	0 0.0%	2 1.6%	8 6.4%	25 20.0%	37 29.6%	52 41.6%	125 100.0%
Total	12 1.2%	11 1.1%	31 3.1%	90 8.9%	211 20.8%	330 32.6%	328 32.4%	1013 100.0%
Frequency missing = 11								
Fisher's exact probability (that Chi-square statistic = 196.42) < 0.0001***								

The Fisher's exact probability associated with the Chi-square statistic of 196.42, calculated on the frequencies for table 5.3, is less than 0.0001. This measurement

indicates a statistical significance on the 0.1% level of significance. This test showed that the response patterns to all questions on the characteristics of an educator as perceived by colleagues were not rated in the same manner. Item 34, which addressed colleagues' conflict-resolution abilities, was rated significantly less positively than the other items in this construct. This evidence is reflected in the cumulative number of responses for categories 5, 6 and 7, which adds up to 76 (59.3%). Conflict resolution, as part of interpersonal relationships, is indicated as one of the proposed core competencies for a nurse educator to be registered with the SANC (South Africa. Department of Health 2012:31).

Furthermore, if construct 1 (own rating of the characteristics of an educator, table 5.2) is compared with construct 2 (characteristics of an educator as perceived by colleagues, table 5.3), the cumulated percentage responses for construct 1 were 95% positive, while for construct 2 the percentage was 85.8% positive. Both these constructs indicated a positive trend towards the measured characteristics of an educator, indicating that respondents perceived themselves and their colleagues as being role models and having the ability to work in a team. However, the respondents' rating of their colleagues' characteristics was slightly less positive. A possible reason for this difference could be, as Vazire and Carlson (2011:107) state, that many aspects of an individual's own behaviour are hidden from his or her conscious awareness. Therefore, colleagues might have been aware of aspects related to the characteristics of an educator that were not known to the respondents themselves. Nevertheless, responses to questions on both these constructs indicate that educators perceived themselves and their colleagues as exhibiting admirable role-model behaviour.

5.4.3 Construct 3 (items 19, 21, 23, 65, 73, 75, 83 and 20, 22, 24, 66, 74, 76, 84, 85)

Construct 3, *aspects related to the values and beliefs of nursing*, describes the ratings of the respondents' perceptions of aspects related to the behaviour concerning educators and students. The following aspects were addressed: the educator portraying respect to others, maintaining honesty in teaching practices, confidentiality of student matters, appropriate selection of candidates entering into the nursing profession, student behaviour and attitudes towards nursing, as well as the self-image of a student. This construct measured the educators' perception of their values and beliefs as manifested in their own adherence to ethical values. In addition, those values

and beliefs as perceived in students' behaviour and attitudes towards nursing were also addressed. Items 66, 74, 76, 84 and 85 provided supportive evidence for this construct, which was a justification for the selected items related to students' behaviour and attitude towards nursing and the reasons for student attrition.

In table 5.4, the percentages and frequencies in the totals row, the cumulative frequencies and percentages of the rating response categories 5, 6 and 7, add up to 663 (nt) (75.9%). This percentage (75.9%) indicates that respondents in general rated the aspects related to the values and beliefs of educators and students as fairly positive. Values and beliefs provide a person with a guide on how to behave (Holland & Hogg 2010:78).

TABLE 5.4: CONSTRUCT 3: ASPECTS RELATED TO THE VALUES AND BELIEFS OF NURSING (ITEMS 19, 21, 23, 65, 73, 75 AND 83)

Aspects related to values and beliefs of nursing								
Frequency Row percentage	Rating negative to positive perceptions: (1 [–] = least positive and 7 [+++] = most positive)							Total N
	1 –	2 –	3 -	4 +-	5 +	6 ++	7 +++	
Respect for significant others [Item 19]	0 0.0%	0 0.0%	0 0.0%	0 0.0%	12 9.4%	38 29.7%	78 60.9%	128 100.0%
Honesty regarding teaching activities [Item 21]	0 0.0%	0 0.0%	0 0.0%	1 0.8%	2 1.6%	45 35.4%	79 62.2%	127 100.0%
Keeping student matters confidential [Item 23]	0 0	0 0	0 0	3 2.4%	12 9.5%	45 35.4%	67 52.8%	127 100.0%
Perceived appropriateness of candidates [Item 65]	22 18.2%	12 9.9%	11 9.1%	19 15.7%	25 20.7%	16 13.2%	16 13.2%	121 100.0%
Students' disciplined behaviour [Item 73]	5 4.1%	2 1.7%	18 15.0%	36 30.0%	33 26.7%	23 19.2%	4 3.3%	121 100.0%
Students' attitude towards nursing [75]	2 1.6%	3 2.4%	12 9.7%	30 24.2%	46 37.1%	24 19.4%	7 5.6%	124 100.0%
Students' self-image [Item 83]	0 0.0%	0 0.0%	13 10.4%	21 16.8%	38 30.4%	34 27.2%	19 15.2%	125 100.0%
Total	29 3.3%	17 1.9%	54 6.2%	110 12.6%	168 19.2%	225 25.8%	270 30.9%	873 100.0%
Frequency missing = 22								
Fisher's exact probability (that Chi-square statistic = 547.78) <0.001***								

However, the Fisher's exact probability associated with the Chi-square statistic of 547.78 calculated on the frequencies for table 5.4 is less than 0.001. This result implies that some items were rated differently on a 0.1% level of significance. This rating is evident when item 65, relating to the perceived appropriateness of candidates who

enter nursing, is inspected. The respondents rated selection of students who followed nursing as a career significantly negatively, as is evident from the cumulative frequencies and percentages for the response to categories 5, 6 and 7 of item 65. These categories add up to 57 (47.1%; N=121). Choosing nursing as a profession is influenced by various factors, of which a person's values and beliefs are significant indicators (Newton, Kelly, Kramer, Kremser, Jolly & Billet 2009:397).

In contrast, the respondents scored themselves very positively on items 19 (100%; N=128), 21 (99.2%; n=126) and 23 (97.7%; n=124), which addressed the educators' own perceived values and beliefs on ethical issues. It could be argued that the respondents' self-assessment is biased and therefore could not be regarded as a true reflection of their adherence to ethical principles. However, this finding concurs with the evidence of Klunklin, Sawasdisingha, Viseskul, Funashima, Kameoka, Nomoto and Nakayama (2011:86), which also reveals positive self-assessment of educators' ethical value orientation.

In addition, for items 20, 22 and 24 (table 5.5), which addressed the rating responses related to the perception of colleagues' display of ethical values, a positive to more positive to very positive rating was obtained for the response categories 5, 6, and 7 (77.4%–92.2%). However, item 20, which addressed the display of respect to others, was rated less positively, as is evident from the summed response categories 5, 6, and 7, which added up to 99 (77.4%). The other two items (22 and 24) were rated more positively. These items addressed honesty (n=113; 89.6%) and confidentiality (n=97; 92%). As indicated in tables 5.4 and 5.5, the respondents rated their view of their own adherence to ethical principles more highly (97.7%–100%) than they rated their colleagues' adherence to ethical principles (77.4%–92.2%).

TABLE 5.5 PERCEPTIONS OF COLLEAGUES' DISPLAY OF ETHICAL PRINCIPLES (ITEMS 20, 22 AND 24)

Adherence to ethical principles by colleagues								
Frequency	Rating negative to positive perceptions: (1 [–] = least positive and 7 [+++] = most positive)							Total N
	1	2	3	4	5	6	7	
Row percentage	--	-	-	+-	+	++	+++	
Colleagues' display of respect [Item 20]	1	2	5	20	37	34	28	128
	0.8%	2.3%	3.9%	15.6%	28.9%	26.6%	21.9%	100.0%
Colleagues' display of honesty [Item 22]	0	0	2	11	27	46	40	126
	0.0%	0.0%	1.6%	8.7%	21.4%	36.5%	31.7%	100.0%
Colleagues' display of confidentiality [Item 24]	0	1	9	19	38	38	21	125
	1.6%	0.0%	2.4%	4.0%	20.8%	43.2%	28.0%	100.0%
Missing frequency = 5								

Regarding item 73 (table 5.4), which addressed the perceptions of the respondents on students' behaviour, the summed response categories of 5, 6 and 7 add up to 60 responses (49.2%; N=121). This total indicates a negative response pattern, meaning that the respondents perceived students to exhibit less disciplined behaviour. The respondents justified their answers to item 73 in an open-ended question in item 74. Of the 111 respondents who responded to this open-ended question (item 74), a number (n=66; 62.1%) gave responses that were related to undisciplined and negative behaviour by students (Annexure XV). The comments on student behaviour were related to absenteeism from class and practice, poor time management, inappropriate professional conduct and inconsiderate or disrespectful behaviour. Similar results were found by Klerk (2010:73), who indicated that professional nurses complained of poor time management and negative attitudes among students. However, 42 (37.8%) of the responses indicated that students adhered to the rules, especially when they progressed towards their final year.

Addressing reported unethical behaviour was further explored in item 85 in an open-ended question (Annexure XV). Of the 117 respondents who responded, 44 (37.6%) indicated they would discuss the issue with the involved parties, while 36 (30.8%) respondents stated that they would follow the protocol on behaviour. Thus, from the above discussion it was concluded that the respondents were not fully convinced that all students behaved in a disciplined manner; however when behavioural issues arose that needed attention, a process was followed to address such issues.

According to Cohen's model on professional socialisation (1981), a professional self-image will be developed on completion of stage IV, the interdependence stage (Chitty & Black 2011:135). As indicated in table 5.4, the 125 respondents' rated perception on the students' self-image (item 83) was fairly positive, as evident from the summed response categories 5, 6 and 7, which added up to 91 (72.8%). This issue was justified by 100 respondents in an open-ended question (item 84), indicating that students were well groomed, especially when reaching their fourth year (n=53; 53%). However, 34 (34%) respondents indicated that students had no pride and had a negative self-image (Annexure XV). This finding suggests that students in their final year of nursing have developed some form of a professional identity.

In item 75 (table 5.4), which addressed the respondents' perception of students' attitude to nursing, the responses of 124 respondents in the rating categories 5, 6, and 7 add up to 77 (63.5%). This figure indicates a fairly positive perception on the issue of students' attitude to nursing. This rating was justified in an open-ended question (item 76). Of the 113 respondents who responded, not all were explicit in their answers, since some answers could be interpreted as either positive or negative; for example, "Some students are positive." Examples of negative responses were that students were only there for the salary, and of a positive response, that most students were hard working (Annexure XV). Stomberg and Nilsson (2010:46) found that having a positive attitude and a desire to become a professional nurse were the main factors that influenced students' motivation to complete their nursing programme.

In item 66, the respondents indicated the reasons for student attrition, as illustrated in figure 5.2. Of the 124 respondents who provided reasons, most of the respondents (n=101; 81.5%) cited poor academic performance. The second most frequently (n=81; 65.3%) selected reason was that nursing was not their first career choice. Price (2011:177) emphasises that individuals have mistaken preconceptions when they enter the nursing profession. They perceive nursing primarily as caring for the sick, without considering the high technological skills and knowledge needed to be a nurse.

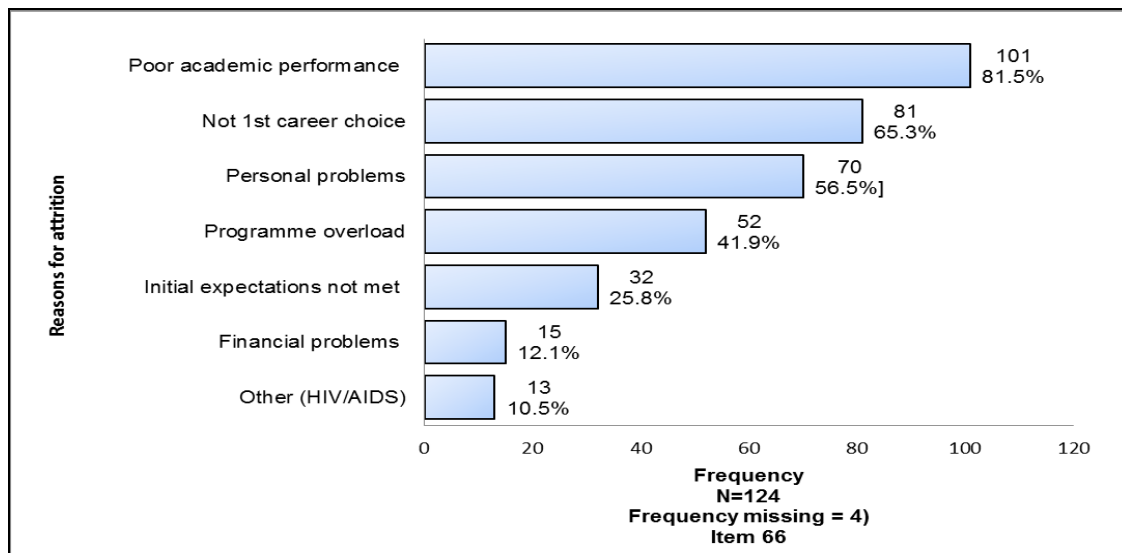


Figure 5.2 Most common reasons for attrition from the undergraduate nursing programme (item 66; N=124)
[Note: respondents could select more than one option]

5.4.4 Construct 4 and related items (items 52, 54, 55, 58, 67, 69 and 46, 53, 56, 60–64, 67-71)

This section addresses the construct (4), *the educator and the clinical field*, with supportive items, namely clinical accompaniment, clinical support staff, challenges of the clinical field and theory-practice discrepancies. In order to understand this construct (4), the items related to clinical accompaniment (items 60–61) and clinical support staff, (items 62–64), will first be discussed.

5.4.4.1 Clinical accompaniment (items 60–61)

Educators not only teach the theory but are also responsible for preparing and supporting students in their clinical learning. In item 60, which addressed the responsibility of clinical accompaniment (N=118), the majority (n=112; 94.9%) of the respondents indicated that they were responsible for clinical accompaniment of students; only 6 (4.8%) respondents were not. Figure 5.3 illustrates the responses of 125 respondents to the question that addressed the challenges educators experienced during clinical accompaniment of students (item 61). Some of the challenges were the large number of students that needed support (n=90; 72%), students that were absent during the accompaniment visits (n=60; 48%) and lack of support from the clinical field (n=59; 47.2%). MacKenzie (2010:208) found in her study that educators are faced with lack of available time to perform clinical accompaniment.

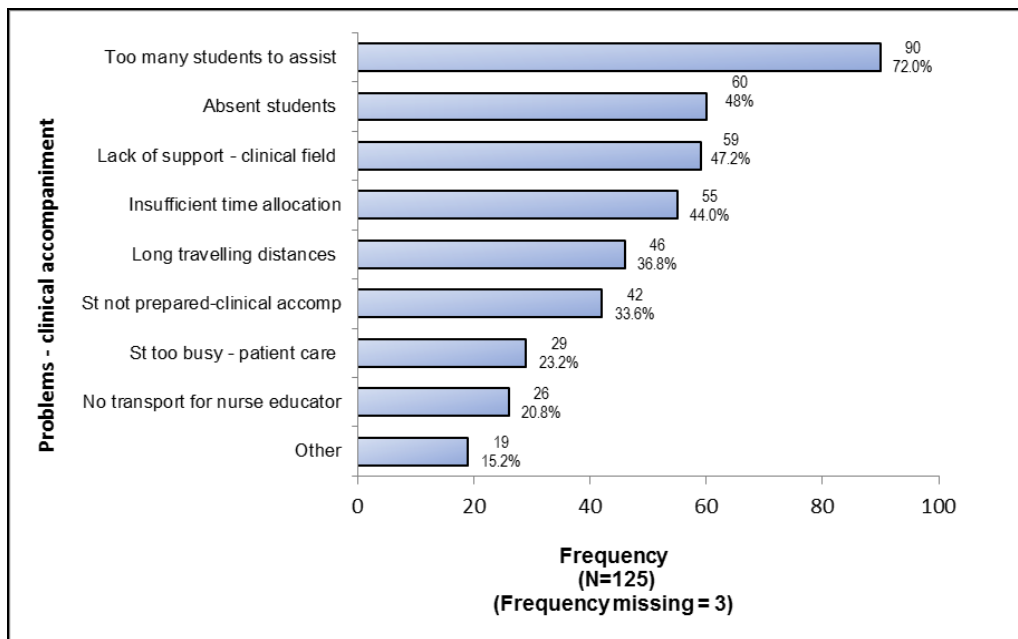


Figure 5.3 Problems experienced during clinical accompaniment (item 61; N=125)
 [Note: respondents could select more than one option]

5.4.4.2 Clinical support staff (items 62–64)

In order to support students in their clinical learning, preceptors, mentors and peer-mentors were utilised; however, not all nursing education institutions used them to the same extent, as indicated in figure 5.4. Of the 125 respondents who responded, a number (n=81; 64.8%) of respondents indicated that they used mentors, 77 (63.6%) indicated peer-mentoring and 61 (49.2%) respondents indicated preceptors. The data indicated that preceptors were the support method used least often. The Clinical Model for Education and Training of SA proposes that clinical preceptors should be employed permanently by nursing education institutions to support students during the clinical learning experience (Nursing Education Stakeholders of SA 2011:7). This suggestion may help educators with the challenges they indicated that they experienced in supporting students in the clinical field.

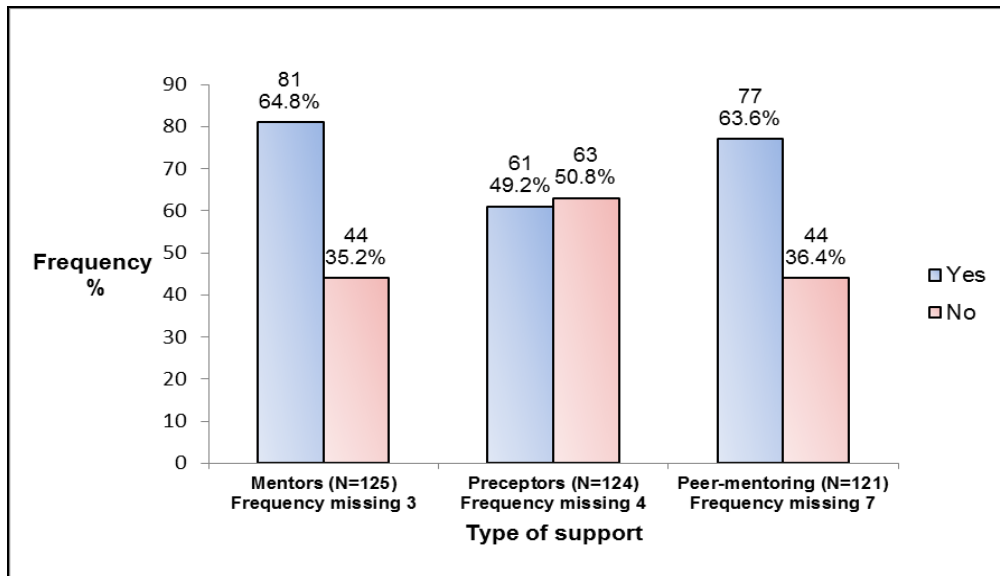


Figure 5.4 Type of support provided (items 62–64)

5.4.4.3 Construct 4: Educator and the clinical field with related challenges (items 52, 54, 55, 58, 67, 69 and 53, 56, 68)

Educators are faced with various challenges in the clinical field, such as student placements, communication and preparation of students for the challenges of the clinical field. The following construct (4), *educator and the clinical field with related challenges*, addresses some of these challenges. Items 53, 56 and 68 are to be discussed as supportive evidence relating to this construct. These items examined rated items on communication and preparation of students for the clinical field.

As indicated in table 5.6, the cumulative numbers and percentages of the rating response categories, 5, 6, and 7 add up to 635 (nt) (84.6%), which is indicated in the bottom row of the totals row. This percentage of 84.6% indicates that the general perceptions of the construct (4), *educator and the clinical field*, were positive to very positive. Of the 125 respondents who responded to item 52, a positive to very positive rating was obtained for the response categories 5, 6, and 7 (n=103; 82.4%). This item addressed the priority given to either the students' learning objectives or the minimum prescribed hours by the SANC. This evidence implied that the minimum hours as prescribed by SANC received preference above the learning objectives of students. In item 53, 102 respondents indicated reasons for their selection regarding the SANC's hours and students' learning objectives. The two most important reasons the respondents offered for their selection were that they strictly followed the requirements

of the SANC (n=60; 58.8%), and that because of the large numbers of students who needed placement in the clinical field, learning objectives were compromised (n=11; 10.8%). (Annexure XV). This evidence may imply that professional socialisation is hindered, since learning outcomes cannot always be reached.

TABLE 5.6 CONSTRUCT 4: EDUCATOR AND THE CLINICAL FIELD WITH RELATED CHALLENGES (ITEMS 52, 54, 55, 58, 67, AND 69)

Educator and clinical field								
Frequency	Rating negative to positive perceptions: (1 [–] = least positive and 7 [+++] = most positive)							Total N
	1	2	3	4	5	6	7	
Row percentage	–	–	–	+-	+	++	+++	
SANC's prescribed minimum hours for clinical placement versus learning objectives [Item 52]	3 2.4%	3 2.4%	6 4.8%	10 8.0%	11 8.8%	35 28.0%	57 45.6%	125 100.0%
Communication within the clinical field [Item 54]	2 1.6%	1 8.0%	9 7.2%	12 9.6%	20 16.0%	39 31.2%	42 33.6%	125 100.0%
Communication between the clinical field & NEI regarding clinical placement [Item 55]	0 0.0%	2 1.6%	5 3.9%	9 7.1%	24 18.9%	40 31.5%	47 37.0%	127 100.0%
Confidence in colleagues' skill competencies [Item 58]	1 0.8%	0 0.0%	2 1.6%	4 3.2%	22 17.5%	55 43.7%	42 33.3%	126 100.0%
Student preparation for the challenges of 1st clinical exposure in the field [Item 67]	3 2.4%	3 2.4%	12 9.8%	9 7.3%	21 17.1%	43 35.0%	32 26.0%	123 100.0%
Opportunities for reflection on practical experiences [Item 69]	2 1.6%	2 1.6%	7 5.6%	9 7.2%	28 22.4%	48 38.4%	29 23.2%	125 100.0%
Total	11 1.5%	11 1.5%	41 5.5%	53 7.1%	126 16.8%	260 34.6%	249 33.2%	751 100.0%
Frequency missing = 17								
Fisher's exact probability (that Chi-square statistic = 45.99) <0.03*								

As presented in table 5.6, the Fisher's Chi-square statistic calculated 45.99, indicating a significance level of $p < 0.03$. This result implies that some items were rated significantly differently on a 5% level of significance. For example, item 67, in which the 123 respondents indicated to what extent students were prepared for their first clinical exposure, the cumulative responses of the response categories 1, 2 and 3 (negative perception), add up to 18 (14.6%). These results signify a more negative response related to the students' preparation for their first clinical exposure. This issue was explored further in item 68 in an open-ended question. Of the 112 respondents who responded, 66 (58.9%) indicated the most frequently used method for preparing

students for the clinical field was simulation and 42 (37.5%) mentioned orientation. Sedgwick and Yonge (2008:625) state that students not only need to have the necessary knowledge and skills, but also need psychological preparation for the diverse challenges of the clinical environment. In this study, only 14 (12.5%) of the respondents indicated discussion and debriefing as a preparation method (Annexure XV).

Regarding items 54 and 55, which addressed communication within the clinical field and communication between the clinical field and the nursing education, the respondents' cumulative responses for the response categories 5, 6 and 7 add up to 101 (80.8%) for item 54 and 111 (87.4%) for item 55. The communication within the clinical field was rated less positively than the communication between the nursing education institution and the clinical field. Brown et al (2011:e27) emphasise that effective two-way communication is essential to ensure optimal learning among students. Although communication was perceived as adequate, 111 respondents provided examples of some miscommunication issues in an open-ended question (item 56). These communication issues were mostly related to professional nurses in the clinical field being unaware of student placement (n=47; 42.3%) and insufficient information regarding absenteeism of students from the clinical field (n=27; 30.0%) (Annexure XV).

5.4.4.4 Theory-practice discrepancies (items 46, 70–71)

This section provides supportive data relating to the construct (4), *educator and the clinical field*, which indicated reporting of and the nature of theory-practice discrepancies and how the educator addressed these issues. As indicated in table 5.7, the summed response categories 5, 6 and 7 add up to 101 (82.1%), indicating a very positive rating ('+' to '+++') regarding the respondents' experience of reported theory-practice discrepancies (N=123; Item 70).

TABLE 5.7 REPORT OF THEORY-PRACTICE DISCREPANCIES (ITEMS 70; N=123)

Report of theory-practice discrepancies [Item 70]								
	Rating negative to positive perceptions: (1 [–] = least positive and 7 [+++]= most positive)							
Frequency	1	2	3	4	5	6	7	Total N
Row percentage	–	–	–	+–	+	++	+++	
Report of theory practice discrepancies [Item 70]	3	5	4	10	26	39	36	123
	2.4%	4.1%	3.3%	8.1%	21.1%	31.7%	29.3%	100.0%
Frequency missing =5								

In item 71, 102 respondents provided further typical examples of such reported discrepancies in answer to an open-ended question. The two most frequently mentioned examples were that the clinical staff would perform procedures differently from the method in the demonstrated procedures (n=49; 48.0%), and that there was a lack of equipment or different equipment (n=20; 19.6%) (Annexure XV). This evidence concurs with Dlamini’s (2011:85) findings at a higher-education institution in Swaziland, where lack of resources was also reported as contributing to theory-practice discrepancies.

Furthermore, the respondents were asked to describe in item 46 how they would facilitate theory-practice integration. Of the 121 respondents who responded, the approaches used most often were clinical accompaniment (n=42; 35.0%), the utilisation of a variety of teaching strategies (n=32; 26.7%), following a sequence of first teaching the theory then applying the practice (n=28; 23.3%), combining discussions with examples (n=26; 21.7%) and simulation of procedures (n=10; 8.3%). The literature suggests reflection and the realignment of teaching strategies as possible solutions to this problem (Curtis, Horton & Smith 2012:790; Dlamini 2011:96). However, only two (1.7%) respondents indicated that they would use reflective teaching as a method to enhance theory-practice integration and none mentioned the realignment of teaching practices.

5.4.5 Construct 5 and items related to teaching strategies (items 39–42, 44 and 37, 38, 43, 45, 50, 51, 25, 26 and 72)

In this section the construct (5), *teaching strategies*, aspects related to the curriculum, student-centred versus educator-centred teaching, learning orientations, education and training facilities, as well as institutional support services, are discussed. The

curriculum philosophy and the emphasis of the curriculum on knowledge, skills, values and beliefs will be discussed first and the construct (5) thereafter.

5.4.5.1 Curriculum philosophy (item 37)

Figure 5.5 illustrates the data related to the underlying curriculum philosophy of the nursing programme followed at the nursing education institutions (item 37). Seventy-four (56.9%) respondents indicated that an outcomes-based approach curriculum philosophy was mostly followed. This was followed by the blended approach (n=37; 28.9%) and problem-based philosophy (n=18; 14.1%); only one (0.8%) respondent indicated a case-based approach. It was noticed that respondents from the same institution selected different approaches. Therefore it was concluded that the respondents would use different teaching approaches, as they indicated different curriculum philosophies followed when the same students were taught. This situation has the potential to create confusion among students. Educators should be familiar with their curriculum philosophy because the beliefs about the purpose of all educational processes are based on a curriculum philosophy (Iwasiw, Andrusyszyn & Goldenberg 2009:172).

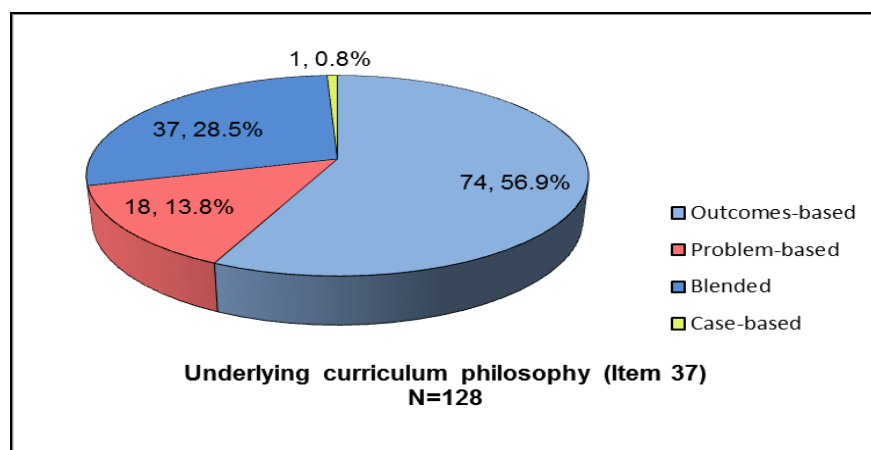


Figure 5.5 Curriculum philosophy (item 37, N=128)

5.4.5.2 Emphasis of the curriculum regarding knowledge, skills, values and beliefs (item 38)

In item 38, the respondents needed to indicate the emphasis of the curriculum regarding the transmission of knowledge, skills, values and beliefs, as illustrated in figure 5.6. Among the 126 respondents that responded, the two options mostly selected regarding

emphasis were 50% knowledge, 40% skills and 10% values and beliefs (n=35; 27.8%); and “other” (n=35; 27.3%). Only eight (6.3%) respondents indicated that the curriculum would mostly emphasise the transmission of knowledge, as they indicated that the ratio of emphasis was 70% knowledge, 25% skills and 5% values and beliefs. The evidence indicated that less emphasis is placed on values and beliefs and more on knowledge and skills. The importance of values and beliefs should not be underemphasised, as every decision a person makes is based on beliefs and values (Chitty & Black 2011:293)

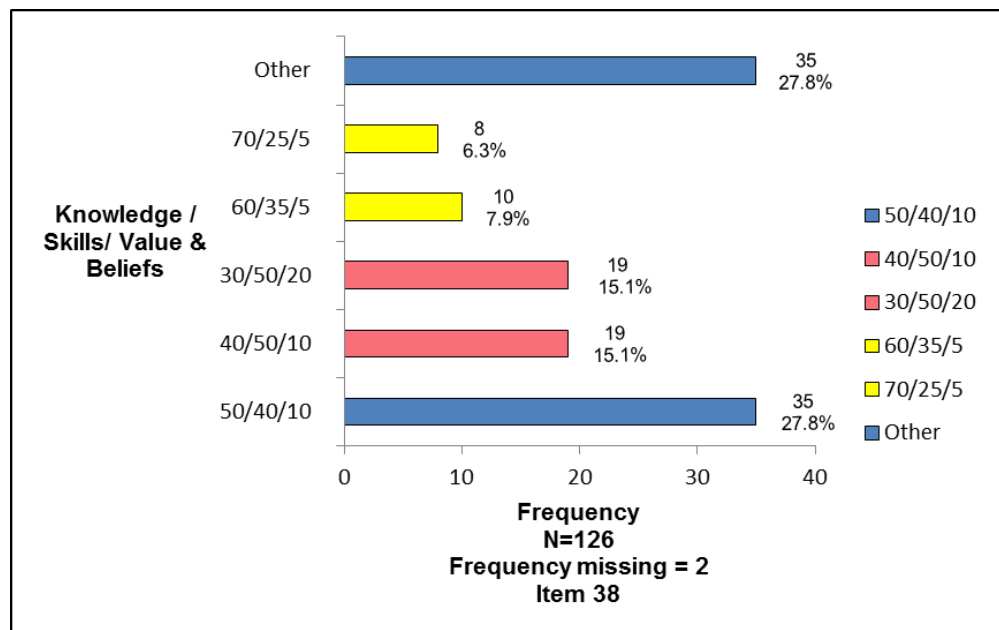


Figure 5.6 Emphasis of the curriculum (item 38; N=126)

5.4.5.3 Construct 5 (items 39, 40, 41, 42, 44 and related items 43, 45)

Construct (5), *teaching strategies*, addresses the perceptions of the respondents on the degree to which students participate during the transmission of knowledge, skills, values and beliefs; consideration of students’ different learning orientations and consideration of students’ work schedule when tests and assignments are scheduled.

Considering the row percentages of the totals row of table 5.8, it is observed that the summed response categories 5, 6, and 7 amounted to 535 (nt) (84.7%). This observation signifies a generally positive perception regarding the construct *teaching strategies*. Furthermore, the Fisher’s exact probability associated with the Chi-square statistic of 66.83 calculated on the frequencies for table 5.8 is less than 0.0001, which

implies a statistical level significance of 0.1%. If item 41 (N=126), which addressed the degree to which students participate in the transmission of values and beliefs, is inspected, it is clear that this issue was rated significantly differently from other items in this construct. The summed response categories 5, 6 and 7 of this item add up to 97 (77.0%), indicating a less student-centred approach. Student-centred teaching is important, as it allows students to participate actively in the learning process, which facilitates the construction of their own knowledge (Struyvena, Dochya & Janssens 2010:44).

TABLE 5.8 CONSTRUCT 5: TEACHING STRATEGIES (ITEMS 39, 40, 41, 42, AND 44, 45)

Teaching strategies								
Frequency	Rating negative to positive perceptions: (1 [--] = least positive and 7 [+++] = most positive)							Total N
	1	2	3	4	5	6	7	
Row percentage	--	-	-	+-	+	++	+++	
The degree to which students participate during knowledge transmission [Item 39]	0 0.0%	3 2.3%	5 3.9%	14 10.9%	35 27.3%	44 34.4%	27 21.1%	128 100.0%
The degree to which students participate during skills transmission (Item 40)	0 0.0%	1 0.8%	4 3.1%	6 4.7%	28 21.9%	48 37.5%	41 32.0%	128 100.0%
The degree to which students participate during values & beliefs transmission (Item 41)	0 0.0%	1 0.8%	9 7.14%	19 15.08%	38 30.16%	38 30.16%	21 16.67%	126 100.0%
Consideration of students' different learning orientations [Item 42]	0 0.0%	0 0.0%	2 1.6%	9 7.1%	36 28.4%	50 39.4%	30 23.6%	127 100.0%
The extent to which student's work schedule is considered re tests & assignments [Item 44]	4 3.3	1 0.8	7 5.7	12 9.8	10 8.1	43 35.0	46 37.4	123 100.00%
Total	4 0.6%	6 0.9%	27 4.3%	60 9.5%	147 23.3%	223 35.3%	165 26.1%	632 100.0%
Frequency Missing = 8								
Fisher's exact probability (that Chi-square statistic = 66.83) <0.0001***								

Accommodating diverse learning orientations of students, especially in the selection of teaching and assessment strategies, is very important. The issue of accommodating the diverse learning orientations of students was explored in an open-ended question (item 43). The 109 respondents who responded to item 43 mentioned that two methods used most frequently were the mentoring of students (52; 8.1%) and the application of different teaching and assessment methods (34; 31.5%) (Annexure XV). Rassool and Rawaf (2008:313) state that the consideration of students' different learning orientations may influence the learning outcomes of students.

In item 44, which tested the degree to which the student’s work schedule was taken into consideration, 123 respondents’ responses of the cumulative frequencies and percentages of the response categories 5, 6 and 7 amounted to 99 (80.5%). This result signifies a positive to very positive rating of the extent to which the student’s work schedule was considered with regard to the scheduling of tests and assignments, indicating that students were to some extent considered regarding their academic and practical responsibilities. In item 45, the respondents were asked to expand on how students were accommodated in terms of writing tests, taking into account the students’ work schedules. Of the 117 respondents who responded, 61 (51.8%) stated that support was provided by the issuing of a planned programme in advance and 29 (24.8%) cited giving students self-study time (Annexure XV). The findings indicate that educators supported students to some extent regarding their academic responsibilities.

5.4.5.4 Education and training facilities (items 50–51)

In order for educators to teach effectively, training facilities and equipment should be adequate. In item 50, the respondents indicated the extent of their satisfaction with their institution’s training facilities and equipment. As indicated in table 5.9, the summed response categories 5, 6 and 7 added up to 100 (80%), indicating that most of the 125 respondents who responded perceived the training and equipment facilities as satisfactory to very satisfactory. A small-scale study conducted at a nursing college in Gauteng, however, revealed that that college had inadequate training facilities and equipment (Van Wyngaard 2008:10).

TABLE 5.9 ADEQUACY OF THE EDUCATION AND TRAINING FACILITIES (ITEM 50; N=125)

Adequacy of training and equipment facilities								
	Rating negative to positive perceptions: (1 [-] = least positive and 7 [+++] = most positive)							
Frequency	1	2	3	4	5	6	7	Total N
Row percentage	--	--	-	+-	+	++	+++	
Degree of adequacy of training and equipment facilities [Item 50]	1	3	5	16	24	39	37	125
	0.8%	2.4%	4.0%	12.8%	19.2%	31.2%	29.6%	100.0%
Frequency missing =3								

In item 51, as illustrated in figure 5.7, out of the 113 responses it was found that the most needed training and equipment facilities were mannequins for skills training (n=47; 41.6%) and sufficient classroom space (n=19; 16.8%). Almost a third of the respondents: 38 (33.6%), indicated 'none', signifying that they were satisfied with their facilities.

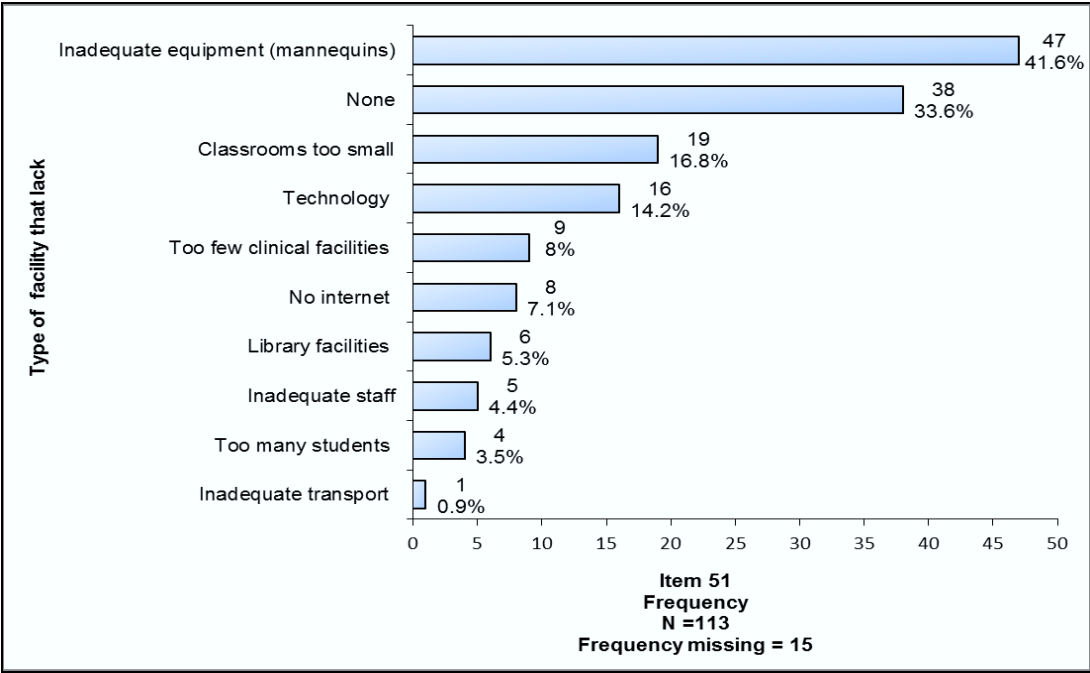


Figure 5.7 Lack of training and equipment facilities (item 51; N=113)
[Note: respondents could select more than one option]

5.4.5.5 Support services (items 25, 26 and 72)

Students in this nursing programme are required to spend an average of 1000 hours per year in the clinical field, which implies that consulting an educator may in some cases be a challenge. This section provides an account of how consultation support is provided, as perceived by the respondents. Table 5.10 indicates that the summed responses to categories 5, 6 and 7 were 124 (97.7%; item 25), indicating that the majority of the 127 respondents indicated that educators were easily to very easily accessible for consultation.

TABLE 5.10 ACCESS TO CONSULTATION (ITEM 25; N=127)

Access to consultation								
Rating negative to positive perceptions: (1 [---] = least positive and 7 [+++] = most)								
Frequency	1	2	3	4	5	6	7	Total N
Row percentage	---	--	-	+-	+	++	+++	
Access to consultation [Item 25]	1	0	1	1	10	31	83	127
	0.8%	0.0%	0.8%	0.8%	7.9%	24.4%	65.4%	100.0%
Frequency missing =1								

Other than being available for consultation, in item 26 the respondents indicated the typical consultation support that was provided (figure 5.8). The two most frequently used support methods were an open-door policy (n=96; 75%) and an appointment system (n=92; 71.9%). The data indicated that students had easy access to educators should they wish to meet with them.

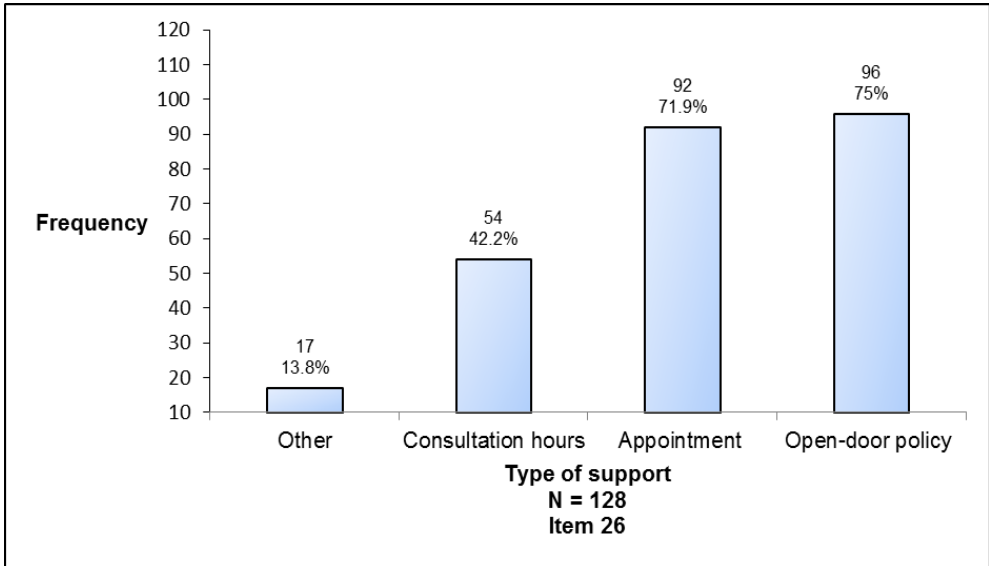


Figure 5.8 Type of consultation provided (item 26; N=128)
 [Note: respondents could select more than one option.]

Apart from the educator’s providing consultation support to students, 125 respondents also indicated the type of support the education institution provided to students, as illustrated in figure 5.9 (item 72). A variety of support systems were available to students.

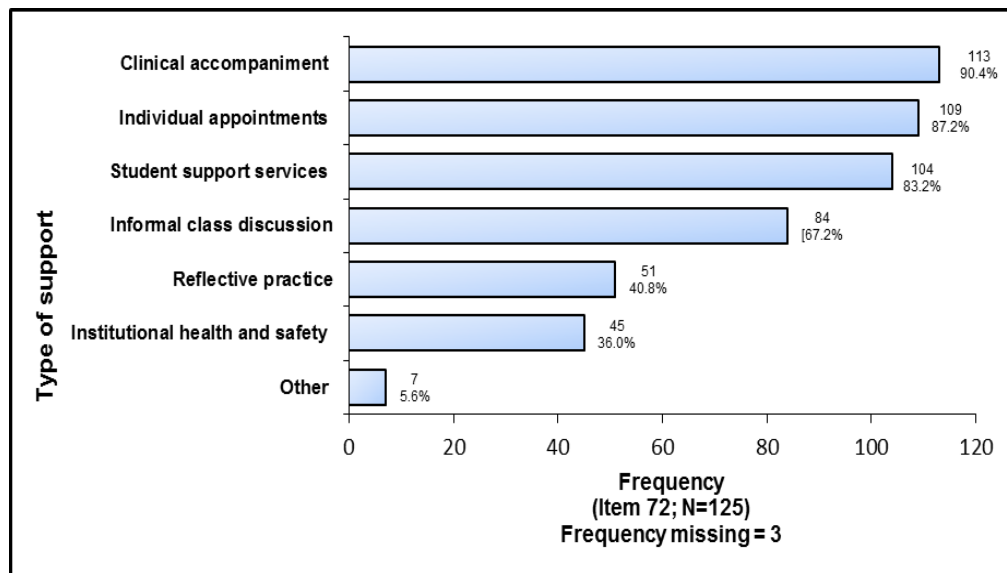


Figure 5.9 Type of institutional support (item 72; N=125)
[Note: respondents could select more than one option.]

The majority (113; 90.4%) of the respondents indicated that they used clinical accompaniment as a means of support, and 109 (87.2%) used individual appointments as a support method. Students are actively participating in patient care, thus being exposed to various health and safety risks. Only 45 (36%) respondents indicated that the educational institution provided health and safety support to students. Nurses are frequently exposed to high levels of health and safety risks, especially in the public sector (Pillay 2009:[7]). Students in this study obtained their learning experiences primarily in public institutions.

5.4.6 Construct 6: Cultural awareness and supportive items (items 28–30, 47, 48 and 27, 77, 78)

This section addresses the construct (6) *cultural awareness*, which is related to educators' and students' cultural awareness. The respondents stated that they reflected as individuals on cultural issues. This evidence could be observed from the summed response patterns of 5, 6, and 7, of item 27 as depicted in table 5.11, which revealed a positive to very positive response rating of 87.5% (n=111) out of 127 responses. Reflecting on one's own cultural values and beliefs will support the process of becoming culturally competent (RNAO 2007:32).

TABLE 5.11 EDUCATORS' OWN REFLECTION ON CULTURAL DIFFERENCES (ITEM 27; N=127)

Reflection on cultural differences								
	Rating negative to positive perceptions: (1 [---] = least positive and 7 [+++]= most positive)							
Frequency	1	2	3	4	5	6	7	Total N
Row percentage	---	--	-	+-	+	++	+++	
Own reflection on cultural differences [Item 27]	7 5.5%	1 0.8%	3 2.4%	5 3.9%	22 17.3%	47 37.1%	42 33.1%	127 100.0%
Missing frequency = 1								

Regarding construct (6) *cultural awareness*, an overall positive rating was obtained. By studying the frequencies and the row percentages of the totals row in table 5.12, it was observed that the cumulative frequencies and percentages of the rating response categories 5, 6 and 7 added up to 462 (nt) (73.4%). These results indicate that the perceptions regarding the cultural awareness of educators and opportunities for students to learn about cultural diversity were generally positive.

TABLE 5.12 CONSTRUCT 6: CULTURAL AWARENESS (ITEMS 28–30, 47 AND 48)

Cultural awareness								
	Rating negative to positive perceptions: (1 [---] = least positive and 7 [+++]= most positive)							
Frequency	1	2	3	4	5	6	7	Total N
Row percentage	---	--	-	+-	+	++	+++	
Cultural and reflective group activities [Item 28]	11 8.7%	6 4.8%	8 6.4%	28 22.2%	28 22.2%	31 24.6%	14 11.1%	126 100.0%
Awareness of different communication styles re culture [Item 29]	1 0.8%	1 0.8%	1 0.8%	5 3.9%	25 19.7%	48 37.8%	46 36.2%	127 100.0%
Colleagues' awareness of different communication styles re culture [Item 30]	3 2.4%	2 1.6%	4 3.1%	15 11.9%	33 26.6%	38 30.2%	31 24.6%	126 100.0%
Opportunities for students to reflect on their own cultural beliefs and values [Item 47]	4 3.2%	2 1.6%	15 12.0%	19 15.2%	46 36.8%	17 13.6%	22 17.6%	125 100.0%
Students' opportunities to reflect amongst each other on cultural differences [Item 48]	4 3.2%	5 4.0%	12 9.6%	21 16.8%	39 31.2%	25 20.0%	19 15.2%	125 100.0%
Total	23 3.7%	16 2.5%	40 6.4%	88 14.0%	171 27.2%	159 25.3%	132 20.9%	629 100.0%
Missing frequency = 11								
Fisher's exact probability (that Chi-square statistic = 100.75) <0.0001***								

However, the Fisher's exact probability associated with the Chi-square statistic of 100.75, calculated on the frequencies for table 5.12, is less than 0.0001, which indicates a statistical level of significance of 0.1%. Concerning item 29 (N=127) and 30 (N=126), which addressed educators' own culturally sensitive communication style and that of their colleagues, the summed responses to categories 5, 6 and 7 were rated significantly positively compared with other items in this construct. The totals of these two items added up to 119 (93.7%) and 102 (81%) respectively. However, the summed responses in categories 5, 6 and 7 of item 28 (N=127), which linked to the respondents' perceptions of opportunities for educators to reflect as a group on cultural issues, were 73 (57.9%), indicating that opportunities existed to some extent for reflective group activities. Cultural differences may generate strong feelings, therefore it is important to create reflective opportunities to explore these feelings (RNAO 2007: 82).

Furthermore, compared with students' opportunities to reflect on their own and others' cultural differences, the summed responses in categories 5, 6 and 7, were 85 (68%; Item 47) and 83 (66.4%; item 48) respectively. It could thus be deduced that although educators perceived themselves as culturally sensitive in their communication with others and reflecting by themselves, fewer opportunities existed for students to reflect on cultural differences. Educators should aspire to be continuously aware of cultural differences and also to create opportunities for students to become culturally sensitive. Insensitivity to cultural diversity could become a barrier to the learning outcomes of students (Hawala-Druy & Hill 2012:1).

Apart from being sensitive to cultural communication and having opportunities for reflection, reports of cultural conflict among students seemed to be less prominent, as is evident from the results presented below. When inspecting item 77 in table 5.13, the summed responses in categories 1, 2 and 3 (negative perception), were 67 (54.5%; N=123), indicating that the respondents were less aware of cultural conflict among students.

TABLE 5.13 AWARENESS OF CULTURAL CONFLICT AMONG STUDENTS (ITEM 77; N=123)

Report of cultural conflict								
Frequency Row percentage	Rating negative to positive perceptions: (1 [--] = least positive and 7 [+++] = most positive)							Total N
	1 --	2 -	3 .	4 +-	5 +	6 ++	7 +++	
Nurse educator awareness of cultural conflict among students [Item 77]	40	15	12	13	19	11	13	123
	32.5%	12.2%	9.8%	10.6%	15.4%	8.9%	10.6%	100%
Frequency missing =5								

Item 78, an open-ended question, confirmed this response pattern, as of the 78 respondents who responded, 27 (34.0%) indicated that cultural conflict was not easily noticed, while only 17 (21.8%) indicated that cultural differences were a challenge (Annexure XV). A possible reason for the respondents' lower awareness of cultural conflict may be the fact that fewer opportunities were provided for students to reflect on cultural differences.

5.5 RELIABILITY TESTING OF THE SIX COMPOSITE PROFESSIONAL SOCIALISATION CONSTRUCTS

Separate scale reliability testing was conducted on the composite construct subsets of questionnaire items, describing each construct of issues related to the professional socialisation of students. The tests were conducted to confirm internal consistency: to establish whether the subsets of all the questionnaire items truly contributed to explaining the relevant constructs or aspects of socialisation.

Table 5.14 presents the results from these analyses. As indicated in table 5.14, the Cronbach alpha values of the subsets of the six composite constructs fall within the region of 0.7 or greater than 0.7, except for the construct related to aspects of the educator and the clinical field, which measured a value of 0.68. A Cronbach alpha value in the region of, or greater than 0.70, is generally regarded as an indicator of internal consistency and therefore reliable (LoBiondi-Wood & Haber 2006:346). These results indicate internal consistency. Thus, these subsets of questionnaire items can be used to describe six aspects of professional socialisation of students. The questions

omitted were mostly open-ended questions or those not suitable for the calculation of Cronbach alpha values.

TABLE 5.14 SCALE RELIABILITY TESTING ON COMPOSITE PROFESSIONAL SOCIALISATION CONSTRUCTS

Results of scale reliability testing conducted on the subsets of item-responses of the perceptions of educators on professional socialisation				
Professional socialisation constructs	Subset of questionnaire items included	Questionnaire items omitted from the respective subsets	Cronbach alpha coefficient	Mean score (and std. dev.)
Own rating of an educator's characteristics (Construct 1)	q9, 11, 13, 15, 17, 31, 33, 35, 57, 59	None	0.73	6.31 (0.46)
Characteristics of an educator as perceived by colleagues (Construct 2)	q10, 12, 14, 16, 18, 32, 34, 36,	None	0.87	5.73 (0.83)
Aspects related to the values and beliefs of nursing (Construct 3)	q19, 21, 23, 65, 73, 75, 83	q20, 22, 24, 66, 74, 76, 84, 85	0.7	5.44 (0.71)
Educator and the clinical field (Construct 4)	q52, 54, 55, 58, 67, 69	q46, 53, 56, 60-64, 68, 70-71	0.68	5.73 (0.82)
Teaching strategies (Construct 5)	q39-42, 44	q25, 26, 37, 38, 43, 45, 49, 50, 51, 72	0.79	5.64 (0.79)
Cultural awareness (Construct 6)	q28-30, 47, 48	q27, 77, 78	0.76	5.18 (1.00)

In addition, measures of the respondents' perceptions of these six professional socialisation constructs were calculated for each respondent, as the mean value of the respondent's responses to each subset of questionnaire items, as indicated in table 5.14. The values of the means are interpreted as rating values as well: '1' implying 'very poor perception' of professional socialisation and '7' indicating a 'very favourable perception' of the specific professional nursing socialising construct. Therefore the respondents perceived the six socialising constructs positively (rating above 4). The most positive perception was expressed regarding the respondents' own rating of the characteristics of an educator (mean score of 6.31), followed by very positive perceptions regarding the construct of colleagues' characteristics (5.73), while perceptions regarding the construct of cultural competencies was just positive (5.18).

5.6 EFFECT OF RESPONDENTS' BIOGRAPHICAL PROPERTIES ON THEIR PERCEPTIONS OF THE SIX CONSTRUCTS OF PROFESSIONAL SOCIALISATION

The issue of whether perceptions are influenced by the biographical properties of the respondents (age, gender, mother tongue, qualifications, institution and duration of reported involvement in the nursing programme) is discussed in this section. A statistical significance on the level of 5% was indicated for the effect of age and duration of involvement in the nursing programme regarding the constructs of cultural awareness, aspects related to the values and beliefs of nursing and the characteristics of an educator as perceived by colleagues.

5.6.1 Age and cultural awareness

The two-way frequency tables and Fisher's chi-square tests are included in this section (significance on the level of 5% indicated as '*').

TABLE 5.15 RELATIONSHIP BETWEEN AGE AND CULTURAL AWARENESS

Age	Cultural awareness							Total
	---	--	-	+-	+	++	+++	
Frequency								
Row Percentage								
<41 years	0 0.0%	0 0.0%	1 4.4%	4 17.4%	12 52.1%	4 17.4%	2 8.7%	23 100.0%
41–50 years	1 2.3	1 2.3	3 6.8	0 0.0	15 34.1	21 47.7	3 6.8	44 100.0%
>50 years	0 0.0	0 0.0	2 3.3	15 25.0	19 31.7	23 38.3	1 1.7	60 100.0%
Total	1	1	6	19	46	48	6	127
Frequency Missing = 1 Fisher's Exact probability (that Chi-square statistic = 23.21) <0.0159*								

The exact probability calculated for the Chi-square statistic of 23.21 in table 5.15 was reported as less than 0.0159. This probability is less than 0.05, which signifies a 5% level of significance. It could thus be deduced that a statistically significant dependency between age and cultural awareness has been established on the 5% level of significance. This implies that the response patterns of respondents grouped according to age categories differed statistically significantly. Different response patterns for the different age groups can be observed through the frequencies and percentage (the ratios within an age group) in table 5.15 and the illustrated ratios in figure 5.10. For

example, if the 'undecided' ('+/-') categories of the three age groups are compared, they are revealed as 17.4%, 0% and 25.0%. Therefore, respondents in the age category 41–50 years are statistically significantly more decisive in their perceptions than are the younger or older age category. In this age group, 88.6% of respondents expressed a positive to very positive perception (response pattern '+' to '+++'). In addition, a greater portion of the group of 41–50 years expressed a very positive perception regarding cultural awareness ('++'; 47.7% and '+++ 6.8%; [54.55%]), than the older group ('++'; 38.3% and '+++ 1.7% [40.0%]) and the younger group ('++'; 17.4% and '+++ 8.7% [26.9%]). Thus respondents in the age group 41–50 years rated their cultural awareness more positively, as illustrated in figure 5.10.

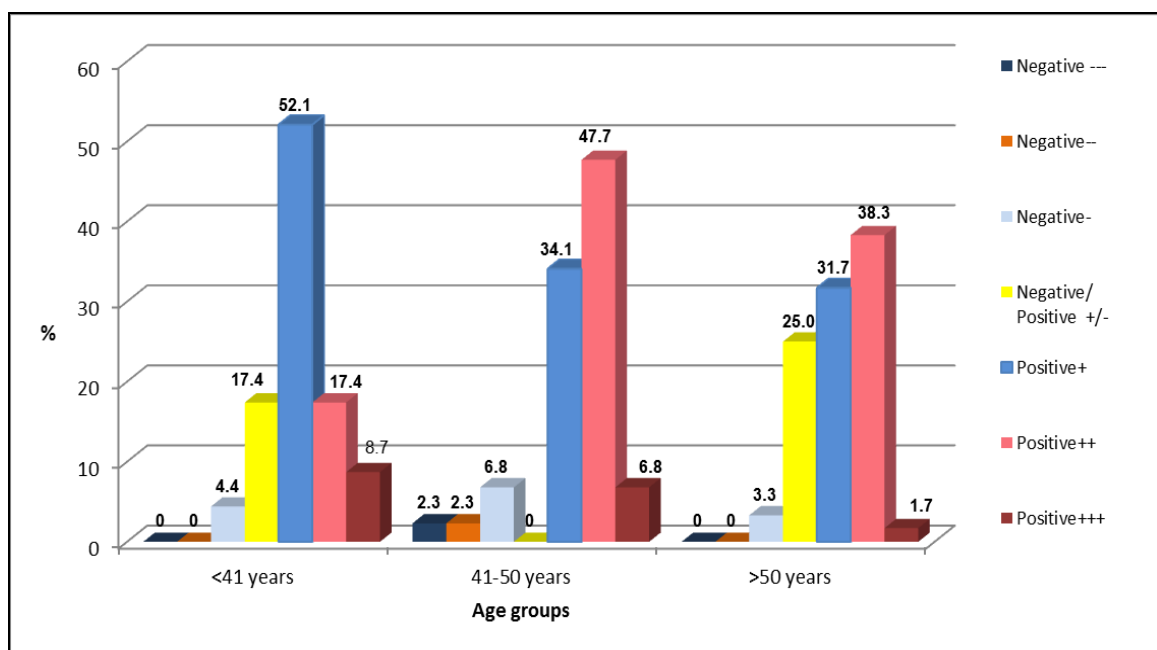


Figure 5.10 Different age groups and responses to cultural awareness

5.6.2 Age and aspects related to the values and beliefs of nursing

A significant observation concerned how the different age groups perceived aspects related to the values and beliefs of nursing. As indicated in table 5.16, the exact probability calculated for the Chi-square statistic of 12.71 was reported as less than 0.047. This probability is less than 0.05, which signifies a 5% level of significance. This implies that the response patterns for some of the age groups differed statistically significantly.

TABLE 5.16 RELATIONSHIP BETWEEN AGE AND ASPECTS RELATED TO THE VALUES AND BELIEFS OF NURSING

Age	Nursing as a profession				
	+-	+	++	+++	Total
Frequency					
Row Percentage					
<41 years	5 21.7%	8 34.8%	10 43.5%	0 0.0%	23 100.0%
41–50 years	4 9.1%	18 40.9%	17 38.6%	5 11.4%	44 100.0%
>50 years	2 3.3%	32 53.3%	24 40.0%	2 3.3%	60 100.0%
Total	11	58	51	7	127
	8.7%	45.7%	40.2%	5.5%	100.0%
Frequency Missing = 1					
Fisher’s Exact probability (that Chi-square statistic = 12.71) <0.0470*					

The differences in the response patterns for the various age groups can be identified via the frequency and percentages in table 5.16 and the illustrated ratios per age group in figure 5.11. When the ratios (%) of the response pattern for an age group are compared against other age groups’ ratio-pattern, the age group 41–50 years presents as the most positive group, since this group reported a 50% somewhat positive to very positive rating response (38.6% + 11.4%) as compared with the 43.5% and 43.3% of the <41 years and >50 years age groups respectively.

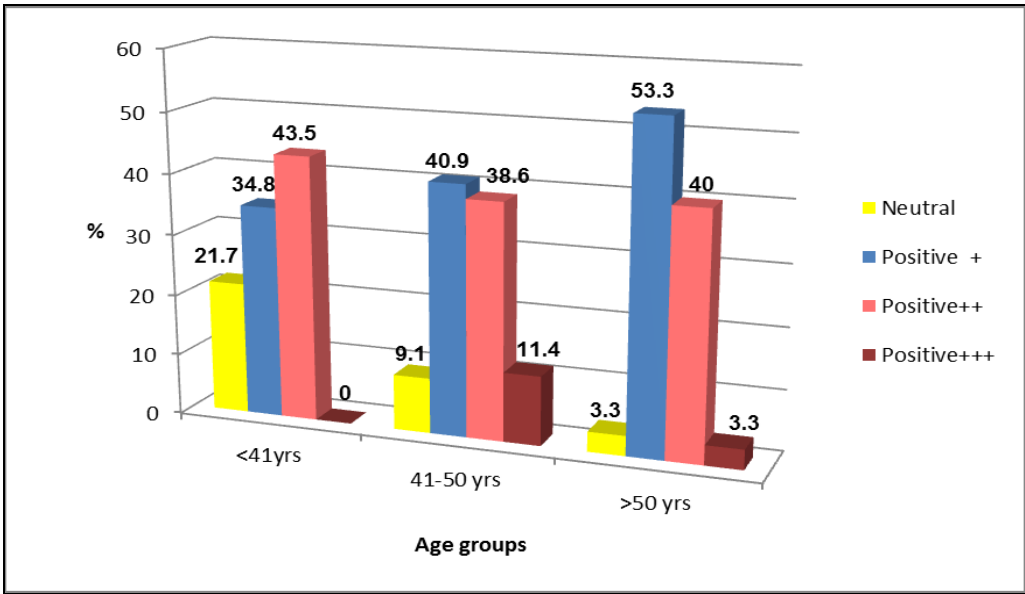


Figure 5.11 Different age groups and responses to aspects related to the values and beliefs of nursing

5.6.3 Duration of involvement in the nursing programme and perception of colleagues having the characteristics of an educator

A significant observation was noted which related to the duration of respondents' involvement in the four-year integrated nursing programme and their perception of their colleagues in terms of the characteristics of an educator. The exact probability calculated for the Chi-square statistic of 14.66, as presented in table 5.17, was reported as less than 0.0499. This implies that the responses grouped according to duration of involvement in this nursing programme and the way in which the respondents perceived their colleagues as having the characteristics of an educator, differed statistically significantly on a level of 5% significance.

TABLE 5.17 RELATIONSHIP BETWEEN DURATION OF INVOLVEMENT IN THE FOUR-YEAR INTEGRATED NURSING PROGRAMME AND PERCEPTION OF COLLEAGUES IN TERMS OF THE CHARACTERISTICS OF AN EDUCATOR

Duration of involvement in four-year integrated nursing programme	Perceptions of colleagues' characteristics as an educator					
	-	+ -	+	++	+++	Total
Frequency						
Row Percentages						
< 5 years	0 0.0%	3 5.8%	15 28.9%	18 34.6%	16 30.8%	52
5-8 years	1 3.2%	1 3.2%	4 12.9%	16 51.6%	9 29.0%	31
> 8 years	0 0%	5 11.6%	12 27.9%	22 51.2%	4 9.3%	43
Total	1	9	31	56	29	126
Frequency Missing = 2						
Fisher's Exact probability (that Chi-square statistic = 14.66) <0.0499*						

When the frequency and percentages of the response patterns related to the duration of involvement with this nursing programme are compared with the other groups' frequency and percentages, the rating of the group with 5 to 8 years of involvement was the most positive regarding their colleagues' display of the characteristics of an educator. This group reported an 80.6% somewhat positive to very positive rating response (51.6% + 29%), compared with the 65.4% and 60.5% of the groups <5 years and >8 years duration of involvement, respectively. Thus the age group with more than 8 years of involvement rated their colleagues in the least positive way. This evidence is presented in table 5.17 and illustrated in figure 5.12. When the response category "somewhat negative" ('-') is examined, the group with 5 to 8 years of involvement was the only group that rated a negative score of 3.2%, while the groups with the shortest

and the longest duration of involvement had no negative scores (0.0%). Thus the group which had been involved for 5 to 8 years tended to have extreme ratings of a very positive to a somewhat negative perception.

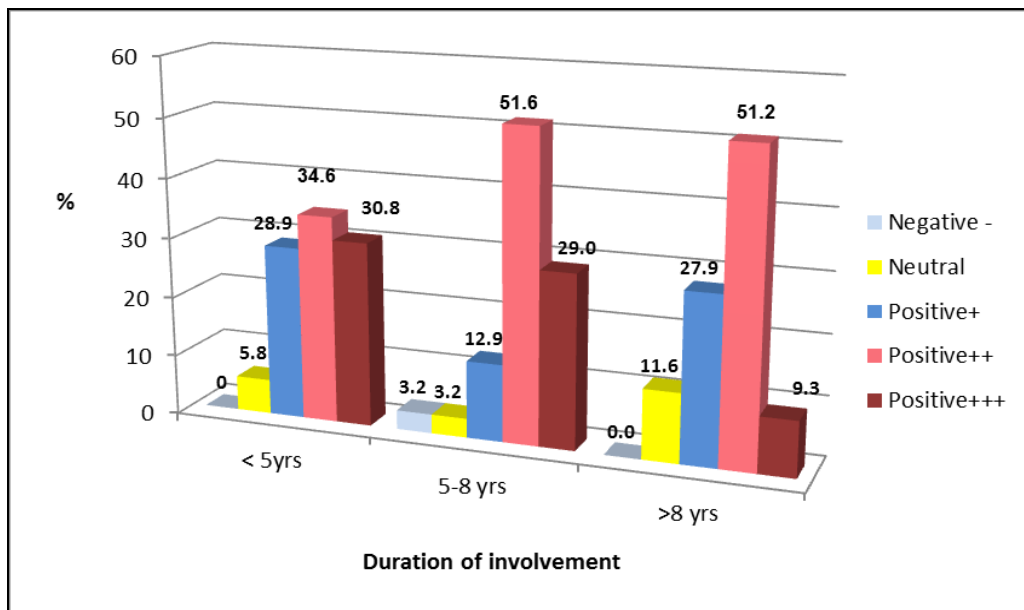


Figure 5.12 Duration of involvement in the four-year programme and perception of colleagues' having the characteristics of an educator

5.6.4 Perceptions on conflict management: College versus university (item 34)

As table 5.18 revealed, the perceptions of respondents related to their colleagues' abilities to resolve conflict were rated significantly differently. The exact probability calculated for the Chi-square statistic of 15.15, as indicated in table 5.18, was reported as 0.018. A Cochran-Armitage trend test was also done to determine the underlying trend of the response pattern. This test indicated a Z-statistic of 3.4, with a significance level of less than 0.001. The response categories related to conflict-solving abilities were reflected from '1', which equalled very poor, to '7', excellent.

Table 5.18 indicates that the highest rating of respondents from universities was 25.7%, which reflected an indecisive rating of 4, compared with the respondents from a college, whose highest rating was 6 (28.6%), indicating a positive perception of conflict-resolving abilities. In addition, if the summed percentages of the rating levels 5, 6 and 7 are compared, the score of respondents from colleges was 68.1% and that of those from universities was 60.0%. It could be concluded that respondents from colleges tend to

rate their colleagues' conflict-resolving abilities more highly than respondents from universities do.

TABLE 5.18 PERCEPTIONS ON CONFLICT MANAGEMENT: COLLEGE VERSUS UNIVERSITY (ITEM 34; N=126)

Perceptions on conflict management: Colleges versus universities (item 34)			
Rating levels	Institution		Total
Frequency Column percentage	College	University	
1	5	4	9
	5.4%	11.43%	
2	3	6	9
	3.3%	17.14%	
3	7	4	11
	7.69%	11.43%	
4	14	9	23
	15.38%	25.71%	
5	20	5	25
	21.98%	14.29%	
6	26	4	30
	28.57%	11.43%	
7	16	3	19
	17.58%	8.57%	
Total	91	35	126
Frequency Missing = 2			
Fisher's exact probability of (chi-square statistic being 15.15) = 0.018 < 0.05*			
Cochran-Armitage trend test: Probability of (Z-statistic being 3.400) <0.001 ***			

The remaining constructs (related to the perceptions of professional socialisation, own characteristics of an educator, the educator and the clinical field and teaching approaches followed) revealed no evidence of statistically significant dependencies on age, duration of involvement in the nursing programme, type of qualifications or mother tongue. Regarding gender, no valid statistically significant calculations could be made, in view of the small number (n=5) of male respondents.

5.7 ADDITIONAL COMMENTS (ITEM 86)

In item 86, the respondents could make any comments pertaining to the research theme. These comments were diverse and multiple. The following themes were identified: selection, career choice and the large number of students. Of the 128 respondents, only 66 made comments. The respondents felt very strongly that the selection of student nurses needed to be improved, especially at the nursing colleges. As one respondent said:

“I am very worried about the recruitment strategy as it serves political agendas. Nursing is a calling, it is not a job.”

Concerns were raised that students pursue nursing as a career for the financial benefit of studying and receiving a salary at the same time; as one respondent stated:

“The greatest concern is that we end up with students who are here only for the money and not because they are interested in nursing – these students become delinquent and are a negative influence on the rest, they are failing and repeating.”

The respondents also mentioned that the large numbers of students that were allocated to the clinical facilities hampered the learning outcomes and patient care; as one mentioned:

“Too many students in one clinical area does not give students enough time to interact with individual patients, thus they take patients as tools to pass and ... unable to have a caring philosophy.”

Other less frequently mentioned topics were concern about poor role models in the clinical area and the insufficient support students received in the clinical area.

A few respondents commented on the questionnaire’s length but nevertheless found it a good opportunity for reflection.

5.8 ITEMS OMITTED

After consultation with the statistician, items 49 and 82 were omitted. Based on the analysis of these items it was evident that these items did not add value to the findings as had been initially envisaged when designing the questionnaire.

5.9 CONCLUSION

The above data provided the grounds for an analysis of the perceived teaching and facilitation strategies of educators regarding the professional socialisation of students, as well as related items that emerged from the data obtained in phase I. The data were described as the perceptions of educators on six composite professional socialisation constructs with related data. These constructs were the rating of the respondents’ own

display of the characteristics of an educator and those of their colleagues; aspects related to the values and beliefs of nursing; the educator and the clinical environment; teaching strategies; and cultural awareness. These constructs proved to be reliable in their measurement, as a Cronbach alpha above 0.7 was measured, except for the construct *the educator and the clinical field*. In addition, open-ended questions and other related items supported the results.

Chapter 6 will discuss the integration of this phase's data with the qualitative data from phase I, with supportive literature.

CHAPTER 6

DISCUSSION OF THE INTEGRATED DATA FROM PHASES I AND II

6.1 INTRODUCTION

Mixing data in a mixed-methods study implies separation of data on the one continuum and combining data on the other continuum (Creswell 2009:209). In this study, qualitative data were obtained from professional nurses and students in phase I, and were then used as a foundation for collecting quantitative data from educators in phase II. In this chapter a discussion on the integrated results of this mixed-methods study is provided. The integrated results were used as evidence for developing and validating the guidelines to support educators and professional nurses in the professional socialisation of students. The topics that are discussed below were the results of investigations into how professional nurses perceived and students experienced professional socialisation, as well as educators' perceptions of their teaching and facilitation of professional socialisation of students. The data generated from the focus-group interviews, field notes and the closed and open-ended questions in the questionnaire are discussed jointly. Since the emphasis of this study was qualitative in nature, the discussion will be presented in a qualitative form. In the discussion the participants of phase I and the respondents from phase II will be referred to as professional nurses and students (participants) and educators (respondents), to maintain clarity.

6.2 THE CONCEPT OF PROFESSIONAL SOCIALISATION

Literature describes professional socialisation as the internalisation of knowledge, skills, attitudes, behaviours, values and ethical standards to form a professional identity (Chitty & Black 2011:131). The educators' understanding of this concept corresponds to a large extent with the description in the literature. They described it as the introduction of a student into the nursing profession and the acquisition of knowledge, skills, values and attitudes of the profession (section 5.3.1). Some of the students were initially not sure what the concept entailed; however, after their peers had clarified the concept they

freely shared their experiences in the focus groups. Students described the concept in terms of their experiences. Students' experiences of professional socialisation are especially important in the clinical field; Levett-Jones and Lathlean (2009:348) found that students would rather attempt to adjust to the ward culture and the staff than focus on learning about patient care. The professional nurses described the concept of professional socialisation of students in relation to their role as a professional nurse in this process. Carlson et al (2009:438) emphasise the importance of this role, as students view the professional nurse's role in terms of the support they hope to receive.

6.3 THE CLINICAL LEARNING ENVIRONMENT

The clinical learning environment is where students are exposed to real patients, where they not only learn to apply their knowledge and skills but also learn the culture of the nursing profession (Billings & Halstead 2009:286; Carlson et al 2005:67). In this study, the clinical learning environment was characterised by heavy workloads, limited resources, theory-practice discrepancies, overcrowding of students, lack of communication between the nursing education institution and the clinical field, as well as a lack within the clinical field, and health and safety risks (sections 3.4.5.2 and 3.4.1.3).

Professional nurses argued that they were burdened with an excessive workload, which hampered their giving support to students (section 3.3.1.3). Students confirmed this situation, but they reported that professional nurses were mostly involved in administrative tasks (section 3.4.1.2). Other studies have also revealed that professional nurses are overloaded with work, resulting in less time being available for student support (Lehasa 2008:87; MacKenzie 2010:269). Students in the current study nevertheless appreciated any support they received, whereas lack of support caused them to be reluctant to attend the scheduled clinical learning experiences; in some instances they even stated that they hated the hostile environment where they ought to be learning. Students want to be accepted regardless of their shortcomings, because they still have to learn (section 3.4.1.1).

This clinical learning environment was characterised by limited resources. Lack of basic equipment such as gloves, and lack of support from professional nurses compelled

students to borrow supplies from adjacent units (section 3.4.1.2). Magobe et al (2010:[4]) also report on primary health care clinics having insufficient basic equipment such as Baumanometers.

Professional nurses also reported a lack of equipment that caused them to perform procedures which differed from those taught in the nursing education institutions. It was stated that this situation could be justified, provided that students were given a clear explanation (section 3.3.1.3). This evidence could partly explain why students reported to educators that procedures were not performed according to the demonstrated procedures in the academic setting (section 5.4.4.4). Similar theory-practice discrepancies have also been reported in other studies (Dlamini 2011:85; Mabuda et al 2008:23).

The allocation of learning opportunities needs to be reviewed. Students reported that learning opportunities were assigned in a fragmented manner, which caused them to become bored and to fail to realise how the assigned nursing interventions fitted into a comprehensive nursing care plan (section 3.4.1.1). Professional nurses, however, reported that some students showed a lack of interest in learning when certain tasks were delegated to them. This situation resulted in professional nurses being reluctant to assign learning opportunities to students (section 3.3.1.3). Klerk (2010:68) also found that students displayed a lack of motivation to learn. Students felt that when learning opportunities were created, such as involving students in the multidisciplinary team, it resulted in them feeling empowered and motivated (section 3.4.1.1).

Educators indicated that SANC's minimum prescribed hours received priority over the learning objectives (section 5.4.4.3). Learning outcomes were further compromised by the overcrowding of clinical facilities with students (section 5.7). Overcrowding of facilities is not an unknown situation, as Mabuda et al (2008:23) found similar evidence in Limpopo province. Educators were especially concerned about this situation, as the result was that students ceased to care and simply used patients as "tools" to achieve their learning outcomes. Overcrowding of facilities was also reported in the United Kingdom and was partly addressed by using a template for student placement (James 2005:[1]). This template entails a mathematical calculation of the total number of students, available clinical facilities and the programme requirements. Careful planning and consideration of the minimum hours that need to be completed for this programme,

available clinical facilities and meaningful learning opportunities are necessary to ensure the best learning outcomes.

Communication between the nursing education institution and the clinical field was found to be ineffective (section 3.4.1.4). Students reported that certain issues such as working on public holidays had repeatedly been discussed, but they experienced no progress in this regard. Educators, however, perceived communication to be adequate in general, except within the clinical field (section 5.4.4.3). They indicated that where communication was inadequate, it was mostly related to student placements and students' absence from the clinical field (section 5.4.4.3). Evidence of ineffective communication between the educational institution and clinical field was also found in other studies (MacKenzie 2010:143; Mabuda et al 2008:23).

Students acquire their clinical learning experiences in an environment where some patients are infected with highly contagious diseases. Students were particularly concerned about the application of health and safety precautionary measures. A situation occurred where students showed similar clinical manifestations (encephalitis) to those of the patients with whom they worked. Although these incidents were reported, they did not receive treatment (section 3.4.1.3). Mntambo (2009:123) also describes a health and safety issue where students were forced to work with patients who suffered from contagious diseases without the necessary protection. From the educators' perspective, moderate health and safety precautionary measures were provided to students by the education institution (section 5.4.5.5). However, the main responsibility lies with the employer (clinical environment), who should provide precautionary measures regarding occupational health and safety risks, according to the Occupational Health and Safety Act, no 85 of 1993 (South Africa 2005b).

Although the clinical environment could provide numerous learning opportunities for students, it is not without challenges such as heavy workloads, limited resources, theory-practice discrepancies, overcrowding of students in the clinical facilities, lack of communication between the nursing education institution and within the clinical field and health and safety risks. A statement of Papastavrou et al (2010:18) was found to be true: that the clinical learning environment is rich in learning opportunities, but unpredictable. In summary, the clinical learning environment in this setting was

characterised by complicated and diverse challenges that were experienced as mostly unsupportive for the effective professional socialisation of students.

6.4 THE PROFESSIONAL NURSE

The role of the professional nurse in the professional socialisation of students was described as that of a role model and a clinical supervisor to students.

6.4.1 The professional nurse as role model

A role model is described as a person who leads by example, has good interpersonal relationships, is knowledgeable, encourages, acknowledges others and has excellent psychomotor and communication skills (Kilgallon & Thompson 2012:15; Perry 2009:41–42). The professional nurses and students identified several characteristics that a role model should portray. Some of these characteristics were that a professional nurse should have sufficient knowledge, be approachable, portray a positive attitude, be aware of his or her own behaviour, be able to function as a good team member and work as an independent practitioner with sound ethical principles (sections 3.3.1.1 and 3.4.2.3).

Although the professional nurses acknowledged that they should have sufficient knowledge, they did not necessarily display the level of knowledge needed to support students (section 3.4.1.1). Students reported that professional nurses were unable to answer questions on basic patient diagnoses. Students were advised instead to read pamphlets posted behind doors if they needed information. Magobe et al (2010:[4]) found that insufficient knowledge of professional nurses was related to limited continued professional development.

The relationship between students and professional nurses was dysfunctional and lacked trust. Students were scared to ask questions and accused the professional nurses of hostility and favouritism (section 3.4.2.1). Students did not experience professional nurses as being respectful to them. Students were called “hazards” and were stereotyped as students that are normally perceived as undisciplined (section 3.4.3.1). Professional nurses themselves stated that they should be aware of how they behaved and talked to students (section 3.3.1.1). Mntambo (2009:127) also reported on

professional nurses calling students stupid and scolding them in front of patients. Professional nurses reported that some students exhibited negative attitudes and were not interested in learning, which contributed to these poor relationships (section 3.3.3.2). Nevertheless, although the relationship between professional nurses and students was reported to be problematic, some students and professional nurses gave an account of good relationships between them (sections 3.3.3.2 and 3.4.2.1).

The inability to work as a united team was another concern of the professional nurses (section 3.3.1.3). Examples were provided of when students needed to be disciplined, but colleagues did not support these actions, which resulted in feelings of division. Students confirmed this inability of professional nurses to work together in a team, as they witnessed them screaming at each other (section 3.4.1.1). Teamwork is important, because students need to learn this skill, which influences patient care positively (Condon & Sharts-Hopko 2010:170). Students also perceived professional nurses as being unable to function independently, as they exhibited subservient behaviour to physicians (section 3.4.2.3). According to Mphahlele (2011:53), professional nurses' attitudes changed from being authoritarian to submissive the moment a doctor entered the room. She concluded that nurses still regard themselves as assistants to the physician, not claiming their autonomous role as nurse practitioner.

Students were gravely concerned about the unethical behaviour of some professional nurses. They explicitly stated they did not wish to participate in practices such as the physical abuse of patients (section 3.4.3.1). Some stated that they wished never to function as a professional nurse in a general ward, because they saw professional nurses cheating and taking shortcuts in relation to patient care (section 3.4.3.3). This evidence is supported by previous studies that reported on unworthy role models in nursing (Mabuda et al 2008: 22; Mntambo 2009:122).

Despite the shockingly negative reports on the experiences of students, they also stated that there were some professional nurses who were willing to help them; however, these were few (section 3.4.1.1). Students need exemplary role models who make a positive impact on their professional socialisation (Koontz et al 2010:244; Perry 2009:43). In the current study it was found that student nurses were often exposed to professional nurses who were unworthy role models and did not support the effective professional socialisation of students.

6.4.2 The professional nurse as clinical supervisor

Clinical supervision, a responsibility of the professional nurse, involves guiding and supporting students to become competent professional nurse practitioners (Severinsson & Sand 2010:670). The professional nurses described this function as being able to assist with theory-practice integration, acknowledging accomplishments, providing continuous support, disciplining and orientating students to their new environment, and including students' ideas in the multidisciplinary team (sections 3.3.1.2 and 3.4.1.1).

Professional nurses were well aware that students experienced a gap between theory and practice, as they suggested strategies to narrow this gap (section 3.3.1.2). Students confirmed this observation, because they stated that the theory taught was very different from the practice (section 3.4.1.1). Professional nurses suggested giving students homework to prepare and then discussing it the following day as a method of integrating theory with practice (section 3.3.1.2). The literature suggests some solutions to overcome this gap. Specifically related to clinical supervision, Baxter (2007:106) proposes a model for clinical supervision that addresses various aspects. This model suggests a close relationship between academia and practice, with the primary aim of providing quality patient care.

Positive feedback to students was identified as an important motivational factor (section 3.3.1.2). Professional nurses suggested that students should be allowed to express their own ideas regarding patient care and that their contribution should be acknowledged. In addition, continuous support should be rendered, especially to those students who experienced difficulties, as students are not prepared on an emotional level to deal with the challenges they experience in practice (section 3.3.1.3). Students, however, did not experience the support from professional nurses, especially with regard to the students' academic responsibilities. Students reported professional nurses being insensitive, particularly with regard to the scheduling of hours for clinical learning experiences when tests needed to be written (section 3.4.1.2). Students were also scared to ask questions, since they experienced the professional nurse as unapproachable and thus did not feel supported (section 3.4.1.1).

According to the professional nurses, students exhibited undisciplined behaviour, such as displaying poor time management. As clinical supervisors the professional nurses

felt that students should be disciplined and coached to learn the appropriate behaviour (section 3.3.2.1). They also found it very difficult to work with students, especially students with negative attitudes (section 3.3.3.2). This finding is consistent with Hathorn et al's finding (2009:230), which revealed that professional nurses are more inclined to help students with a positive attitude.

Orientation is essential, as students' sense of wellbeing and self-esteem is enhanced when the professional nurse exhibits a warm and receptive attitude to students (Chesser-Smyth 2005:325). Professional nurses explained that it was not always possible to orientate students to their new environment, because patient care was their first priority (section 3.3.1.3). However, students stated that they rarely received orientation, even on their first day of being a student in the clinical field (section 3.4.1.2).

Although professional nurses emphasised the importance of being a clinical supervisor, several obstacles hindered them in this role. In general students did not experience the professional nurse as a supportive clinical supervisor, although the professional nurses who participated in the study could identify the requirements of a professional nurse as clinical supervisor.

6.5 CHARACTERISTICS OF AN EDUCATOR

This section addresses the educators' rated perceptions of their own and colleagues' degree of compliance with a set of characteristics related to the behaviour of a role model. In general the educators perceived themselves and their colleagues positively, but they rated themselves slightly more highly than their colleagues in terms of these characteristics (sections 5.4.1 and 5.4.2). This phenomenon of rating one's own abilities more highly than those of one's colleagues could be ascribed to the fact that individuals all have "blind spots", in that some information is unknown to the person concerned, but is known to others. This phenomenon is described as the Johari Window (West & Turner 2010:274).

Educators perceived themselves as maintaining high standards of teaching practice, having outstanding knowledge and skills on the subjects they teach and having good interpersonal skills (section 5.4.1). They were also positive about nursing education as a career and indicated that they acknowledged others' accomplishments, were

committed to teach students to become competent and accepted their teaching responsibilities (section 5.4.1). These findings concur with the evidence of Klunklin et al (2011:86), who used a self-evaluation scale that revealed a positive perception of educators, using similar characteristics of an educator. It could be argued that people will always rate their own abilities higher than those of their colleagues. However, students confirmed this positive rating related to the level of knowledge and support educators provided to them (section 3.4.1.1). In contrast, Mabuda et al (2008:22) found that educators in their study were unsupportive and were only seen during assessments.

Although educators viewed themselves as clinically competent, they indicated that restricted time prevented them from remaining competent (section 5.4.1). This issue is important, as the Clinical Model for Education and Training of South Africa proposes that educators should spend 10% of their time doing active patient care to maintain their clinical skills (Nursing Education Stakeholders of SA 2011:5).

Another significant evidence was that educators who had been involved as an educator in the four-year integrated nursing programme for more than eight years rated their colleagues' characteristics as an educator significantly lower than did those educators who had less than eight years of experience. It was concluded that the more experienced educators tended to rate these characteristics of an educator differently from the less experienced educators (section 5.6.3).

The issue of how comfortable educators felt about disagreeing with one another, as well as the perception of colleagues' conflict-resolving abilities, was rated significantly less positively than other items that described the characteristics of an educator (sections 5.4.1 and 5.4.2). The ability to resolve conflict could influence effective teamwork (West 2012:50). Students should learn effective teamwork, and educators could be an example of such teamwork. It was interesting that educators from universities rated their colleagues' conflict-resolving abilities less positively than did educators from colleges (section 5.6.4). Role-model behaviour, such as displaying conflict-resolving abilities, is important in student professional socialisation, as students will justify inappropriate behaviour by pointing to the less desirable behaviour of their superiors (Altmiller 2012:15).

Educators, on the whole, were found to perceive themselves and their colleagues as exemplary role models who could be imitated by students. Students also experienced the educators' level of knowledge and the support they received from them as positive. However the data indicated that educators' conflict-management skills could be improved.

6.6 THE NURSING EDUCATION INSTITUTION AND THE CLINICAL ENVIRONMENT

Students spend a minimum of 4 000 hours in the clinical environment, which necessitates support during this time. Apart from learning the theory, they also need to learn the skills in practice. The intention was to determine how the education institution provided support to the students regarding students' clinical learning experiences. The following discussion addresses aspects of clinical accompaniment, support in terms of preceptors, mentors and peer-mentoring, preparing students for their first clinical exposure and theory-practice integration (section 5.4.4).

Clinical accompaniment of students is a requirement of the SANC with regard to the four-year integrated nursing programme (SANC 1985:par 2.2). The majority of educators were responsible for clinical accompaniment of students as a method of supporting the students (section 5.4.4.1). Educators indicated that they found it very difficult to fulfil this responsibility because of the large number of students, and students being absent during clinical accompaniment visits. Other support systems, such as the utilisation of mentors, preceptors and peer-mentoring, were also investigated. The educators indicated that nursing education institutions used mentors, and to a more limited extent peer-mentoring. Preceptors were the least utilised to support students (section 5.4.4.2). The value of a preceptor is highlighted by Smedley (2008:185), as this type of support is regarded as vital in preparing students to become a professional nurse. The role of the mentor and preceptor was highly appreciated by the professional nurses and students; however the perception of the person who should fulfil this role was unclear (sections 3.3.1.3 and 3.4.1.1). This finding is supported by the literature, which indicates that this type of support is valuable, as it enhances students' confidence, competence and critical thinking abilities (Myrick, Caplan, Smitten & Rusk 2011:264).

Another challenge was the preparation of students for their first clinical exposure. Students stated that they were shocked when they first entered the clinical field (section 3.4.1.2). This phenomenon is described as the reality shock (Masters 2009:134). Educators prepared students predominantly by means of simulation and orientation to their new environment and to a limited extent through debriefing on the emotional challenges they might encounter (section 5.4.4.3). Although preparation of students for their first clinical exposure is important, however, Grealish and Ranse (2009:90) suggest that students mostly benefit from working alongside a professional nurse.

As already highlighted, theory-practice discrepancies were identified by both the students and professional nurses as an issue of concern. Educators would address these discrepancies through clinical accompaniment and the use of different teaching strategies; however, only a small number of educators would use reflection as a method of support (section 5.4.4.4). The literature also suggests strategies such as case studies, reflective practice, clinical supervision and realignment of teaching strategies to bridge this gap (Billings & Kowalski 2006:248; Curtis et al 2012:1; Sharif & Masoumi 2005:6; Malesela 2009:3).

As is evident from the above discussion, educators were faced with various challenges in preparing and supporting students in the clinical field. The large number of students and limited preceptor support complicated effective clinical support.

6.7 TEACHING AND FACILITATING STRATEGIES USED IN THE NURSING EDUCATION INSTITUTION ENVIRONMENT

Students learn the theory of nursing primarily at a college or university. This section addresses the teaching and facilitation strategies followed by educators regarding the theory related to professional socialisation of students. The aspects covered are curriculum matters, a student-centred versus an educator-centred teaching approach, students' learning orientations, availability of educators for consultation and support in terms of the students' academic and practical responsibilities (section 5.4.5).

The educational environment has to consider not only the clinical preparedness of students, but also the theory that underpins the skills, values and beliefs of the nursing profession, which is guided by the curriculum. At the nine educational institutions that

offer the four-year integrated nursing programme, an outcome-based philosophy was the most frequently selected curriculum philosophy (section 5.4.5.1). It was observed that educators from the same nursing educational institution indicated different curriculum philosophies, suggesting that educators were uncertain about the curriculum philosophy that guided their teaching and facilitation strategies.

The emphasis of a curriculum will guide the educators' teaching focus. The data indicated that less emphasis is given to the teaching of values and beliefs of the nursing profession (section 5.4.5.2). Values are basic beliefs and are manifested in behaviour (Masters 2009:128; Rassin 2008:615). It is therefore important to develop appropriate professional values though emphasising those values. Although the teaching of values and beliefs is important, Van Mook, Van Luijk, De Grave, O'Sullivan, Wass, Schuwirth and Van der Vleuten (2009:e107) indicate that values and beliefs are mostly learned implicitly. This learning is also described as the influence of the hidden curriculum. Furthermore, educators followed a student-centred approach in the facilitation of knowledge and skills transfer, while the teaching of values and beliefs was more educator-centred (section 5.4.5.3). Although less content can be taught using a constructivist (student-centred) approach, students are able to apply critical analytical thinking, which results in deep learning (Yuen & Hau 2006:279, 288). Thus, the teaching of values and beliefs should be more student-centred.

The literature suggests that diverse teaching, facilitation and assessment strategies have the best learning outcomes with regard to students' different learning orientations (Rassool & Rawaf 2008:308). Educators accommodated students' different learning orientations by means of support and mentoring, while limited diverse teaching and assessment strategies were employed to address the students' different learning orientations (section 5.4.5.3). Another aspect that could influence the teaching strategies is the availability of training facilities and equipment. Educators perceived their education institution's training facilities and equipment to be satisfactory to very satisfactory. Mannequins for skills training and sufficient space to accommodate the large number of students were the two most needed entities (section 5.4.5.4).

According to Meyer and Van Niekerk (2008:171) students spend 65% of their total time in the clinical field, therefore they may have limited time to consult educators regarding academic concerns. The data suggest that most of the educators were easily to very

easily accessible by means of an open-door policy or an appointment system (section 5.4.5.5).

Students have to balance their academic and clinical learning responsibilities. Educators provided students with a planned programme in advance (section 5.4.5.3). Despite this programme, students still struggled to arrange their hours in order to have sufficient time to prepare for tests. They experienced professional nurses being insensitive regarding the scheduling of hours for clinical learning experiences, especially when tests needed to be written (section 3.4.1.2). This situation illustrates the importance of adequate communication between the educational institution and the clinical field.

It was found that different strategies were followed regarding the teaching and facilitation of aspects of professional socialisation. Some teaching and facilitation strategies to achieve student professional socialisation were more supportive than others.

6.8 WORK ETHIC OF PROFESSIONAL NURSES AND EDUCATORS

In essence, ethics are concerned with moral decisions to judge right from wrong (RNAO 2007:42). Respect for human dignity is one of the core values endorsed by the South African “Nurse’s Pledge of Service”, which all registered professional nurses take when they complete their training (SANC 2012b:[1]). This section addresses the self-assessed work ethic of educators, as well as the professional nurse’s work ethic as experienced by the students.

Educators and professional nurses should display sound professional conduct (Bartzak 2010:85; Rosenkoetter & Milstead 2010:138). Educators’ ratings of their own adherence to ethical principles such as respect, honesty and confidentiality were very positive; however, they rated their colleagues’ work ethic less positively (section 5.4.3). Similar evidence was found of Thailand educators who also revealed high scores using a self-evaluation instrument to measure aspects of respect and social appropriateness. They ascribed these results to the Thai culture (Klunklin et al 2011:86). The most effective way to teach professional attitudes to students is for educators to model sound ethical behaviour (Hosseini, Fatemeh, Fatemeh, Katri & Tahereh 2010:10). Students did

not comment on the educators' ethical behaviour per se; however, when students reported that they had witnessed unethical behaviour by professional nurses, students perceived educators to be indifferent to the reported incidents (section 3.4.3.1).

Regarding the work ethic of professional nurses, students reported incidents where they witnessed physical abuse of patients by professional nurses. Patients were hit with a ruler, pinched with forceps and pillowcases were stuffed into their mouths to force them to deliver a baby. Oosthuizen (2012:58) also reports on nurses displaying inhumane and disrespectful behaviour towards patients. Moreover, students witnessed food being stolen from patients by staff members (section 3.4.3.1). Students stated that they did not want to be part of such behaviour. Sound ethical behaviour of role models is important, as role models influence students' professional development (Illingworth 2009:815). Not only patients but students themselves were victims of professional nurses' unethical behaviour. Students were compelled to do favours for professional nurses, for example to drive them around to do shopping just because they owned a car (section 3.4.3.1). The reported inhumane and disrespectful behaviour of professional nurses in this study is in direct contrast with the "Nurse's Pledge of Service", which all nurses take when they qualify.

In conclusion, educators perceived themselves as having sound ethical standards, although they indicated that their colleagues did not always demonstrate respectful behaviour. Considering that students spend most of their time in the clinical field, the reported professional nurses' misconduct would not support the professional socialisation of students.

6.9 STUDENTS' BEHAVIOUR

Regardless of the reason, students' disruptive behaviour and incivility in the nursing environment is a serious cause for concern (Clark et al 2008:260). Professional nurses stated that students should be coached to internalise the correct professional behaviour. They gave examples, such as having proper time management and taking responsibility for their actions (section 3.3.1.3). Professional nurses experienced students as undisciplined and disrespectful, for example not showing the necessary respect for senior persons (section 3.3.2.1). Students themselves were also concerned about some of their peers' behaviour; for example, some were caring for patients with

earphones in their ears, listening to music (section 3.4.3.4). It is advisable to identify disruptive behaviour early and follow a clearly defined policy to address undesirable behaviour among students (Clark et al 2008:260). Despite this negative report on student behaviour, professional nurses indicated that some students were dedicated and eager to learn (section 3.3.3.2).

Educators indicated that students displayed undisciplined behaviour (section 5.4.3). They justified their answer in an open-ended question indicating that some students were absent from class and practice, had poor time management, and displayed inappropriate professional conduct and disrespectful behaviour (section 5.4.3). They further indicated that students in their second year of study were perceived as being the most rebellious, compared with other study years (section 5.3.2). This behaviour trend coincided with Cohen's (1981) second stage, the negative-independence stage of professional socialisation (section 5.3.2). This stage is characterised by questioning and challenging the system (Chitty & Black 2011:135). Despite professional nurses' and educators' negative perception of students' behaviour, they indicated that some students were dedicated and became more disciplined in their third and fourth year of their programme (section 5.3.2). Cohen (1981) suggests that during stage III students will be able to demonstrate empathy, and in stage IV will consult others to solve problems that will eventually lead to independent decisions (Chitty & Black 2011:135). Most of the educators indicated that stages III and IV of Cohen's (1981) stages of professional socialisation occurred during the fourth year of study. The data suggest that the students' progression through the study years resembles to some extent Cohen's (1981) stages of professional socialisation (sections 3.4 and 5.3.2).

It was reported that educators, professional nurses and students experienced some students exhibiting undisciplined and disrespectful behaviour. However, they became more disciplined, especially when they reached the third and fourth year of the programme.

6.10 THE NURSING PROFESSION

Selecting nursing as a profession is influenced by personal, situational and organisational factors (Price 2009:18). In this study, educators, professional nurses and students indicated that nursing was for some students not their first career choice

(sections 3.3.2.2 and 5.7). This section describes the students' selection of nursing as a profession and how educators, students and professional nurses viewed the nursing profession.

Professional nurses and educators indicated that students enter the nursing profession for reasons such as the financial benefit of being remunerated while studying (sections 3.3.2.2 and 5.7). A reason indicated for nursing as a career choice was that students were unable to gain entry into other courses, such as medicine (section 3.4.3.4). Educators were also concerned about the types of candidate who entered into the nursing programme (sections 5.4.3 and 5.7). Selecting the appropriate candidate is important, as it will most probably ensure completion of the course (Newton et al 2007:443). Educators indicated that the most frequent reasons for students not completing their course were that nursing was not their first career and poor academic performance (section 5.4.3). In an open-ended question educators raised their concern about the selection of inappropriate candidates (section 5.7). Prospective candidates should be carefully selected. Price (2009:12, 14), however, maintains that selecting the appropriate candidate might not be easy, as the reasons for choosing nursing as a career are not fully understood.

Morris-Thompson, Shepherd, Plata and Marks-Maran (2011:687–688) reported that in the UK nurses' attitudes to nursing as a profession were positive. The researchers found that nurses viewed themselves as being privileged to be in the profession and that nursing was a fulfilling career with diverse career options and opportunities. In the current study, educators' perceptions of their colleagues' and their own attitude to nursing education as a career were also positive to very positive (section 5.4.1). The data indicated that educators in the age group 41–50 years viewed their career the most positively, compared with the age groups younger than 41 years and older than 50 years (section 5.6.2).

Regarding the attitude to nursing as a profession, professional nurses indicated that students did not portray a positive attitude (section 3.3.3.2). They felt students' attitudes were negative; for example, their dress code and behaviour did not support the desirable image of the nursing profession (section 3.3.3.2). Students did not share any specific aspect on the professional nurses' attitude to nursing as a profession. However, the data on some of the professional nurses' misconduct reported by students in this

study suggests that those professional nurses were not positive about nursing as a profession (section 3.4.3.1). Professional nurses also stated that the public had little respect for their career choice, as they indicated that the public perceived nursing as a less respectable career to follow (section 3.3.2.3). This negative perception is also found to be true for other countries; professional nurses in New York discourage prospective candidates who are interested in nursing, because nursing is not valued by others (Emeghebo 2012:e52).

In general, professional nurses and educators were not satisfied with the candidates that entered nursing, while students were also not proud of how some of their peers portrayed the profession, nor with the portrayal of the profession by some of the professional nurses. Educators, however, were positive about nursing education as a career.

6.11 CULTURAL AND GENDER AWARENESS

South Africa is known for the cultural diversity of its population. This section deals with how educators perceived their own cultural competence and that of students. Students and professional nurses also described their experiences and perceptions of cultural and gender-related issues.

Students felt excluded from the team when professional nurses reported on patient-related issues in a language other than English (official language) (section 3.4.3.2). They were deprived of learning opportunities, because they were unable to understand the conversation. Ineffective communication not only influences student learning, but could also result in inadequate patient care and misinterpretation of patients' progress (Jirwe, Gerrish & Emami 2010:443).

Apart from language differences, students experienced racial tension, to such an extent that in one case they physically attacked one another (section 3.4.3.2). However, students reported that there were examples of good relationships between the different races (section 3.4.3.2). In order to address racial tension, Schaefer (2008:117) has suggested that reflection be used as a teaching strategy, as it could positively influence students' perceptions of race and cultural ideologies.

Educators were asked to indicate to what extent they and their colleagues reflected on cultural diversity, as well as what opportunities students would have to reflect on their cultural differences. Educators rated their opportunities to reflect as a group significantly higher than the opportunities students would have to reflect on cultural differences (section 5.4.6). In addition, educators rated their own and their colleagues' level of cultural awareness as high to very high (section 5.4.6). While students freely shared their experiences on cultural issues in the focus-group interviews, educators indicated that cultural conflict was not easily noticed (section 5.4.6). Although educators indicated that they provided students with opportunities to reflect on their cultural differences, the findings indicated that students found it difficult to be culturally sensitive in interacting with peers (section 3.4.3.2).

Regarding gender, professional nurses experienced male students' attitude as negative and uncaring, because they disregarded the authority of female professional nurses when asked to care for patients (section 3.3.3.1). Male students claimed that female professional nurses treated them differently from their female peers (section 3.4.3.2). They admitted that some female professional nurses would not approach them directly because of the cultural belief that males are superior to females. Male students perceived this situation as giving them privileges that female students did not have. While this study indicated that male students were perceived to receive preferential treatment, other studies have also indicated that male students felt they were treated differently and that people tended to be biased about men in nursing (Meadus & Twomey 2011:275).

It can be concluded that some students were unable to understand the language used during clinical communication and experienced racial tension between students. This caused students to have negative learning experiences, such as an inability to understand implemented nursing interventions. While professional nurses experienced male students as portraying a negative attitude, male students perceived it as having privileges that female students did not have. Despite students having opportunities to reflect on their cultural differences, they still seemed to have difficulty with being sensitive to different cultures. Educators, on the other hand, were to some extent culturally sensitive but did not easily notice cultural conflict.

6.12 CONCLUSION

Chapter 6 presented a discussion on the integrated data of the qualitative data (phase I), obtained from professional nurses and students, and the quantitative data (phase II) obtained from educators. Findings were supported with mention of the literature where applicable.

Professional socialisation of students was influenced by professional nurses who were in general regarded as unsupportive and unworthy role models. Educators believed they exhibited positive role model behaviour. Various supportive teaching and facilitation strategies were applied, but the teaching of values and beliefs of nursing as a profession received less emphasis. According to the students, professional nurses displayed unprofessional, improper and inhumane behaviour towards patients and students. It was reported that professional nurses who upheld the values of the nursing profession were a minority. On the other hand, educators and professional nurses believed that some students entered the nursing profession for the wrong reasons and displayed undisciplined behaviour, while others were dedicated, especially students in their third and fourth year. Students experienced the clinical environment as unsupportive, while a situation that was culturally diverse and gender-volatile complicated the socialisation process. In conclusion, professional socialisation of students occurred in a complex and mostly unsupportive clinical environment.

In the next chapter, these perspectives are discussed in the form of guidelines, which recommend interventions that could support the professional nurse and educator in the professional socialisation of student nurses.

CHAPTER 7

DISCUSSION ON THE DEVELOPMENT AND VALIDATION OF GUIDELINES TO SUPPORT EDUCATORS AND PROFESSIONAL NURSES IN THE PROFESSIONAL SOCIALISATION OF STUDENTS

7.1 INTRODUCTION

Chapter 7 discusses the process followed to develop and validate the guidelines for educators and professional nurses to support students with their professional socialisation. The development of the guidelines was based on the findings of phase I (qualitative data) and phase II (quantitative data), and supportive literature as discussed in chapter 6. The final objective was reached when the guidelines were developed and validated by field experts.

7.2 DEVELOPMENT OF THE GUIDELINES

Logical reasoning was applied in the process to develop the guidelines. Logical reasoning entails a process of drawing inferences or conclusions (Nickerson 2010:2). Both deductive and inductive reasoning were used during this process. Evidence from the literature, qualitative and quantitative data was used to reach concluding statements. From the specific concluding statements, guidelines were proposed to address these statements. These guidelines were given to field experts, experts in guideline development, a manager of a nursing education institution, educators, nurse managers and professional nurses, to validate and make suggestions for improvement. A detailed discussion of the process was provided in chapter 2.

7.3 VALIDATION OF THE GUIDELINES

After the purposively selected guideline validators agreed to participate, they were provided with a hard or electronic copy of the proposed guidelines, a validation form and a letter explaining the validation process (Annexures XVI and XVII). They were requested to validate these guidelines according to the criteria: clarity, comprehen-

siveness, applicability, adaptability, credibility and validity. A total of twelve field experts were approached, of whom two indicated that they were not available. Ten participants initially agreed to participate, but eventually nine participated in the validation process. Table 7.1 indicates the wide-ranging attributes of the nine participants. The attributes include employment positions, employers, field expertise and academic qualifications.

TABLE 7.1 ATTRIBUTES OF THE FIELD EXPERTS

Descriptor	Frequency
Position	
Nursing education manager	2
Head of student counselling	1
Nurse manager	2
Educator	2
Professional nurse	2
Total	9
Employed by:	
University	2
College	3
Clinical facility	4
Total	9
Expertise	
General nursing	5
Critical care nursing	1
Management	2
Ethos	3
Education	2
Guideline experts	2
Psychiatry nursing	1
Community nursing	1
Midwifery	1
Industrial psychology	2
Academic qualifications	
Doctoral degree	2
Master's degree	3
Diploma	4
Total	9

Table 7.2 displays the results of the validated guidelines. As is evident from the comments on these guidelines, varied input was obtained. Some comments supported the evidence reflected in the concluding statements. However, one participant stated that professional nurses' behaviour had not been fully investigated, while some of the professional nurses stated that not all professional nurses behaved unethically. These comments were acknowledged; however, the focus of the study was not on investigating professional nurses' behaviour, but the experiences of students regarding

their professional socialisation, and the role of the professional nurse in the professional socialisation of students. Furthermore, the data relating to the professional nurse were qualitative in nature; thus the focus was to understand the phenomenon and not to generalise the findings.

Regarding adaptability and applicability, the participants mentioned that financial constraints might be a challenge in implementing the guidelines. It was suggested that the guidelines be published to be tested in the practical field. Other comments stated that the guidelines were practical and clear. Despite the few comments on adaptability and applicability, the guidelines were found to be valid. The suggestions from the participants were incorporated and are discussed below.

TABLE 7.2 RESULTS OF THE VALIDATED GUIDELINES

Criteria	Not acceptable	Acceptable with recommended changes	Acceptable as described	Comments from experts
Clarity		1	8	<ul style="list-style-type: none"> • Very clear • Comprehensive • Educator as role model not clear • Some statements too theoretical
Comprehensiveness		1	8	<ul style="list-style-type: none"> • Not all professional nurses are unethical • All aspects sufficiently addressed • Underlying reasons for professional nurses' behaviour not sufficiently addressed
Applicability		3	6	<ul style="list-style-type: none"> • Cost implications not addressed • Some aspects could be expanded to the Positive Practice Environment • Difficult to implement in cost-sensitive environments, where students are part of the workforce
Adaptability		3	6	<ul style="list-style-type: none"> • Short staff and increased workload • Financial restraints • Should be transferable
Credibility			9	<ul style="list-style-type: none"> • Well presented • Once there is proper buy-in
Validity		1	8	<ul style="list-style-type: none"> • Valid

7.4 PRESENTATION OF DEVELOPED AND VALIDATED GUIDELINES

After the guidelines had been developed, the experts' suggestions were incorporated. These guidelines emerged as three themes, illustrated in figure 7.1. These themes were the clinical environment, the nursing education institution environment and the nursing profession. Each theme consisted of categories, and for each category a guideline was formulated. A rationale for each guideline is presented, followed by recommendations on implementation.

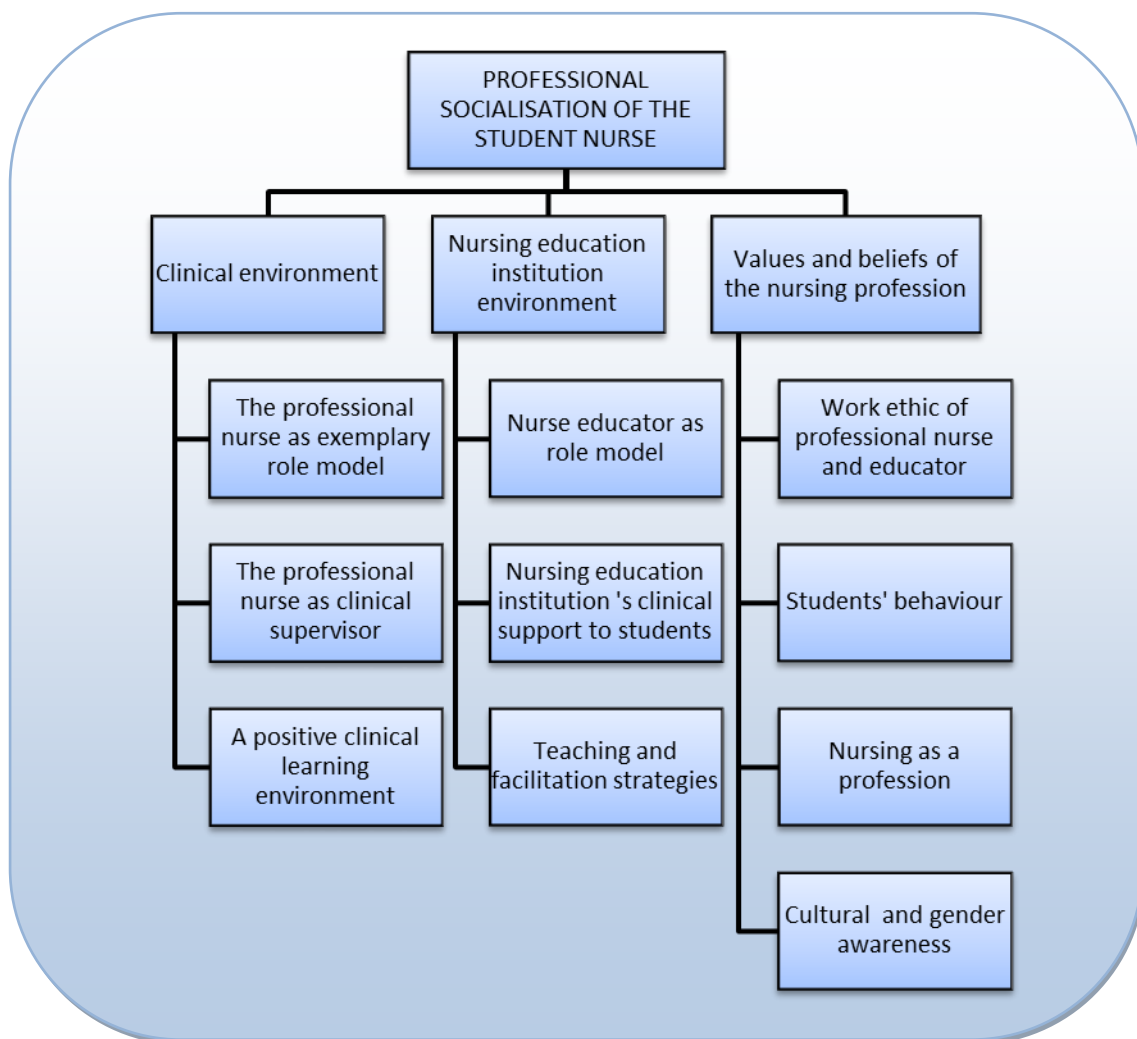


Figure 7.1 Themes and categories related to the guidelines to support educators and professional nurses in the professional socialisation of students

7.5 THEME 1: CLINICAL ENVIRONMENT

Theme 1, the clinical environment, encompassed three categories, namely the professional nurse as exemplary role model; and as clinical supervisor; and a positive

clinical learning environment for students. The evidence suggested that the issues discussed in these categories were influential in the professional socialisation of students related to the clinical environment.

7.5.1 Category: The professional nurse as exemplary role model

From the category *the professional nurse as exemplary role model* a guideline was formulated that addresses those attributes of a professional nurse that will support the professional socialisation of students. This guideline is based on the concluding statements, as presented in box 7.1.

Box 7.1 Summary of concluding statements regarding the professional nurse as exemplary role model

- Students experienced and witnessed many professional nurses as
 - having insufficient knowledge
 - displaying disrespect and unethical behaviour
 - being unable to act independently
 - being unable to work in a team
 - having an antagonistic attitude to students: students accused them of hostility and favouritism
- The above-mentioned experiences detracted from students' self-confidence and the development of a professional identity.
- Few professional nurses were mentioned as exemplary role models.
- A professional nurse as role model was described as a person who
 - has sufficient knowledge
 - has a positive attitude
 - is aware of her/his own behaviour
 - is approachable
 - is able to communicate effectively
 - has excellent psychomotor skills
 - is able to acknowledge others' accomplishments
- These above-mentioned attributes enhance motivation and learning of skills, knowledge, values and beliefs in students.

GUIDELINE 1: The professional nurse as exemplary role model

Rationale for the implementation of the guideline

Facilitation and support of *the professional nurse as exemplary role model* might enhance the desirable professional socialisation of students, as they could imitate professional nurses' role-model behaviour.

Recommendations on the implementation of the guideline

- Nursing management and professional nurses should collaboratively:
 - Empower professional nurses to develop their level of knowledge and psychomotor skills, as well as their ability to function as good team members and act as independent practitioners, for instance by providing in-service training on the above-mentioned issues.
 - Assist professional nurses to develop their communication abilities and the skill to acknowledge others' accomplishments.
 - Assess the qualities (level of knowledge, psychomotor skills, teamwork, communication, acknowledgments of others) through performance appraisals in which student support receives significant weight. In-service training on these aspects could be linked to incentives such as continued professional development (CPD) points. CPD points could form part of the professional nurses' performance appraisal. As suggested, CPD points could be linked to the licensing as a professional nurse, of which professionalism and ethics should be a compulsory aspect (South Africa. Department of Health 2012:7).
 - Encourage professional nurses to reflect on their own values, beliefs and behaviour, for example by using reflective discussions, portfolios and social media. During these reflective activities, reasons could be explored why some professional nurses exhibit unethical behaviour.
 - Motivate professional nurses to commit themselves to the "Nurses' Pledge of Service", by creating opportunities for affirmation, such as on Nurses' Day.
 - Create structures such as meetings, suggestion boxes, student forums, anonymous telephone lines and email facilities to report unethical

behaviour. Nursing management should take note and vigorously implement the necessary interventions when undesirable incidents are reported.

- Acknowledge exemplary role models, considering different cultural orientations on this issue, for instance by issuing certificates and celebrating achievements in meetings and asking students to select the best mentors and preceptors.
- Encourage all stakeholders to create a healthy work environment by demonstrating respect for one another's views and values and making it a visible part of the culture of the institution. Create opportunities to display the core values of nursing, such as posters on notice boards, Living our Value competitions and value practice exercises during induction.

7.5.2 Category: The professional nurse as clinical supervisor

To support the professional socialisation of students, the *professional nurse as clinical supervisor* emerged as a category. Based on the concluding statements in box 7.2, a guideline was developed to describe the attributes a professional nurse should have to act as a clinical supervisor to students. Related recommendations on implementation are proposed for this guideline.

Box 7.2 Summary of concluding statements regarding the professional nurse as clinical supervisor

- Students experienced many professional nurses as clinical supervisors as
 - unapproachable
 - insensitive to students' situations
 - not orientating them to their new environment
 - performing procedures differently from the taught procedures
- The professional nurse as clinical supervisor should be an exemplary role model who
 - orientates students to their new environment
 - assists with theory-practice integration
 - is able to acknowledge others' accomplishments
 - provides continuous support
 - disciplines and coaches students when needed
 - includes students in the multidisciplinary team
- Professional nurses were challenged by the negative attitudes of students and their own increased workload.

GUIDELINE 2: The professional nurse as clinical supervisor

Rationale for the implementation of the guideline

It is envisaged that the implementation of the guideline related to the professional nurse as clinical supervisor could help students to have positive clinical learning experiences that might consequently enhance their effective professional socialisation.

Recommendations on the implementation of the guideline

- Professional nurses should:
 - Orientate students to their new environment. The practical situation can be overwhelming, especially for a first-year student. Orientation should be part of the ward policy and be done as soon as possible.
 - Aspire to be exemplary role models by taking an honest interest in students' learning outcomes and achievements.
 - Assist students with their theory-practice integration in collaboration with nursing education institutions; for instance, encourage discussions, give students homework, use case studies to encourage students to consult the theory and compare it with the current practical situation, apply reflective activities.
 - Understand students' level of training and outputs required at the different stages.
 - Incorporate the suggestions of students related to nursing care, treating them as valued members of the multidisciplinary team.
 - Coach and monitor students regarding acceptable behaviour through fair judgement and honest feedback, as far as possible.
 - Attempt, in cooperation with students, to improve relationships and to foster approachability through purposeful student feedback or reflection sessions.
 - Encourage students to communicate their learning needs to the professional nurses, to enable them to provide the necessary support by creating opportunities for student engagement, also realising that they could in turn learn from students.

- Nursing management should:
 - Support the professional nurse to be a manager, care giver and clinical supervisor without neglecting patient care, for example by providing sufficient staff, equipment, mentors and preceptors.
 - Drive the development of mentors and preceptors as part of a career development plan for professional nurses. In collaboration with nursing education institutions, adopt the Clinical Model for Education and Training of SA.
 - Develop a structured approach to mentoring clinical supervision and standards of care as a permanent item for discussion at monthly meetings in order to monitor progress.
 - Involve all levels of staff when a review of resources and infrastructural plans is done on an annual basis.

7.5.3 Category: A positive clinical learning environment for students

A positive clinical learning environment as a category emerged as an important determinant to support the professional socialisation of students. The recommendations on the implementation of this guideline are founded on the concluding statements presented in box 7.3.

Box 7.3 Summary of concluding statements on a positive clinical learning environment for students

- The clinical environment is characterised by
 - unpredictability
 - rich learning opportunities
 - heavy workloads
 - limited resources
 - health and safety risks
 - overcrowding with students
- Learning opportunities were fragmentally assigned and did not match the students' learning objectives.
- Students did not always utilise all learning opportunities that were provided.
- Minimum hours prescribed by the SANC received priority over learning objectives.
- Many professional nurses were unsupportive regarding the students' situation, as they displayed favouritism and negative attitudes.
- The value of the preceptor, mentor and peer-mentoring in support of students has been emphasised; however, this study found that their role seemed unclear, and preceptors were used least often as a support structure.
- Communication between the clinical field and the nursing education institution, as well as within the clinical field, was reported to be ineffective.

GUIDELINE 3: A positive clinical learning environment

Rationale for the implementation of the guideline

The creation of a positive clinical learning environment could facilitate desirable learning outcomes and consequently the desirable professional socialisation of students.

Recommendations on the implementation of the guideline

- Educators and professional nurses should:
 - Prepare students for the unpredictable and sometimes harsh clinical environment through role play and guided clinical observation sessions followed by reflective learning exercises.

- Ensure that meaningful learning opportunities are assigned as part of daily delegation schedules and are in line with the learning outcomes of each level.
- Teach students to communicate and display accountability regarding their learning objectives through a structured programme and mentorship.
- Nursing education institutions and clinical facilities should:
 - Coordinate student placement, considering available clinical facilities, learning objectives and minimum hours prescribed by the SANC. A clinical placement coordinator and the use of a placement template could be of assistance in this regard. Emphasis should be placed on competency rather than minimum hour requirements.
 - Ensure that adequate communication occurs on student-related matters with all relevant stakeholders (students and line managers).
 - Ensure that precautionary measures for health and safety risks are in place and measure compliance with health and safety standards.
- Nursing management should:
 - Support staff regarding workload and equipment, as discussed in guideline 2.
- Professional nurses should:
 - Guard against favouritism regarding students and be considerate about students' situation, using unbiased approaches.
- Nursing education institutions and nursing management should:
 - Clarify and expand the role of the mentor and preceptor and adopt the Clinical Model for Education and Training of SA.
 - Encourage peer-mentoring by formally assigning peers as a support structure as part of delegation schedules.

7.6 THEME 2: THE NURSING EDUCATION INSTITUTION ENVIRONMENT

In theme 2, the nursing education institution environment, three categories emerged as influential factors in students' professional socialisation: the educator as role model; the nursing education institution's clinical support to students; and teaching strategies.

7.6.1 Category: Educator as role model

The category *educator as role model* describes the attributes of an educator that were considered as being exemplary in a role model. A guideline to support these attributes was developed, based on the concluding statements as presented in box 7.4. Recommendations on implementation were derived from these concluding statements.

Box 7.4 Summary of concluding statements regarding the educator as role model

- Educators considered themselves as having
 - noteworthy teaching practices
 - noteworthy levels of subject knowledge and skills
 - good interpersonal skills
 - a positive attitude to their career
 - the skill to acknowledge others' accomplishments. However, they viewed their colleagues as exhibiting the above-mentioned qualities to a more limited extent. Educators with more than eight years of experience rated their colleagues' characteristics as an educator significantly lower than did educators with less than eight years of experience.
- Students experienced educators as knowledgeable and supportive.
- Although educators considered themselves as clinically competent, they indicated that they were prevented by time constraints from maintaining these skills.
- Educators, especially those at universities, perceived their colleagues' conflict-resolving abilities as average.

GUIDELINE 4: The educator as role model

Rationale for the implementation of the guideline

This guideline is intended to maintain and support educators to be role models whose behaviour students could imitate.

Recommendations on the implementation of the guideline

- Educators and the management of nursing education institutions should:
 - Commit themselves to maintaining high standards of teaching practices, for example by attending workshops, continually reflecting on teaching practices and attending conferences; maintaining a high standard of subject knowledge and skills, and attending in-service training and conferences, as well as earning CPD points.
 - Motivate educators to practice evidence-based education, for example by reading scientific journals, and implementing evidence-based teaching and facilitation practices.
 - Provide educators access to scientific information through partnerships with universities.
 - Demonstrate sound ethical principles. This could be accomplished through CPD training and reflective activities.
 - Assess the above-mentioned qualities through performance appraisals.
 - Provide and allocate sufficient time to ensure that educators stay clinically competent. The Clinical Model for Education and Training of SA (Nursing Education Stakeholders SA 2011:5) suggests educators should work 16 days per year in the clinical field to stay clinically competent. Clinical competency should be included in the nursing education institution's policy.
 - Acknowledge those educators who are considered as exemplary role models, for instance through performance appraisals and celebrating achievements in meetings, but with a culturally sensitive approach.
- The management of nursing education institutions should:
 - Create opportunities for educators to improve their conflict management skills, by for example workshops and reflective activities.

7.6.2 Category: The nursing education institution's clinical support to students

In the category, the *nursing education institution's clinical support to students*, a guideline was developed to address strategies the nursing education institution could use to support students with their clinical learning. The suggested recommendations for

implementation regarding clinical support to students are based on the concluding statements presented in box 7.5.

Box 7.5 Summary of concluding statements regarding support from the nursing education institution to students to improve their clinical learning experiences

- The majority of educators' job descriptions include clinical accompaniment of students.
- The large number of students and student absenteeism limited educators' ability to provide clinical support to students.
- Students were mostly prepared for their first clinical exposure by means of simulation and orientation and, to a more limited extent, debriefing and discussions on the diverse challenges of the clinical field.
- Reflection on clinical experiences was provided to some extent.
- The two examples of theory-practice discrepancies reported most often were lack of equipment and procedures that were performed differently from what was taught in academia. Clinical accompaniment and different teaching strategies were the approaches mostly used to address these discrepancies.

GUIDELINE 5: Nursing education institution's clinical support to students

Rationale for the implementation of the guideline

It is envisaged that sufficient support structures provided to students by the nursing education institution could improve their clinical learning experiences.

Recommendations on the implementation of the guideline

- Management of nursing education institutions and management of the clinical field should:
 - Clarify and expand the role and function of the mentor, preceptor and peer-mentoring (also mentioned in Guideline 3). This would assist educators and professional nurses in supporting students with their clinical learning. The Department of Health's *Strategic plan for nursing education, training and practice* (South Africa. Department of Health 2012:7) proposes the reinstatement of a clinical teaching department in clinical facilities to support students with their clinical competencies

- Encourage direct visibility of educators in the clinical field according to formal plans.
- Educators should:
 - Explore possibilities such as expanding simulation laboratories and virtual learning to deal with large numbers of students.
 - Prepare students to deal with the diverse challenges of the clinical field by developing not only the cognitive and psychomotor domains, but also the affective domain. Reflective opportunities on clinical experiences could enhance affective domain development, for instance the use of authentic case studies.
 - Prepare students for theory-practice discrepancies and realign teaching strategies and reflective sessions; for example, teach students how to deal with a lack of equipment and complicated circumstances, using authentic case studies.
 - Address student absenteeism in collaboration with professional nurses who are in the clinical field according to a formal protocol (DoHE and DoH guidelines) on student behaviour.

7.6.3 Category: Teaching and facilitation strategies

From the category *teaching and facilitation strategies*, a guideline was developed to address the teaching and facilitation strategies to be followed to promote the professional socialisation of students. The concluding statements as indicated in box 7.6 guided the recommendations on implementation related to this guideline.

Box 7.6 Summary of concluding statements on the teaching and facilitation strategies

- Educators were uncertain about the philosophy that underpinned their curriculum. The most frequently selected philosophy was outcomes-based.
- Knowledge and skills received greater emphasis in the curriculum than values and beliefs. Teaching strategies regarding knowledge and skills were more student-centred than strategies of values and beliefs, which tended to be educator-centred.
- Values and beliefs are mostly learned through the hidden curriculum (Van Mook et al 2009:e107).
- Individual learning orientations were mostly addressed through support and mentoring, while different teaching and assessment strategies were not often used.
- Most of the educators were satisfied with their training facilities and equipment; however, mannequins for skills training and more class space for the large number of students were among the greatest needs.
- Educators perceived themselves as easily accessible for consultation. An open-door policy was mostly adopted to render this support.
- A planned programme of tests and assignments was provided in advance for students to plan ahead, though students experienced professional nurses to be insensitive to their needs in this regard.

GUIDELINE 6: Teaching and facilitation strategies

Rationale for the implementation of the guideline

It is anticipated that the implementation of certain teaching and facilitation strategies would support the professional socialisation of students.

Recommendations on the implementation of the guideline

- Educators should:
 - Integrate the underlying curriculum philosophy with regard to their teaching and planning by ensuring effective integration of theory and practice in preparing the students to be able to function in the realities of practice.

- Ensure that the teaching of values and beliefs of the nursing profession receives sufficient emphasis in the curriculum and that the teaching is student-centred; include these aspects in the curriculum design, study guides and lectures and utilise authentic case studies where students actively participate.
- Be aware of the influence of the hidden curriculum in the learning of values; therefore create opportunities for reflection on practical experiences. Constantly be aware of how the educators themselves are portraying values.
- Utilise a variety of creative teaching, facilitation and assessment strategies to address the different learning orientations of students.
- Budget for and explore innovative strategies to upgrade facilities and equipment of the skills laboratory. Virtual teaching, technology, duplication of classes or the appointment of student assistants could be explored to deal with the large number of students in classes.
- Be available according to a structured system, considering both students' and educators' programmes, for instance by having consultation hours.
- Communicate planned test schedules to the unit managers responsible for the professional nurses in the clinical field.
- Educators and the management of nursing education institutions should:
 - Formulate a policy that addresses innovative teaching strategies.

7.7 THEME 3: THE VALUES AND BELIEFS OF THE NURSING PROFESSION

In theme 3, four categories are discussed, namely the work ethic of the professional nurse and educator; students' behaviour; nursing as a profession; and cultural and gender awareness. From these categories four guidelines related to the nursing profession were developed.

7.7.1 Category: Work ethic of the professional nurse and educator

The category *work ethic of the professional nurse and educator* targets the ethical behaviour of the professional nurse and educator. The recommendations on implementation of the guidelines are based on the concluding statements as shown in box 7.7.

Box 7.7 Summary of concluding statements on the work ethic of the professional nurse and educator

- Severe violations of basic human rights were witnessed and experienced by students. Professional nurses physically abused patients, while students were humiliated and exploited.
- Students perceived educators as indifferent to issues related to professional misconduct reported to them.
- Educators perceived themselves as adhering to ethical principles such as respect, honesty and confidentiality, although they did not assess their colleagues as highly as themselves on the issue of respect. This self-assessment report may not be a true reflection of the educators' work ethic.
- Values are basic beliefs about what is desirable and are manifested in behaviour (Rassin 2008:615).
- One of the core values promised by all qualified nurses in the "Nurses' Pledge of Service" is respect for human dignity

GUIDELINE 7: Work ethic of the professional nurse and educator

Rationale for the implementation of the guideline

It is anticipated that if professional nurses and educators are supported in applying a good work ethic, students will very probably imitate this ethical behaviour.

Recommendations on the implementation of the guideline

- Management of nursing education institutions and nursing management of clinical facilities should:
 - Create structures, as already discussed in Guideline 1, where students and patients' significant others could anonymously report cases of misconduct, to enable management to address these cases appropriately.
 - Assess the professional conduct of professional nurses and educators through performance appraisals.
 - Support individuals who display inappropriate behaviour and misconduct by measures such as counselling and in-service training.

- Create a healthy work environment where basic human rights are valued, and staff, patients and their significant others are treated with respect.
- Create awareness of the various legislative measures: the Nursing Act (South Africa 2005a:34), Regulation to the Scope of Practice (SANC 1984:R2598), the Regulations on Acts or Omissions (SANC 1985a:R387), *Batho Pele* principles (South African Government Information 2007:[1]) and the Patient's Rights Charter (Mellish et al 2010:170). This could be done through discussions, case studies, attending SANC disciplinary hearings and the implementation of quality processes. The Department of Health's Strategic Plan for Nursing Education, Training and Practice suggests all nurses participate in CPD training on the ethos of nursing (South Africa. Department of Health 2012:34).
- Professional nurses and educators should:
 - Be committed to upholding the nursing values as pledged in the "Nurses' Pledge of Service".
 - Report cases of misconduct and follow specific institutional guidelines dealing with misconduct.

7.7.2 Category: Students' behaviour

The category *students' behaviour* focuses on appropriate student behaviour. Box 7.8 indicates recommendations on implementation, based on the concluding statements.

Box 7.8 Summary of concluding statements regarding students' behaviour

- Professional nurses and educators stated that some students exhibited undisciplined behaviour and portrayed negative attitudes.
- Students were concerned about some of their peers' inappropriate behaviour.
- Professional nurses felt that students should be reprimanded and, where indicated, disciplinary procedures should be followed.
- Students tended to demonstrate rebellious behaviour during their second year of study, but to improve towards the third and fourth year.
- Students' level of training coincided to a certain extent to Cohen' (1981) model of professional socialisation.

GUIDELINE 8: Students' behaviour

Rationale for the implementation of the guideline

This guideline proposes interventions that might facilitate appropriate behaviour of students.

Recommendations on the implementation of the guideline

- All stakeholders involved in student education should:
 - Report undisciplined student behaviour and promptly follow institutional policies regarding student misbehaviour.
 - Provide a clear structure, such as policies and student rules, whereby students are made aware of limits and the consequences should they not adhere to these limits.
- Educators and professional nurses should:
 - Acknowledge well-behaved students in a culturally sensitive manner by such measures as affirming work well done or giving awards.
 - Provide opportunities for debate, discussion, case studies and reflection on professional behaviour to create awareness of professional conduct.
 - Take note that students in their second year of study may become rebellious. Provide sufficient opportunities for discussion and support (student support services) to students during this year. First-year students should be coached particularly regarding correct professional behaviour and this behaviour should be reinforced throughout the study years.
 - Be mindful of students who exhibit signs of undisciplined behaviour and refer them early for counselling if necessary.

7.7.3 Category: Nursing as a profession

The guideline related to the category *nursing as a profession* addresses the perceptions and experiences of educators, professional nurses and students regarding nursing as a profession. The recommendations on the implementation of this guideline are founded on the concluding statements indicated in box 7.9.

Box 7.9 Summary of concluding statements on nursing as a profession

- Professional nurses, educators and students themselves stated that for some students nursing was not a first career choice. Financial gain and exclusion from other courses were some of the reasons why nursing was pursued.
- Educators and professional nurses were dissatisfied with the type of candidates who entered into the nursing programme. They perceived the candidates as uncaring and not really interested in becoming a nurse.
- The reasons most frequently given for student attrition were poor academic performance and a wrong career choice.
- Educators indicated that they had a positive attitude to nursing education as their career.
- Professional nurses indicated that some public members perceived nursing as being not a respectable career to follow.
- Professional nurses and students were concerned about some nurses' unprofessional behaviour and dress code, which contributed to the undesirable image of nursing.

GUIDELINE 9: Nursing as a profession

Rationale for the implementation of the guideline

This guideline suggests interventions that may improve the image of the nursing profession.

Recommendations on the implementation of the guideline

- All stakeholders, such as SANC, nursing unions, nursing education institutions, clinical facilities and individual educators, professional and student nurses, should:
 - Promote nursing as a profession, by for instance using the media, holding career exhibitions and participating in community projects.
- All members of the nursing profession should:
 - Take responsibility for the professional conduct of nurses.
 - Become part of a professional association to promote nursing collectively, be aware of new developments and speak with a strong professional voice to address issues of concern.

- Be conscious of how the image of the nursing profession is portrayed: how one speaks, dresses and interacts with other people. Debate, discussions and symposiums could contribute to awareness and a sense of responsibility in the profession.
- Nursing education institutions should:
 - Evaluate their selection process for possible improvements. This recommendation is supported by the Department of Health's *Strategic plan for nursing education, training and practice 2012–2017* (South Africa. Department of Health 2012:7)
 - Explore the reasons why certain candidates might pursue nursing and adjust their selection accordingly.
- Government should:
 - Reconsider the way in which financial assistance is provided to students. The Department of Health's *Strategic plan for nursing education, training and practice 2012–2017* proposes that students should rather be funded than used as employees, thus enabling them to have full student status (South Africa. Department of Health 2012:7).

7.7.4 Category: Cultural and gender awareness

This guideline focuses on the creation of *cultural and gender awareness* among educators, professional nurses and student nurses. The recommendations of this guideline are based on the concluding statements indicated in box 7.10.

Box 7.10 Summary of concluding statements regarding cultural and gender awareness of students, educators and professional nurses

- Professional nurses at times disregarded English as the official language of communication during discussion of patient-related matters, which excluded some students from learning opportunities.
- Racial tension caused students in extreme cases to attack one another physically. However, good relationships between different races were also reported.
- Although educators were to some extent aware of cultural conflict, they stated that it was not easily noticed, while professional nurses did not mention any aspects of cultural issues.
- Professional nurses perceived male students as having negative attitudes. In some cultures it is believed that males should be treated differently from females. Male students experienced this as preferential treatment.
- Educators were to some extent aware of cultural differences during their communication with others; however, they seldom reflected as a group among themselves on cultural differences.
- Students had limited opportunities to reflect among themselves on their different cultural orientations.

GUIDELINE 10: Cultural and gender awareness

Rationale for the implementation of the guideline

The facilitation of cultural and gender awareness might promote better understanding of different cultural orientations among educators, professional nurses and student nurses that might encourage improved interpersonal relationships.

Recommendations on the implementation of the guideline

- Professional nurses should:
 - Adhere to the institutional policy on using the official language during communication in the workplace regarding patient-related matters. All stakeholders should also be encouraged to learn an African language.

- Students and professional nurses should:
 - Be encouraged to report any cultural or gender conflict anonymously to nursing management to enable it to be addressed appropriately.
- Management of education institutions, nursing management, professional nurses and students should:
 - Become more aware of different cultures, in order to become culturally competent. This could be done by being aware of one's own cultural beliefs and values, and respecting others' views in this regard. Reflective activities such as group discussions and portfolios may assist with this issue.
- Educators should:
 - Incorporate cultural and gender competencies in the nursing curriculum, by for instance making opportunities for students to reflect on their own cultural values and beliefs, and learn about other cultures that students would probably come across.
 - Teach and facilitate these competencies to allow students to become culturally competent through active multicultural engagement opportunities.

7.8 CONCLUSION

Chapter 7 presented a discussion on the developed and validated guidelines to support educators and professional nurses in students' professional socialisation. These guidelines were formulated based on concluding statements of data obtained in the qualitative (phase I) and quantitative (phase II) phases, with supportive literature. The guidelines were also validated by field experts for clarity, comprehensiveness, applicability, credibility and validity. Their suggestions were incorporated in the guidelines. These guidelines are intended to be implemented as a whole to ensure the best possible professional socialisation of students. Chapter 8 discusses the conclusions, recommendations and limitations of the study.

CHAPTER 8

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

8.1 INTRODUCTION

This chapter discusses the key findings, conclusions and limitations of the study, and makes recommendations for further research, practice and education with regard to the professional socialisation of students.

8.2 PURPOSE OF THE STUDY

The purpose of this sequential mixed-methods study was to explore and describe the perceptions of professional nurses regarding their role in the professional socialisation of students, and student nurses' experiences of professional socialisation as members of the nursing profession. Themes generated from the qualitative data (phase I) were developed into items for a questionnaire to determine and describe educators' perceptions on their teaching and facilitation of professional socialisation of students (phase II). Qualitative and quantitative data were integrated and used to develop and validate guidelines that could support nurse educators and professional nurses in the professional socialisation of students.

8.3 RESEARCH DESIGN AND METHODS

This was a two-phased, sequentially explorative mixed-methods study. The reason for selecting a mixed-methods research design was that it could best answer the question, namely *How could the internalisation of skills, knowledge, values and beliefs in student nurses be guided to help them become effectively socialised as professional nurses?* Combining qualitative and quantitative methods established methodological triangulation, resulting in better understanding of the phenomenon *professional socialisation*. Furthermore, the strengths and weaknesses of both qualitative and quantitative approaches complemented each other. A pragmatic philosophical belief allowed the application of both a post-positivist and naturalistic worldview to address the problem

from different angles. Although this type of design has several advantages, it was challenging in terms of being complex and time consuming; however, expert guidance and methodological rigour dealt with these challenges.

8.3.1 Phase I

Phase I consisted of a qualitative component in which data were collected from two purposive samples, namely sample A (professional nurses) and sample B (students). The participants of sample A needed to have had experience in guiding students registered for the four-year integrated nursing programme in their clinical learning experiences. Sample B's participants were students registered for this nursing programme who were placed for clinical learning experiences in the same academic hospital in Gauteng where sample A's participants worked. The data became saturated after conducting two focus-group interviews with sample A and five with sample B. The qualitative data were supported with field notes. The data were analysed using Tesch's method of data analysis (Tesch 1990:142–145), which generated three themes and nine categories from sample A and three themes and 11 categories from sample B. The integrated data from samples A and B emerged as five themes, which guided the item generation of a questionnaire used in the second phase. In addition, trustworthiness was established by using the criteria credibility, confirmability, dependability, transferability and authenticity, as suggested by Lincoln and Guba (1981, in Polit & Beck 2008:539). This phase addressed the first two objectives as indicated in chapter 1, section 1.9.

8.3.2 Phase II

In Phase II, quantitative data were collected from a population of educators from nine educational institutions that offered the four-year integrated nursing programme in Gauteng. The total number of possible respondents was 277, of whom 128 (46%) responded. A self-administered questionnaire developed from the themes from the qualitative phase and the literature was used to determine and describe educators' perceptions on the teaching and facilitation of professional socialisation of students. The data were analysed with the support of a statistician using the Statistical Analysis System (SAS) Version 9.2 and presented by means of descriptive and inferential statistics. Furthermore, validity was established through content and face validity, while

pre-testing of the questionnaire and the Cronbach alpha test were applied to establish reliability. In addition, validity was enhanced by using a mixed-methods design. On completion of Phase II, the third objective was achieved, as described in chapter 1, section 1.9.

8.3.3 Development and validation of guidelines

The final objective, to develop and validate guidelines to support educators and professional nurses in the professional socialisation of students, was achieved after the qualitative and quantitative data had been integrated. From the integrated data, concluding statements were grouped to form themes and categories that were formulated into guidelines. A final set of 10 guidelines, with recommendations for implementation, was developed and validated by field and guideline experts, a manager of a nursing education institution, educators, nurse managers and professional nurses.

8.4 CONCLUSIONS OF THE STUDY

Conclusions are presented after being drawn from the integrated themes and categories on professional nurses' perceived role in the professional socialisation of students, as well as the professional socialisation experiences of students as members of the nursing profession (phase I). Additional conclusions were drawn from the data obtained from educators' teaching and facilitation of professional socialisation of students (phase II). Finally, the conclusions of phases I and II were integrated and presented as concluding statements for the validated guidelines, as presented in table 8.1.

8.4.1 Conclusions on phase I

From the integrated data of sample A (professional nurses) and sample B (students), five themes emerged as influential determinants in the professional socialisation of students: the characteristics of the professional nurse, the clinical learning environment, values and beliefs related to nursing as a profession, the educator, and cultural and gender orientation.

The first theme, *characteristics of a professional nurse*, was described in terms of the professional nurse as role model and clinical supervisor. In order to fulfil these roles,

certain characteristics were identified, namely being approachable and aware of one's own behaviour and communication patterns, having a sufficient level of knowledge, providing support to students experiencing theory-practice discrepancies, acknowledging students' accomplishments, disciplining students when indicated and including students' suggestions in the multidisciplinary team. Although these characteristics were identified as important, students experienced and witnessed limited application of these characteristics in the clinical field. They described professional nurses as role models who did not lead by example, were unethical and were unable to act as a clinical supervisor to them. Third-year students were very explicit in sharing their views regarding role models who exhibited unethical behaviour. Cohen (1981) indicates that students will associate with role models during the third stage of professional socialisation, which coincided in this instance also with the level of training of the students. Students in this study were able to identify role models they did not wish to imitate. Despite this negative picture of the professional nurse, students indicated that there were some professional nurses who were exemplary role models and clinical supervisors.

The second theme emerged as the *clinical learning environment* for professional socialisation of students. A supportive environment was described as one where students are orientated to their new environment, supported by mentors and accepted as neophytes who still need to learn. However, the clinical environment was characterised by professional nurses being overloaded with work, mostly busy with administrative tasks, as well as by limited resources, lack of communication between the educators and professional nurses in the clinical field, and health and safety risks. Students experienced learning opportunities as less meaningful and found that what they experienced in the practical environment differed from the theory they had learned. Professional nurses displayed favouritism and negative attitudes to students, causing students to be negative to the clinical learning environment. Thus the clinical environment did not support the desirable professional socialisation of students.

The third theme emerged as the *values and beliefs related to the nursing profession*. Students reported that a number of professional nurses exhibited inhumane behaviour to patients and exploited students' goodwill for favours. Professional nurses experienced some students as uncaring and not interested in nursing as a profession. It was stated that some students pursued nursing for the financial benefit and that it was

not their first career choice. Both professional and student nurses accused one another of negative attitudes and portraying an unprofessional image with regard to behaviour and dress code. Nevertheless, even though students' professional socialisation occurred in an environment where the values and beliefs of the nursing profession were not respected, some professional nurses and students were dedicated and upheld the values and beliefs of the nursing profession.

In the fourth theme, namely the *educator*, students experienced the educators as supportive and knowledgeable; however, when they reported unethical behaviour of professional nurses, they perceived educators as indifferent to the issues that related to professional misconduct. Professional nurses were concerned about the lack of communication between educators and professional nurses, especially during the educators' clinical accompaniment visits. Students experienced the educator as supportive and knowledgeable but were discouraged when these educators did not act on their reports of and concerns about the misconduct of professional nurses that they witnessed in the wards.

The last theme, *cultural and gender orientation*, revealed that students experienced professional nurses as insensitive and excluding them from learning opportunities when communicating in a different language from English, the official language. Although good relationships between different races were described, students also described racial tension to such an extent that students physically attacked each other. Furthermore, male students were experienced as uncaring by female professional nurses, while male students stated that female professional nurses approached them differently because of their cultural beliefs. Male students experienced this approach as preferential treatment. Professional socialisation of students occurred in a culturally diverse environment and the beliefs regarding gender complicated the professional socialisation of students.

As is evident from the discussion of the data obtained from professional nurses' perceptions and students' experiences regarding students' professional socialisation, students were socialised in an environment that was to a large extent unsupportive. Moreover, some students had selected nursing for other reasons than the core values of the nursing profession.

8.4.2 Conclusions on phase II

The conclusions on phase II were drawn from the perceptions of 128 educators in Gauteng on their teaching and facilitation of professional socialisation of students. In this phase (II), the respondents gave their perceptions on six composite professional socialisation constructs, supported by open-ended questions and issues related to these constructs. These professional socialisation constructs were: the characteristics of an educator as perceived by educators themselves (construct 1) and their perceptions of the characteristics of their colleagues (construct 2), values and beliefs related to the nursing profession (construct 3), the educator and the clinical environment (construct 4), teaching strategies (construct 5), and cultural awareness (construct 6). Since this study's emphasis was qualitative in nature, the conclusions from the quantitative phase will be discussed in a qualitative form.

In an open ended-question the respondents indicated that being a role model and guiding students about the professional conduct of nursing were the two teaching strategies used to teach and facilitate professional socialisation to students. The two composite constructs (1 and 2) that addressed the self-assessment of *educators' own perception of the characteristics as an educator* was positive to very positive, whereas the rating of *their colleagues' display of characteristics of an educator* was slightly less positive. This self-assessment may not be a true reflection of the educators' qualities, as they might have overestimated themselves. Regarding the conflict-resolving abilities of colleagues, the educators from colleges rated their colleagues' abilities significantly ($p < 0.0001$) higher than did those from universities. Overall, the educators perceived themselves and their colleagues as exhibiting the characteristics of an educator, therefore displaying behaviour that could be imitated by students and having the ability to work in a team.

The composite construct (3), related to *the values and beliefs of nursing*, measured the educators' perceptions of adherence to ethical principles, their perception of candidates who entered nursing, and students' behaviour and self-image. A generally positive response was obtained for this construct. Although educators could have overrated their own ethical behaviour, similar evidence was found by Klunklin et al (2011:86) on educators' self-assessed ethical behaviour. The educators believed that less suitable candidates entered the nursing profession. Regarding student behaviour, additional

evidence to this construct (3) suggested that students were most rebellious during the second year of study, which coincided with Cohen's (1981) second stage of professional socialisation (independence stage II), characterised by rebellion. In a supportive question on student attrition, it was indicated that students who failed to complete their course did so because of poor academic performance or because nursing was not their first career choice. The evidence of construct 3, *values and beliefs of nursing* and related items, indicated that educators believed themselves and their colleagues to have sound ethical principles. Students' behaviour and orientation to nursing as a career did not reflect the values and beliefs of nursing.

Regarding construct 4, *the educator and the clinical field with related challenges*, a generally positive to very positive perception was obtained. One challenge was students' clinical placement according to the SANC requirements for clinical hours. This positive perception implied that the SANC's requirements regarding minimum clinical hours received preference over students' learning objectives. It was explained that educators strictly adhered to the SANC's requirements and that learning objectives were compromised by the large number of students. Another challenge was the inadequate communication within the clinical field regarding student-related matters.

Educators prepared students for their first clinical exposure mostly through simulation and orientation, while the affective domain preparation received less attention. Apart from emotional challenges, students experienced discrepancies between theory and practice. Educators stated that students experienced the procedures performed in practice as different from those they were taught. Students were supported in the clinical field through clinical accompaniment, orientation, mentors, peer-mentoring and to a lesser extent by preceptors. The large number of students that needed support, as well as students who were absent from accompaniment visits, impeded clinical accompaniment of students by educators. Thus educators were faced with several challenges regarding the clinical field, such as ineffective communication, absenteeism of students and the large numbers that needed support. However, educators applied some strategies to support students.

The composite construct (5), *teaching strategies* and related aspects, addressed aspects related to the curriculum, a student-centred versus an educator-centred teaching approach, different learning orientations of students, consideration of students'

learning needs, education and training facilities and support to students. An outcomes-based curriculum philosophy was mostly followed, while the teaching of knowledge and skills was more student-centred than the teaching of values and beliefs. Less emphasis was given to the teaching of values and beliefs. Van Mook et al (2009:e107) highlight the fact that the learning of values and beliefs occurs mainly implicitly, through what is described as the hidden curriculum. Students' academic responsibilities (tests and assignments) were accommodated, while students' different learning orientations were addressed through mentoring and limited teaching and assessment methods. Regarding equipment and training facilities, the two most needed items were mannequins for skills training and more classroom space to accommodate the large number of students. Students were further supported by educators being easily available for consultation. Students were provided with institutional support in terms of clinical accompaniment and having individual appointments; however, limited health and safety support measures related to the clinical field were provided. The overall evidence indicated that students were positively supported by the teaching strategies of educators. However, some areas could be improved, such as following a student-centred approach in the teaching of values and beliefs, and educators having knowledge about the underlying curriculum philosophy.

The last composite construct (6), *cultural awareness*, indicated a fairly positive rating. Educators indicated that they reflected as individuals and to lesser extent as a group on cultural issues. However, students had fewer opportunities to reflect as an individual and as a group on their cultural differences, as these issues were rated significantly differently ($p < 0.0001$) from the other items in this construct. In addition, educators indicated that cultural conflict was not easily noticed among students. Thus educators viewed themselves as having more opportunities for cultural reflection than students would have, which might have an influence on students' development of cultural competency.

8.4.3 Conclusions on data from phases I and II

The findings of phases I and II were integrated, and formed the basis of the guidelines for educators and professional nurses to support students in their professional socialisation. The integrated data resulted in three themes, namely the clinical environment, the nursing education institution environment and the values and beliefs of

the nursing profession. Each theme consisted of categories from which 10 guidelines were developed, based on the concluding statements from phases I and II and the literature. These guidelines propose suggestions not only to the educator and professional nurse, but also to associated stakeholders such as the nursing management, management of the nursing education institutions and government. The following 10 validated guidelines are presented as concluding statements with associated recommendations for their implementation, as indicated in table 8.1.

TABLE 8.1 SUMMARY OF VALIDATED GUIDELINES TO SUPPORT EDUCATORS AND PROFESSIONAL NURSES IN THE PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Theme	Category	Concluding statements	Guideline	Recommendations for implementation
Theme 1: Clinical environment	① The professional nurse as exemplary role model	<ul style="list-style-type: none"> • Students experienced and witnessed the professional nurse as a role model who did not lead by example. These role models negatively influenced students' self-confidence and the development of a professional identity. • Few professional nurses were mentioned as exemplary role models. • A description of an exemplary role model was provided, which would contribute to the motivation and learning of skills, knowledge, values and beliefs in students. 	<p>The professional nurse as exemplary role model</p> <p>To facilitate and support professional nurses' becoming role models whose behaviour students could imitate</p>	<ul style="list-style-type: none"> • Nursing management and professional nurses should collaboratively: <ul style="list-style-type: none"> ○ Empower professional nurses to be exemplary role models (e.g. in-service training) ○ Assess professional nurses on the qualities of an exemplary role model (e.g. performance appraisals) ○ Encourage professional nurses to reflect on their own values, beliefs and behaviour (e.g. portfolios, discussions) ○ Motivate professional nurses to commit themselves to the "Nurses' Pledge of Service" ○ Create structures to report unethical behaviour (e.g. suggestion boxes) ○ Acknowledge exemplary role models (e.g. celebrate achievements) ○ Be encouraged to create a healthy work environment (e.g. display of the core values of nursing)

TABLE 8.1 SUMMARY OF VALIDATED GUIDELINES TO SUPPORT EDUCATORS AND PROFESSIONAL NURSES IN THE PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Theme	Category	Concluding statements	Guideline	Recommendations for implementation
Theme 1: Clinical environment	② The professional nurse as clinical supervisor	<ul style="list-style-type: none"> Students experienced the professional nurse as not fulfilling the role of a clinical supervisor. As clinical supervisor, the professional nurse should have the skill to facilitate the learning by students of skills, knowledge, values and beliefs of nursing. Professional nurses found it difficult to deal with students' negative attitudes and their own increased workload and limited resources. 	<p>The professional nurse as clinical supervisor</p> <p>To support the professional nurse in being a clinical supervisor who will foster positive learning experiences</p>	<ul style="list-style-type: none"> Professional clinical supervisor nurses should: <ul style="list-style-type: none"> Orientate students to their environment and help them to apply theory to practice (e.g. case studies, orientation) Take an honest interest in students' learning outcomes and achievements, taking into consideration their training and input needs at the different stages Acknowledge students' suggestions and incorporate them in the multidisciplinary team Guide students on professional behaviour (e.g. give honest feedback, acknowledge respectable behaviour) Attempt, in cooperation with students, to improve relationships (e.g. purposeful feedback) Encourage students to communicate their learning needs Nursing management should: <ul style="list-style-type: none"> Support the professional nurses in fulfilling their responsibilities (e.g. supply sufficient staff) Develop and maintain structures that will support the clinical supervision of students (e.g. adopt the Clinical Model for Education and Training of SA, provide sufficient staff) Support the development of mentors and preceptors (e.g. career planning) Involve all levels of staff in the annual review of resources and infrastructural plans

TABLE 8.1 SUMMARY OF VALIDATED GUIDELINES TO SUPPORT EDUCATORS AND PROFESSIONAL NURSES IN THE PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Theme	Category	Concluding statements	Guideline	Recommendations for implementation
Theme 1: Clinical environment	③ A positive clinical learning environment	<ul style="list-style-type: none"> • The clinical environment was characterised by various learning opportunities; however, it posed challenges that did not support students' professional socialisation, such as unpredictability, increased work load, limited resources and health and safety risks. • Learning opportunities were fragmentally assigned, while students did not always use all learning opportunities that were provided. • Minimum hours prescribed by the SANC received priority over learning objectives. • Professional nurses displayed favouritism and negative attitudes. • The value of the preceptor, mentor and peer-mentoring in support of students was emphasised; however, their role was not clear. Preceptors were the least utilised. • Communication was ineffective within the clinical field as well as between the nursing education institution and the clinical field. 	<p>A positive clinical learning environment</p> <p>To create a positive clinical learning environment that could facilitate desirable learning outcomes</p>	<ul style="list-style-type: none"> • Educators and professional nurses should: <ul style="list-style-type: none"> ○ Prepare and support students for the complex clinical environment (e.g. role play) ○ Ensure the assignment of meaningful learning opportunities, considering all related aspects (e.g. placement template) ○ Teach students to display accountability regarding their learning objectives (e.g. use a structured programme) • Nursing education institutions and clinical facilities should: <ul style="list-style-type: none"> ○ Ensure coordinated clinical placement of students, considering all requirements ○ Ensure that adequate communication with all relevant stakeholders occurs on student-related matters ○ Ensure that precautionary measures for health and safety risks are in place and maintained • Nursing management should: <ul style="list-style-type: none"> ○ Support staff regarding workload and equipment (Guideline 2) • Professional nurses should: <ul style="list-style-type: none"> ○ Support students in their clinical learning (e.g. consider students' situations, be unbiased) • Nursing education institutions and nursing management should: <ul style="list-style-type: none"> ○ Clarify and expand the role of the mentor and preceptor and adopt the Clinical Model for Education and Training of SA ○ Encourage peer-mentoring (e.g. use a structured system)

TABLE 8.1 SUMMARY OF VALIDATED GUIDELINES TO SUPPORT EDUCATORS AND PROFESSIONAL NURSES IN THE PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Theme	Category	Concluding statements	Guideline	Recommendations for implementation
Theme 2: Nursing education institution environment	④ Educator as role model	<ul style="list-style-type: none"> • Educators considered themselves as exemplary role models (e.g. noteworthy teaching practices, interpersonal skills, subject knowledge). • Students experienced educators as knowledgeable and supportive. • Educators considered themselves as clinically competent but were restricted by time constraints from maintaining their clinical skills. • Educators, especially those at universities, perceived their colleagues' conflict-resolving abilities to be average. 	<p>The educator as role model</p> <p>To maintain and support educators in being role models whose behaviour students could imitate</p>	<ul style="list-style-type: none"> • Educators and the management of a nursing education institution should: <ul style="list-style-type: none"> ○ Commit themselves to maintaining the skills and attributes that characterise an exemplary educator (e.g. workshops, CPD points) ○ Motivate educators to use evidence-based teaching practices (e.g. apply evidence in teaching strategies) ○ Have access to scientific information through partnerships with universities ○ Evaluate educators on the qualities of an exemplary educator (e.g. performance appraisal) ○ Provide and allocate sufficient time to stay clinically competent ○ Acknowledge exemplary educators (e.g. celebrate achievements) • Management of the nursing education institution should: <ul style="list-style-type: none"> ○ Create opportunities for educators to improve their conflict-management skills (e.g. workshops)

TABLE 8.1 SUMMARY OF VALIDATED GUIDELINES TO SUPPORT EDUCATORS AND PROFESSIONAL NURSES IN THE PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Theme	Category	Concluding statements	Guideline	Recommendations for implementation
Theme 2: Nursing education institution environment	⑤ The nursing education institution's clinical support to students	<ul style="list-style-type: none"> • Educators' job descriptions included clinical accompaniment of students but the large number of students and student absenteeism hindered this support to students. • Simulation and orientation were mostly used to prepare students for their first clinical exposure – debriefing was less used. • Reflection on clinical experiences was provided to some extent. • Lack of equipment and procedures performed differently were reported as theory-practice discrepancies. These discrepancies were addressed by clinical accompaniment and different teaching strategies. 	<p>The nursing education institution's clinical support to students</p> <p>To provide support to students through support structures of the nursing education institution, with the aim of improving the clinical learning experiences of students</p>	<ul style="list-style-type: none"> • Management of nursing education institutions and the management of the clinical field should: <ul style="list-style-type: none"> ◦ Clarify and expand the role and function of the mentor, preceptor and peer-mentoring (also mentioned in Guideline 3) ◦ Encourage visibility of educators in the clinical field • Educators should: <ul style="list-style-type: none"> ◦ Explore possibilities to employ innovative teaching strategies (e.g. expanding simulation laboratories) ◦ Prepare students to deal with the diverse challenges of the clinical field by including all domains (e.g. reflection on clinical experiences) ◦ Prepare students for theory-practice discrepancies and realign their teaching strategies accordingly (e.g. expectations of the clinical field) ◦ Address student behaviour in collaboration with all stakeholders, and student absenteeism according to clear policies on student behaviour.

TABLE 8.1 SUMMARY OF VALIDATED GUIDELINES TO SUPPORT EDUCATORS AND PROFESSIONAL NURSES IN THE PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Theme	Category	Concluding statements	Guideline	Recommendations for implementation
Theme 2: Nursing education institution environment	<p>⑥</p> <p>Teaching and facilitation strategies</p>	<ul style="list-style-type: none"> • An outcomes-based curriculum philosophy was mostly used, though not all educators were sure which philosophy they followed. • The teaching values and beliefs were educator-centred while the teaching of knowledge and skills was more student-centred. • The learning of the values related to the nursing profession occurs implicitly through the hidden curriculum (Van Mook et al 2009:e107). • Support and mentoring were mostly used to address individual learning orientations of students. Limited diverse teaching and assessment methods were used to address students' learning orientations. • Mannequins and more class space were among the greatest needs regarding training and equipment facilities. • Educators were easily accessible for consultation. • A scheduled programme of tests and assignments was provided in advance. Students experienced professional nurses in the clinical field as insensitive to their needs in this regard. 	<p>Teaching and facilitation strategies</p> <p>To support students by utilising teaching strategies that will enhance professional socialisation</p>	<ul style="list-style-type: none"> • Educators should: <ul style="list-style-type: none"> ◦ Integrate the underlying curriculum philosophy with regard to their teaching and planning (e.g. teaching and assessment strategies) ◦ Ensure that the teaching of values and beliefs of the nursing profession is sufficiently emphasised and that the teaching is student-centred (e.g. through curriculum design and teaching) ◦ Incorporate teaching strategies that will positively influence the effect of the hidden curriculum (e.g. being a role model, having discussions and reflection on practical experiences) ◦ Utilise a variety of teaching, facilitation and assessment strategies to address the different learning orientations of students ◦ Budget for and explore innovative strategies to upgrade the facilities and equipment of the skills laboratory (e.g. virtual learning, technology) ◦ Have consultation hours according to a structured system ◦ Communicate important student-related matters to the clinical field (e.g. tests and assignments) • Educators and the management of nursing education institutions should: <ul style="list-style-type: none"> ◦ Address innovative teaching strategies (e.g. have a formal policy)

TABLE 8.1 SUMMARY OF VALIDATED GUIDELINES TO SUPPORT EDUCATORS AND PROFESSIONAL NURSES IN THE PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Theme	Category	Concluding statements	Guideline	Recommendations for implementation
Theme 3: Values and beliefs of the nursing profession	⑦ Work ethic of the professional nurse and educator	<ul style="list-style-type: none"> • Students witnessed and experienced gross violations of human rights. • Students perceived educators to be indifferent regarding reported misconduct issues. • Educators perceived themselves as having a sound work ethic, yet perceived their colleagues as acting less respectfully to others. This evidence was from the educators' own perspective. • Values are basic beliefs of what is desirable and are manifested in behaviour • Respect for human dignity is one of the core values promised in the "Nurses' Pledge of Service" when a nurse qualifies. 	<p>Work ethic of the professional nurse and educator</p> <p>To facilitate and support a good work ethic of the professional nurse and educator</p>	<ul style="list-style-type: none"> • Management of nursing education institutions and nursing management of clinical facilities should: <ul style="list-style-type: none"> ○ Provide structures for students and patients' significant others to report cases of misconduct anonymously ○ Evaluate the professional conduct of professional nurses and educators (e.g. performance appraisals) ○ Counsel professional nurses and educators who exhibit professional misconduct behaviour ○ Facilitate a healthy work environment where basic human rights are valued ○ Create awareness of the various legislative measures (e.g. Nursing Act [South Africa 2005a:34]) • Professional nurses and educators should: <ul style="list-style-type: none"> ○ Commit themselves to uphold the nursing values as pledged in the "Nurses' Pledge of Service" ○ Report cases of misconduct and apply the institutional guidelines

TABLE 8.1 SUMMARY OF VALIDATED GUIDELINES TO SUPPORT EDUCATORS AND PROFESSIONAL NURSES IN THE PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Theme	Category	Concluding statements	Guideline	Recommendations for implementation
Theme 3: Values and beliefs of the nursing profession	® Students' behaviour	<ul style="list-style-type: none"> • Professional nurses and educators indicated that some students displayed undisciplined behaviour and negative attitudes. • Inappropriate behaviour of some students concerned their peers. • Professional nurses indicated that students should be reprimanded and, where indicated, disciplinary procedures should be followed. • Rebellious behaviour was noted more in second-year students; students' behaviour improved towards the third and fourth year. • The students' level of training coincided to some extent with Cohen's (1981) model of professional socialisation. 	<p>Students' behaviour</p> <p>To facilitate appropriate student behaviour</p>	<ul style="list-style-type: none"> • All stakeholders involved in student education should: <ul style="list-style-type: none"> ○ Report undesirable behaviour and follow the institutional policy in this regard ○ Provide clear guidelines regarding students' behaviour (e.g. student rules) • Educators and professional nurses should: <ul style="list-style-type: none"> ○ Reward and acknowledge well-behaved students (e.g. award ceremonies) ○ Provide opportunities to create awareness of professional conduct (e.g. reflective opportunities) ○ Be aware that students in their second year might need more opportunities to discuss issues of concern ○ Acceptable behaviour should be reinforced in all study years ○ Refer students, if indicated, for counselling when signs of undisciplined behaviour are exhibited

TABLE 8.1 SUMMARY OF VALIDATED GUIDELINES TO SUPPORT EDUCATORS AND PROFESSIONAL NURSES IN THE PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Theme	Category	Concluding statements	Guideline	Recommendations for implementation
Theme 3: Values and beliefs of the nursing profession	© Nursing as a profession	<ul style="list-style-type: none"> • Students, professional nurses and educators indicated that for some students, nursing was not a first career choice. Financial gain and exclusion from other courses were some of the reasons offered. • Educators and professional nurses perceived some students who entered the nursing programme as uncaring and not interested in nursing; therefore were dissatisfied with some candidates who entered the nursing profession. • Student attrition was ascribed to poor academic performance and a wrong career choice. • Educators have a positive attitude to nursing education as a career. • Professional nurses experienced that some public members disparaged their career. • Unprofessional behaviour and inappropriate dress code concerned professional nurses and students, as it contributed to an undesirable image of the profession 	<p>Nursing as a profession</p> <p>To improve the image of the nursing profession</p>	<ul style="list-style-type: none"> • All stakeholders, such as the SANC, nursing unions, nursing education institutions, clinical facilities and individual educators, professional and student nurses should: <ul style="list-style-type: none"> ○ Promote the nursing profession (e.g. media, career exhibitions) • All members of the nursing profession should: <ul style="list-style-type: none"> ○ Take responsibility for the professional conduct of nursing ○ Participate in professional nursing associations to promote the nursing profession ○ Be conscious of how they portray the image of nursing (e.g. speak, dress and interact) • Nursing education institutions should: <ul style="list-style-type: none"> ○ Assess their recruitment and selection strategies • Government should: <ul style="list-style-type: none"> ○ Review the method of financial assistance to students (e.g. provide student support rather than paying a salary)

TABLE 8.1 SUMMARY OF VALIDATED GUIDELINES TO SUPPORT EDUCATORS AND PROFESSIONAL NURSES IN THE PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Theme	Category	Concluding statements	Guideline	Recommendations for implementations
Theme 3: Values and beliefs of the nursing profession	Ⓜ Cultural and gender awareness	<ul style="list-style-type: none"> • English as the official language of communication was not used by all professional nurses, which excluded some students from learning opportunities. • Some students physically attacked one another due to racial tension; however, good relationships between different races were also reported. • Educators indicated that cultural conflict was not easily noticed, while professional nurses did not mention any aspects of cultural issues. • Educators were to some extent aware of cultural differences during their communication with others. • Male students were perceived as having negative attitudes, while professional nurses in some cultures believed that males should be treated differently from females. Male students experienced this as preferential treatment. • Students had limited opportunities to reflect among themselves on different cultural orientations. 	<p>Cultural and gender awareness</p> <p>To facilitate cultural and gender awareness among educators, professional nurses and students</p>	<ul style="list-style-type: none"> • Professional nurses should: <ul style="list-style-type: none"> ○ Respect the institutional policy regarding the use of the official language (English) during communication in the workplace. All stakeholders should be encouraged to learn an African language • Students and professional nurses should: <ul style="list-style-type: none"> ○ Be able to report anonymously any cultural or gender conflict so that nursing management can address it appropriately • Management of education institutions, nursing management, professional nurses and students should: <ul style="list-style-type: none"> ○ Take cognisance of cultural differences, in order to become culturally competent • Educators should: <ul style="list-style-type: none"> ○ Include cultural and gender competencies in the nursing curriculum (e.g. create an awareness of cultural differences) ○ Teach and facilitate these competencies to help students to become culturally competent (e.g. reflecting on different cultural orientations)

8.5 STUDY LIMITATIONS

The researcher acknowledges that more probing could have been done about the students' experiences and about professional nurses' perceptions of the educators' work ethic. This information would have supported the educators' own rating of educators' displaying the characteristics of an educator. In the second phase of the study, educators described their perceptions of themselves and their colleagues from their subjective viewpoint and they could therefore have overestimated their abilities. Another limitation was the self-report instrument, which some respondents found too lengthy; however, it was judged to be a good instrument for reflection.

Notwithstanding these limitations, the study gave insight into the perceptions of professional nurses and the experiences of students regarding the phenomenon *professional socialisation*. In addition, the educators' perspective on their teaching and facilitation of the professional socialisation of students provided an additional perspective on this phenomenon, which resulted in comprehensive evidence.

8.6. RECOMMENDATIONS

The following recommendations are based on the findings of the study and the proposed guidelines.

8.6.1 Recommendations regarding nursing education

The following recommendations regarding nursing education are proposed.

Educators should:

- Familiarise themselves with the curriculum philosophy and align their teaching and facilitation strategies accordingly.
- Prepare students to adhere to the professional conduct of nurses by having clear policies and procedures that are followed.
- Empower and assist students to deal with the diverse clinical and cultural challenges of the clinical field, for example by clarifying values, and help students to deal with limited resources and different cultural beliefs.

- Display a sound work ethic and treat other persons with respect, thus acting as role models whom students could imitate.

Management of nursing education institutions should:

- Help educators to implement appropriate teaching and facilitation strategies that would enhance the professional socialisation of students, by for example having in-service training on the utilisation of diverse teaching and assessment strategies, and providing sufficient training equipment and teaching facilities.
- Re-assess the current approach to recruitment and selection of candidates for nursing.
- Provide a clear structure in which preceptors, mentors and a peer-mentoring system could function to support students. This should be done in collaboration with all stakeholders. The adoption of the Clinical Model for Education and Training of South Africa could be of support in a South African context.
- Allow educators to remain clinically competent by providing them with sufficient time to practise their clinical competencies.
- Ensure, in collaboration with relevant stakeholders, coordinated clinical placement of students, considering students' learning objectives and the SANC requirements.

8.6.2 Recommendations regarding practice

The professional nurse is one of the most influential social determinants in the professional socialisation of students. The professional nurse should:

- Act as an exemplary role model to students, by for example having a sufficient level of knowledge, being approachable and treating others with respect. This could be achieved through performance appraisal, in-service training and reflection on their own values and beliefs.
- Be a competent clinical supervisor to students, by teaching and supporting students to reach their learning objectives and becoming a professional nurse displaying appropriate professional conduct.

- Create, in collaboration with the educator and nursing management of the clinical facilities, a positive clinical learning environment. This could be done through orientation of students and the assignment of meaningful learning opportunities.
- Utilise opportunities to reflect on cultural and gender differences to enhance their sensitivity in this regard.
- Be committed to upholding the values and beliefs of the nursing profession.

Management of the clinical facilities should:

- Empower professional nurses to function in a healthy work environment by providing adequate resources and support to professional nurses to develop and maintain their skills and knowledge.
- Provide structures where all stakeholders concerned could report professional misconduct, for instance through anonymous suggestion boxes.
- Create a nursing culture and environment characterised by sound ethical principles, by for example increasing awareness of the core values of nursing, such as respect.
- Provide opportunities for nursing staff to become more gender sensitive and culturally competent, by for instance having reflective discussions in order to understand different cultural orientations.

8.6.3 Recommendations for implementation of the guidelines

The following aspects should be considered during the implementation of the guidelines, which were aimed at supporting educators and professional nurses in the professional socialisation of students.

Nursing education institutions, clinical practice and nursing unions/associations should:

- Consider the adoption and implementation of the guidelines applicable to their unique needs.
- Develop a plan to implement and monitor the outcomes of the guidelines.
- Identify key stakeholders that would support the implementation of the guidelines. Such stakeholders could, for example, be students, professional

nurses, educators, nursing management of clinical facilities and nursing education institutions, other health care professionals and political leaders.

- Establish support groups to determine the process to be followed in implementing the guidelines: for example holding workshops, meetings and discussion forums.
- Assess and adjust the plan according to the needs that may arise during the implementation process.

8.6.4 Recommendations for further research

The study found that the professional socialisation of students is influenced by various social determinants. The researcher recommends that further research be conducted into issues that emerged as problems in the socialisation process of students. Studies could be conducted on the following issues:

- Evaluating the implementation of the guidelines related to the professional socialisation of students.
- The selection and recruitment process of students, specifically at nursing colleges in the Gauteng province; for example exploring the reasons why students select nursing as a career.
- Methods of adjusting the teaching and facilitation strategies to accommodate the large number of students that higher education institutions have to deal with.
- Approaches to implementing a structured mentor, preceptor and peer-mentoring programme with regard to the professional socialisation of students.
- Ways in which professional socialisation of students as an ethical component could be taught and facilitated in both the academic and clinical field.
- The influence of the educator as role model on the professional socialisation of students.

8.7 CONTRIBUTION OF THE STUDY

This study makes a unique contribution to the body of knowledge in nursing in that it provides guidelines to implement the principles of professional socialisation on an operational level.

8.8 CONCLUSION

The question of how students could be guided to help them to internalise skills, knowledge, values and beliefs to become effectively socialised provided diverse evidence. The evidence revealed that students' professional socialisation was influenced by role models such as the professional nurse and educator, the clinical environment with its unique challenges, the support and teaching and facilitation strategies followed by the educator, the work ethic of the educator and the professional nurse, motivational factors for pursuing nursing as a career and awareness of different cultural and gender orientations.

It could therefore be concluded that this study's objectives of exploring and describing the perceptions of professional nurses and the experiences of students regarding the phenomenon *professional socialisation* were achieved. In addition, the study determined and described the way in which educators teach and facilitate the professional socialisation of students. Finally, a set of guidelines was developed and validated. It is hoped that this set of guidelines may be used to assist professional nurses and educators to guide students in their professional socialisation process.

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INVITATION TO TAKE PART IN A RESEARCH STUDY

TITLE OF THE STUDY

GUIDELINES FOR PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Dear participant

You are invited to participate in a research study that forms part of a DLitt et Phil degree. This information leaflet will help you to decide if you would like to participate. Please familiarise yourself with the purpose of the study and your responsibility and rights as participant before you agree to participate.

WHAT IS THE PURPOSE OF THE STUDY?

Nurse education is concerned with the preparation of student nurses in order to equip them with the necessary skills, knowledge and appropriate attitudes to provide competent nursing care. However, a lack of skills and knowledge and inappropriate behaviour has often been observed in student nurses. The purpose of this study is to develop guidelines for nurse educators and professional nurses to support the professional socialisation of student nurses.

WHAT WILL BE EXPECTED FROM YOU?

You will have to sign this consent form. After consent you will take part in a focus group interview where you will share your perceptions of your role as a professional nurse in the professional socialisation of student nurses. It will take approximately one and a half hours. The interview will be tape-recorded in order to analyse the data on a later stage. You will be contacted after the transcription to verify the correctness of verbatim transcription.

WHAT ARE THE RISKS INVOLVED IN THIS STUDY? or CAN ANY OF THE STUDY PROCEDURES RESULT IN PERSONAL DISCOMFORT OR INCONVENIENCE?

The study involves no foreseeable physical discomfort or inconvenience. Your time and expertise regarding the subject will be appreciated.

WHAT ARE THE POTENTIAL BENEFITS THAT MAY COME FROM THE STUDY?

Your contribution to the study will help the researcher to develop guidelines for nurse educators and professional nurses to support professional socialisation in student nurses. Furthermore nursing as a profession and patient care may benefit from this study.

WILL YOU RECEIVE ANY FINANCIAL COMPENSATION OR INCENTIVE FOR PARTICIPATING IN THE STUDY?

Unfortunately no financial compensation will be given.

WHAT ARE YOUR RIGHTS AS A PARTICIPANT IN THIS STUDY?

Your participation in this study is totally voluntarily. You have the right to withdraw at any stage without any penalty or future disadvantage whatsoever. You don't even have to provide the reason/s for your decision.

HOW WILL CONFIDENTIALITY AND ANONYMITY BE ENSURED IN THE STUDY?

All information obtained during the course of this study is strictly confidential. The study data will be transcribed and analysed. All information will not be linked to your name. Your identity will not be revealed when the study is reported. After transcription and analysing the data, it will be stored in a secure place.

IS THE RESEARCHER QUALIFIED TO CARRY OUT THE STUDY?

The researcher is a nurse educator closely involved in teaching student nurses and has done previous qualitative research.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

Unisa's Research and Ethics Committee of the Department of Health Studies, [REDACTED] Academic Hospital Management, Gauteng Department of Health and Social Development and the promoters, Profs GH van Rensburg and MJ Oosthuizen from UNISA approved this study and the study procedures. All parts of the study will be conducted according to internationally accepted ethical principles.

WHO CAN YOU CONTACT FOR ADDITIONAL INFORMATION REGARDING THE STUDY?

The researcher, Ms HC de Swardt can be contacted at Tel (012) 382-5034, (012) 9933938 or on her cellular phone at 0725188003.

DECLARATION: CONFLICT OF INTEREST

There is no conflict of interest that may influence the study procedures, data collection, data analysis and publication of results.

DATE AND VENUE

Date: 2 September 2010

Venue: [REDACTED] Academic Hospital, 10th Floor, Seminar room

Time: 12:30

A FINAL WORD

Your co-operation and participation in the study will be greatly appreciated. Please sign the underneath informed consent if you agree to participate.

INFORMED CONSENT

I hereby confirm that I have been adequately informed by the researcher about the nature, conduct, benefits and risks of the study. I have also received, read and understood the above written information. I am aware that the results of the study will be anonymously processed into a research report. I understand that my participation is voluntary and that I may, at any stage, without prejudice, withdraw my consent and participation in the study I had sufficient opportunity to ask questions and of my own free will declare myself prepared to participate in the study.

Research participant's name: _____ (Please print)

Research participant's signature: _____

Date: _____

Researcher's name: Ms HC de Swardt

Researcher's signature: _____

Date: _____

PERSONAL DETAILS - FOCUS GROUP INTERVIEW PROFESSIONAL NURSES

(To confirm the correctness of data obtained during the interview)

Name	
Contact details	
Tel nr (ward)	
Cell number	
Other	
E-mail	
Qualifications	
Years of experience as a professional nurse	
Date	

Thank you for your participation!

Annexure I

Health Studies, Unisa: Research and Ethics Committee
Clearance Certificate

Annexure II

Gauteng Department of Health and Social Development
approval to conduct the research

Annexure III

Academic hospital approval

Annexure IV

Phase I: Approval of nursing education institutions

Annexure V

Letter of consent – students

Annexure VI

Phase I: Letter of consent – professional nurses

Annexure VII

Phase I: Possible probing questions (Sample A)

Annexure VIII

Phase I: Possible probing questions (Sample B)

Annexure IX

Phase I: Initial data analysis

Annexure X

Phase I: Example of analysed transcribed data

Annexure XI

Phase I: Field notes

Annexure XII

Phase II: Approval – Nursing education institutions

Annexure XIII

Phase II: Informed consent – Educators

Annexure XIV

Phase II: Questionnaire

Annexure XV

Phase II: Data of open-ended questions

Annexure XVI

Guideline appraisal: Letter to guideline validators

Annexure XVII

Guideline appraisal: Validation instrument

Annexure XVIII

Letter from statistician

Annexure XIX

Letter from editor

FOCUS GROUP TOP GUIDE FOR SAMPLE A: GUIDELINES FOR PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Time of interview:
Date:
Place:
Facilitator:
Participants: Professional nurses

TOPIC GUIDE / INTERVIEW GUIDE

Can you please describe how you perceive / view your role as a professional nurse in the professional socialisation of student nurses?

Related probing concepts possible probing questions:

- Role model
- Mentor / preceptor
- Learning environment
- Values
- Attitudes
- Knowledge
- Skills (competencies)
- Teaching strategies

**FOCUS GROUP TOP GUIDE FOR SAMPLE B: GUIDELINES FOR PROFESSIONAL
SOCIALISATION OF STUDENT NURSES**

Time of interview:	
Date:	
Place:	
Facilitator:	
Participants: Student nurses	Year :

Broad question

Please share your experiences regarding your professional socialisation as a student nurse?

Possible probing topics

- Role model
- Mentor
- Preceptor
- Skills
- Knowledge
- Values
- Attitudes
- Work load
- Learning environment
- Financial issues
- Personal issues
- Professional nurses
- Nurse educators

**EXPERTS' OPINION ON THE GUIDELINES FOR NURSE EDUCATORS AND
PROFESSIONAL NURSES TO SUPPORT STUDENT NURSES WITH THEIR
PROFESSIONAL SOCIALISATION**

DEMOGRAPHIC DATA

Complete the following information with regard to your own data:

Academic qualifications		
Current occupation	Manager	
	Guideline expert	
	Educator	
	Professional nurse	
	Other (specify)	
Employed by	University	
	College	
	Clinical facility	

Indicate your field/s of expertise or interest from which perspective you would assess the guidelines.

Field of expertise or interest	Expertise / interest	Comments (Optional)
Guideline expert		
Education		
General nursing		

Field of expertise or interest	Expertise / interest	Comments (Optional)
Psychiatry nursing		
Community nursing		
Midwife		
Other (specify - e.g. ethos and professional practice)		

Please disclose any other information regarding your expertise you would consider being important to the researcher.

APPRAISAL FORM: PROPOSED GUIDELINES FOR NURSE EDUCATORS AND PROFESSIONAL NURSES TO SUPPORT STUDENTS WITH THEIR PROFESSIONAL SOCIALISATION

Please rate the proposed guidelines according to the following criteria:

- 1= Not acceptable need major changes**
2= Acceptable with recommended changes
3= Acceptable as described.

Please add any comments if you wish to

Criteria	1	2	3	Comments
Clarity Recommendations provided are concrete and precise with clear descriptions.				
Comprehensiveness Address all aspects of professional socialisation				
Applicability The potential barriers regarding the implementation and cost implications.				
Adaptability Could be applied in different circumstances				
Credibility Guidelines are based on the true findings				
Validity Correct interpretation of the available evidence to support the implementation of the guidelines				

UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
College of Human Sciences

CLEARANCE CERTIFICATE

Date: 17 February 2010 Project No: 3135 840 3

Project Title: **GUIDELINES FOR PROFESSIONAL SOCIALISATION OF STUDENT NURSES**

Researcher: **HC de Swardt**

Supervisor/Promoter: **Prof GH van Rensburg**

Joint Supervisor/Joint Promoter: **Prof MJ Oosthuizen**

Department: **Health Studies**

Degree: **D Litt et Phil**

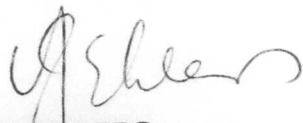
DECISION OF COMMITTEE

Approved

Conditionally Approved

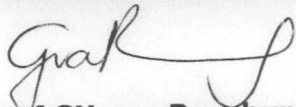
17 February 2010

Date:



Prof VJ EHLERS

MEMBER OF RESEARCH & ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES



Prof GH van Rensburg: Supervisor



Prof MJ Oosthuizen: Joint Supervisor

Female participant: Okay let me say S let me say the majority of the wards are horrible, but there are those, just a drop in the ocean that are enjoyable, D used to work every single day because I enjoyed, sister M made me do what I came there for, I was the sister, she will shout at me, she will call me and reprimand me for not being their supervisor because she said you are a third year and your first years and your auxiliary nurses you're the sister, they didn't do intake and output, you were supposed to go to them and reprimand them, that is why as the in charge I'm reprimanding you. I felt like okay she's giving me an opportunity to do my unit management, I enjoyed it. Some other wards, like they said some days you look at the off duties for tomorrow and then you say sister so and so is coming, tomorrow, in the morning you wake up thinking sister S is there, okay, must I go, my day is going to be horrible and then you go let me just "astray" myself ..(unclear). I remember I had an experience in C with the in charge when I was a first year, it was my first time working in a hospital, but she .., I don't know maybe she never liked me from the first day she saw me because she used to be on my case every single day for whatever. I remember one day we went for tea and yes we were wrong, we took instead of 30 minutes we went for 45 minutes, as a group, I think we were about 4, we were mixed, it was T, X then we went and we came back late 45 minutes later. She called me alone to her office and then the one time I came there at 07:05 and then she called me to her office again and then someone came after me, nothing, it was the same thing every time, she just used to .., when she really needs to do these lousy jobs it was me, even if I'm not working in that room, "G they want a bed pan in the other" I'm like there are students in that room but it was always me. And she's the in charge. So one day I went to her office, I told her sister it's not fair the way you're treating me wara wara, after I said that to her it was worse to a point that I even went to the college and told them the story and then they took me to Ms P they had to change my ward because really I used to cry every day when I went to that ward, eventually I was like, I told my colleagues from X that I'm not going to come this ward anymore, then they advised me to go the college and asked her to change my unit because everyday I used to cry, because really some sisters are just horrible. It was awful in that ward, only me others had fun in that ward, just me. I was like is it because I'm Zulu and the others are Tswana? It's a matter of the environment you're working in therefore you would want to go to work. I remember working in G, I was working in a man's unit, it stinks in there, and it was summer and it was very hot but because of the staff that is in there we would laugh the whole day while doing our job, you would go to work everyday, even though you see horrible things but you would go. I mean in C

Comment [RdS1]: [Fact sup / un supp environment]- [Fact know + pract] - [Learn opp / prac exp]

Comment [RdS 2]: [Att] - [Absenteeism]

Comment [RdS3]: [Att] - [Relat]

Comment [RdS4]: [Att] - [Relat]

Comment [RdS 5]: [Val] - [Cul val] - [Language]

there's nothing horrible there it's a gynae ward but it is bad, so really the attitude of the staff, even the auxiliary nurses sometimes can become silly, they become sisters in the ward, they boss you around like nobody's business especially at S.

Comment [RdS 6]: [Att]- [Att md team]

Female participant: You know I have a problem with respect you know in hospital they take you as a student not as a human being, you are just a student nothing else because sometimes you find that some things really, I am a human being, some things happen to me, I also can be stuck in traffic as much as the staff can be stuck in traffic, I also can have a death in the family. Remember I was working in labour ward and we had a funeral at home, so the off duties were already made so I was asking the sister in charge for her to change my off duties, it was a problem, I explained to her that I have a funeral at home and I have to be there, I can't go to work while other people are from my home going to the funeral. I tried to tell her to change my off duties, she was like "you know students from X I know them, you know you will always have stories", I know that students will always have stories, I know that students will always have stories but you know try to accommodate their problems, we all have problems, we are all human beings, we're all from families like they are. So the sisters don't accommodate us and they don't treat us as human beings, we just students.

Comment [RdS7]: [Val]- [Eth val]- [Respect]

Comment [RdS 8]: [Att]- [Percept diff NEI's SN's]

Comment [RdS 9]: [Val]- [Eth val]- [Respect]

Researcher: So it seems to me there's a lack of communication, understanding and respect between the students and the sisters. T you were so very quiet. What is your view on this topic?

Female participant: I think also the sisters, they forget that very soon we going to be their colleagues as well, we going to be working together so why not start now, the base now, start now to work together and understand each other because now the sisters when we do favours for the sisters because there are other sisters, they don't do anything for the students because you're just a student, you're just there to fill in the position to do the bed pans, to do all the staff that is done by the first years I can say, next year probably we will be part of them, you will be part of the team with them but they don't want to start now to involve us in everything that they do.

Comment [RdS10]: [Fact sup / un_supp environment] - [Ward mang] - [Ward mang]

Researcher: It's more or less what R was saying, ja.

Participant: I want to talk about the attitude of the sisters towards us, I think the negative by the sisters mostly affects females, I don't know why but it affects females a lot because I think, I think maybe they are maybe scared of us or something because if I come late ..., maybe it's because we males come prepared that is why I think we come prepared for them, they don't usually shout at us but they shout at females on daily basis.

Comment [RdS11]: [Val] - [Cul val] - [Gender]

Researcher: So you experience there's a difference in the way they treat males students than female students?

Male participant: Ja

Comment [RdS 12]: [Val] - [Cul val] - [Gender]

Researcher: Have you also experienced that M?

Male participant: Ja I do as well.

Comment [RdS 13]: [Val] - [Cul val] - [Gender]

Female participant: I think it's just female/female relationships honestly because even if it was a male sister he wouldn't shout at you if you are a woman, they don't, but if it's a female sister and you are girl, boy you really in for it. I think it's just female/female relationships, I don't know why but it's like that, I think almost everywhere you get that. And another problem with the sisters is reprimanding you in front of the patients, like you are totally stupid and the patients put their trust in you, the next time you go to the patient you yourself are not even confident because you're thinking she's thinking this one doesn't even know how to take my BP, it is really difficult. I once had a fight, I shouldn't have. I once had a fight with a sister because she reprimanded me in front of the patient and she was really harsh and she was very loud and the patient was just like ..., and it really hurt me because I'm thinking the patient will lose faith in me, she will lose trust in me, I loose confidence as well and that makes it difficult for patient care.

Comment [RdS 14]: [Att] - [Relat]

Comment [RdS15]: [Val]- [Eth val]- [Respect]

Comment [RdS16]: [Val]- [Eth val]- [Respect]

Researcher: Have you also experienced the same, anything else that you would like to share as students that you had during these past three years of professional socialisation? A?

Female participant: I'd like to say something that is very negative. When I started nursing, I started four years ago with like .., I loved it, I really loved it, I think I worked

with L when she was still at T, I was with her. I enjoyed every minute of it and we used to do 40 hours and sometimes 42 hours, I never bunked not even one day. When I came to this part of nursing, I hated .., I'm sorry to say that, I come to work not because I hate giving patient care, I hate coming to work because of the units that I work in. There are certain units C, oncology, I love it, I never thought I would love it because I hate ..(unclear), I thought I would hate it because of what, when you are alone and you don't have anybody to talk to "see I don't like that sister, she treated me or", but now I've made friends and whatever, it depends on which unit you're in, but half the time you find that the units that you are in are very horrible and nasty hence you hate it, hence you have any excuse, I have an excuse to bunk but usually I don't have the courage to stay home I just have to drive myself and come to work, not because I want to because I have to and that is not good especially if you are in this profession. If you are in this profession you need to have that open mind because at the end of the day its not about the sister, its about the patients, but usually when we come to work its about the staff for us, that's how I felt. Its about this type of thing, "sister M" (speaking very low and all of them laughing) you know and that is how I feel and that is how I feel because so many times in C from last year, she has chased me, she chased us from the unit, we never worked from 8 in the morning until 10:00 until the matron downstairs had to sort out the problem, even when we went back, chose orientating us, there's the slouch, there's the what etc., and when you have to go to her she just gives you this attitude that you really, you know you even look at yourself and say am I really worth that much and you hate it, I hate it.

Comment [RdS 17]: [Array emo]-
[Discontent]

Comment [RdS 18]: [Fact sup /
unsupp environment]

[Att]- [Absenteeism]

Comment [RdS19]: [Att] -[Att PN/SN]

AN EXAMPLE OF FIELD NOTES

Field notes

Date: 26/11/2010

Focus group interviewed: Second years

Participants: 10 students

Venue: Seminar room, XXX Academic Hospital

1 Background information

The researcher arrived about 08:00 at the hospital. After the unit manager of the unit where the participants were placed for their clinical learning experiences were approached, the time and venue were confirmed. As with previous focus group interviews some participants were not available and new participants had to be recruited despite that the participants were phone the previous day to finalise the arrangements. The recruitment took the researcher about 2 hours. The researcher went to the venue to prepare the venue. Picture 1 displays the venue used

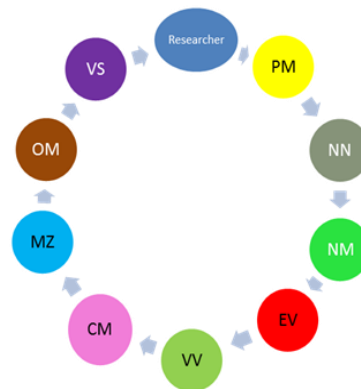


Figure 1: Venue during the focus group interview and seating order

The participants arrived about 11.45. Refreshments were served and the participants were introduced. After they were more relaxed the researcher asked them to take their seats and the order of the seating arrangement as indicated in Figure 1 was noted. The question of how do they experienced their professional socialisation as a member of the nursing profession was then introduced. The participants did not hesitate and were very eager to share their thoughts. This group particularly were very eager to share their thoughts, even after the interview was terminated, some still wanted to share experiences. The interview lasted for an hour and 35 minutes.

2 Personal notes

One male and one female participant were very vocal, had strong views and did not hesitate to express their opinions. Some participants were initially very reserved but as the discussion developed all participated. There were good interactions between all the

participants and at some point they even disagree with some statements. Two participants had previously studied other courses. They seemed more confident in what they want and were more outspoken on this issue.

Although the venue was initially very quiet, some building activities started during the discussion which was at some stage disturbing. Except for this incident the venue was suitable and quiet. I was amazed with the confidence some of these students could express themselves.

3 Methodology

During the interview, I tried as much as possible to listen to the conversations keeping limited notes and guided the discussion when indicated. Most of the notes were taken directly after the interview as it were challenging to listen and take notes at the same time. During the discussion the researcher tried to keep eye contact to allow free flowing of the conversations.



We empower people

FACULTY OF SCIENCE

Ms HC de Swardt

10 August 2010

745 Bates Street

Moreleta Park

Pretoria

0181

Permission to approach students from the Adelaide Tambo School of Nursing Science

The Adelaide Tambo School of Nursing Science hereby grant you permission to approach the undergraduate BTech Nursing Science students to participate in your study. The students themselves also need to give consent before participating.

Yours sincerely

Prof SCD Wright

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UNIVERSITY
YUNIBESITHI

Denkleiers • Leading Minds • Dikgopolo tša Dihlalefi

Navrae / Enquiries:

☎ : (012) 354-2125

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✉ : nursing@medic

Private Bag X323 ARCADIA 0007 Pretoria – Republic of South Africa
Web: <https://> Tel: (012) 354-2125 Fax: (012) 354-1490

4 May 2012

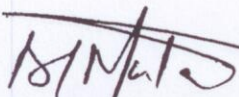
Mrs R de Swardt
Tshwane University of Technology
Private Bag x 680
Pretoria 0001

Dear Mrs de Swardt

STUDY: PROFESSIONAL SOCIALIZATION

I hereby wish to grant you permission to continue with the second phase of your study.

Kind regards



Prof FM Mulaudzi

Head: Department of Nursing Science

TABLE 1: DESCRIPTION OF THE CONCEPT PROFESSIONAL SOCIALISATION (ITEM 7; N=110)

Categories on the concept professional socialisation	Frequency	% Responses
Introduction into the nursing profession	38	34.5
Acquiring the skills, knowledge, values and attitudes of the nursing profession	25	22.7
Teaching professional conduct of the nursing profession	22	20.0
Learn the norms and values (to socialise of the workplace)	13	11.8
Being a role model	11	10.0
Teaching ethics	7	6.4
Teaching the skills and knowledge	3	2.7
Learning the professional activities	1	0.9
Assertiveness in the professional community	1	0.9
Participation in a of higher education system	1	0.9
Frequency missing		18

TABLE 2: EXPLANATION OF HOW TEACHING AND FACILITATION OF PROFESSIONAL SOCIALISATION WERE ACCOMPLISHED (ITEM 8; N=115)

Categories	Frequency	% Responses
Role modelling	62	53.9
Guide students about professional conduct e.g. teaching ethics	47	40.9
Utilise different teaching strategies	19	16.5
Linking theory with practice	16	13.9
Mentoring and be available for consultation	7	6.1
Making students aware of their roles and responsibilities	5	4.3
Use case studies [scenarios] or discussions	3	2.6
Teach cultural sensitivity	3	2.6
Workshops or outings in restaurants	3	2.6
Frequency missing		8

TABLE 3: ACCOMMODATION OF STUDENT'S INDIVIDUAL LEARNING ORIENTATIONS (ITEM 43; N=109)

Categories	Frequency	% Responses
Through support and mentoring of students	52	48.1
Different teaching / assessment methods	34	31.5
Allow students to express themselves during discussions	18	16.5
Determine different learning styles and brain orientation	11	10.2
Relate teaching to the practical field	5	4.6
Large classes consist of students with different backgrounds which are taken into consideration	5	4.6
Do not take it into account	1	0.9
Frequency missing		19

TABLE 4: ACCOMMODATION OF STUDENTS' TEST AND ASSIGNMENTS (ITEM 45; N=117)

Categories	Frequency	% Responses
Planned beforehand	61	51.8
Support e.g. self-study time, test only content taught, revision	29	24.8
Block system which has prescribed schedules	23	19.7
Involve / negotiate with students	9	7.7
Only when student is sick / for other reasons that student could not write a test or do an assignment	3	2.6
Not always possible, e. g. curriculum overload	3	2.6
No control when placed in the clinical area	1	0.9
Frequency missing		11

TABLE 5: STRATEGIES TO ENHANCE THEORY-PRACTICE INTEGRATION (ITEM 46; N=121)

Categories	Frequency	% Responses
Clinical accompaniment	42	35.0
Using different teaching strategies e.g. case studies, application of practice during lectures	32	26.7
First teach the theory and then apply practice	28	23.3
Discussions and explain by using examples	26	21.7
Simulation / specific lectures for clinical	10	8.3
Theory and practical assessments	7	5.8
Pre knowledge testing	4	3.3
Using the same book in theory as practice	2	1.7
Reflective teaching	2	1.7
Use evidence based practice	1	0.8
Frequency missing		7

TABLE 6: REASONS PROVIDED FOR CLINICAL PLACEMENT VERSUS LEARNING OBJECTIVES (ITEM 53; N=102)

Categories	Frequency	% Responses
Work according to SANC requirements	60	58.8
Due to large numbers of students, placement is compromised (only met the minimum requirements)	11	10.8
Hours unevenly distributed	9	8.8
Hours and objective is equality important / skills done before practice	6	5.9
Need more clinical exposure	4	3.9
Not completing nursing objectives	4	3.9
Answer does not correlate with question	4	3.9
Prescribed hours not completed	3	2.9
Programme too overloaded	2	2.0
Coordinated by programme manager, therefore has no knowledge thereof	2	2.0
Frequency missing		26

TABLE 7: REASONS FOR MISCOMMUNICATION WITHIN CLINICAL AREA AND BETWEEN NURSING EDUCATION INSTITUTIONS (ITEM 56; N=111)

Categories	Frequency	% Responses
Clinical facilities not aware of placements due to various reasons such as new staff, admin staff not giving allocation)	47	42.3
New information not communicated (absenteeism, changes in allocation)	27	30.0
Another person responsible for hours allocation / no experience	13	11.7
Good communication	9	8.1
Inability to place students due to lack overcrowded facilities	5	4.5
Collaboration meetings no held or attend	4	3.6
Student provide incorrect information to clinical staff	1	0.9
Frequency missing		17

TABLE 8: EXAMPLE STUDENT PREPARATION FOR FIRST CLINICAL EXPOSURE (ITEM 68; N=112)

Categories	Frequency	% Responses
Simulation	66	58.9
Orientation	42	37.5
Provide theory, followed by simulation	15	11.4
Discussions and debriefing before clinical visits	14	12.5
During clinical accompaniment	13	11.6
Provide study materials and work books	4	3.6
Case studies, role play and videos	5	4.5
Not much / not all student are prepared - they are shocked	2	1.8
Through peer review	1	0.9
Not responsible for clinical support	1	0.9
Frequency missing		16

TABLE 9: EXAMPLES OF REPORTED THEORY-PRACTICE DISCREPANCIES (ITEM 71; N=102)

Categories	Frequency	% Responses
Ward staff does procedures different compare to as taught to students (take short cuts)	49	48.0
Equipment is different or lack	20	19.6
The practical environment does not allow the ideal nursing interventions as taught in theory	15	14.7
New interventions such as evidence based practice not applied in the clinical environment	7	6.9
Student placement not according to objectives	3	2.9
Students see poor role models due to low morale and violation of patient's rights	3	2.9
Ward staff see the discrepancies not the educators	2	2.0
Delayed implementation of theoretical content due to block system	1	1.0
Clinical staff not knowledgeable	1	1.0
Not aware of any	1	1.0
Frequency missing		26

TABLE 10: JUSTIFICATION OF STUDENT NURSES BEHAVIOUR (ITEM 74; N=111)

Categories	Frequency	% Responses
Majority adhere to rules when progressing to higher levels	42	37.8
Absenteeism from practice and class	20	18.0
Unpunctuality and poor time management / not prepared for class	20	18.0
Inappropriate professional conduct (dress code, inconsiderate behaviour)	15	13.5
Demonstrate inconsiderate / disrespectful behaviour	10	9.0
Students are more disciplined in a military setting	6	5.4
Follow nursing as a career due to financial reasons	5	4.8
Aggressive / rebellious behaviour / depends on year level	3	2.7
Not sure	2	1.8
Challenge due to large number of students	2	1.8
Substance abuse	1	0.9
Have rights as employee	1	0.9
Frequency missing		17

TABLE 11: JUSTIFICATION OF STUDENT'S ATTITUDE TOWARDS NURSING (ITEM 76; N=113)

Categories	Frequency	% Responses
Most are hardworking / positive behaviour / pass tests	30	26.5
Some are positive	23	20.4
Only there to receive a salary	20	17.7
Irresponsible behaviour and not interested in nursing	16	14.2
Few students are positive	11	9.7
Demotivated by role models	7	6.2
3-4th Year level is more responsible	5	4.4
Already have qualified in another field when entering into the nursing field	2	1.8
They are taught to be respectful	1	0.9
Respondents		15

TABLE 12: EXAMPLES OF CULTURAL CONFLICT (ITEM 78; N=78)

Categories	Frequency	% Responses
Rare / not easily picked up	27	34.0
Challenge to teach different cultures	17	21.8
Tribalism / undermining other cultures / victimisation	12	15.4
Racism	6	7.7
Language differences, educator teach in another language than the official language	6	7.7
Experience religion and gender differences	3	3.8
Tends to group formation	2	2.6
Problems are addressed according to cultural orientation	1	1.3
Frequency missing		50

TABLE 13: MOTIVATION OF SELF-CONCEPT OF STUDENT NURSES (ITEM 84; N=100)

Categories	Frequency	% Responses
Well groomed and confident especially towards their 4th year	53	53.0
No pride and negative self-image (They have emotional baggage)	34	34.0
Some students have a negative self-image / regret that followed nursing as a career	9	9.0
Could express their personal views without fear however have poor academic performance	5	5.0
Work in an environment that does not support personal growth	3	3.0
Experience humiliation by other professions and are compared with other professions	3	3.0
Males struggle with their sexual orientation	1	1.0
Depends on the success experienced in the tertiary environment	1	1.0
Frequency missing		18

TABLE 14: ADDRESSING UNETHICAL BEHAVIOUR IN THE CLINICAL FIELD (ITEM 85; N=117)

Categories	Frequency	% Response
Discussed with the involved parties	44	37.6
Disciplinary measures or protocol are followed	36	30.8
Report the problem	24	20.5
Class discussion on the correct behaviour	14	12.0
Have collaboration meetings	6	5.1
No experienced of such problems	4	3.4
Frequency missing		11

**INFORMATION LEAFLET AND INFORMED CONSENT
NURSE EDUCATORS INVOLVED IN THE FOUR-YEAR INTEGRATED NURSING
PROGRAMME**

GUIDELINES FOR PROFESSIONAL SOCIALISATION OF STUDENT NURSES

Primary researcher: Mrs HC de Swardt
Promoter: Prof GH van Rensburg (UNISA)
Joint promoter: Prof MJ Oosthuizen (UNISA)

Dear respondent,

You are invited to participate in a research study that forms part of a doctoral study. This information leaflet contains information about the purpose of the study and about your rights and responsibilities regarding the study. Please familiarise yourself with the purpose of the study before you agree to participate.

WHAT IS THE PURPOSE OF THE STUDY?

The researcher is closely involved in teaching student nurses who are registered for the four-year integrated nursing programme and is concerned about the professional socialisation of student nurses. The reason for this study is to develop guidelines that will assist nurse educators and professional nurses to support the professional socialisation of student nurses.

WHAT WILL BE EXPECTED FROM YOU?

Before you participate in the study, you need to understand what the study is all about and give permission to participate. You need to sign this consent as well as to complete an anonymous questionnaire regarding your role as nurse educator in the professional socialisation of student nurses. It will take approximately **30** minutes to complete the questionnaire.

WHAT ARE THE RISKS INVOLVED IN THIS STUDY? or CAN ANY OF THE STUDY PROCEDURES RESULT IN PERSONAL DISCOMFORT OR INCONVENIENCE?

The study involves no foreseeable physical and psychological discomfort or inconvenience. However I realise that you are busy therefore appreciate your time and expertise regarding the subject.

WHAT ARE THE POTENTIAL BENEFITS THAT MAY COME FROM THE STUDY?

The benefits of participating in this study are:

- You will assist the researcher to understand professional socialisation of student nurses from the perspective of nurse educators.
- You will contribute to the development of guidelines for professional socialisation of student nurses that might help you in future.
- Your contribution to the study may help to support professional socialisation of student nurses and consequently the nursing profession.

WILL YOU RECEIVE ANY FINANCIAL COMPENSATION OR INCENTIVE FOR PARTICIPATING IN THE STUDY?

Unfortunately **no financial compensation** will be given.

WHAT ARE YOUR RIGHTS AS A PARTICIPANT IN THIS STUDY?

Your participation in this study is totally voluntarily. You have the right to withdraw at any stage without any penalty or future disadvantage whatsoever. You do not have to provide the reason/s for your decision to withdraw.

HOW WILL CONFIDENTIALITY AND ANONYMITY BE ENSURED IN THE STUDY?

All information obtained during the course of this study is strictly confidential. None of the information will be linked to your name. Your identity will not be revealed while the study is being conducted or when the study is reported in scientific journals. All the data information that has been collected will be stored in a secure place after analysing the data.

IS THE RESEARCHER QUALIFIED TO CARRY OUT THE STUDY?

The researcher is a nurse educator and professional nurse that is closely involved in teaching student nurses.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The Research and Ethics Committee of the Department of Health Studies at Unisia approved the study proposal. In addition the Gauteng Department of Health and Social Development gave

approval for the study. All parts of the study will be conducted according to internationally accepted ethical principles.

WHO CAN YOU CONTACT FOR ADDITIONAL INFORMATION REGARDING THE STUDY?

The researcher, Mrs HC de Swardt can be contacted during office hours at Tel (012) 9933983, or on her cellular phone at 0725188003 or at deswardtr@tut.ac.za. The promoters, Proff GH van Rensburg and MJ Oosthuizen and can be contacted during office hours at Tel (012) 429 5614.or (012) 429 6719

DECLARATION: CONFLICT OF INTEREST

There is no conflict of interest that may influence the study procedures, data collection, data analysis and publication of results.

INFORMED CONSENT

I hereby confirm that I have been adequately informed by the researcher about the nature, conduct, benefits and risks of the study. I have also received, read and understood the above written information. I am aware that the results of the study will be anonymously processed into a research report. I understand that my participation is voluntary and that I may, at any stage, without prejudice, withdraw my consent and participation in the study. I had sufficient opportunity to ask questions and of my own free will declare myself prepared to participate in the study.

Research respondent's signature: _____

Date: _____

Researcher's name: Ms HC de Swardt

Researcher's signature:

Date:

Preliminary analysis of sample A (Professional nurses)

Major topic	Unique topics	Left overs
<p>Factors related to knowledge and practica [FAC KNOWL & PRAC]</p> <ul style="list-style-type: none"> • Learning opportunities (Doc 2) • Level of knowledge (Doc 1), (Doc 2) • Theory practice integration (Doc 1), (Doc 2) • Increased practical hours (Doc 1) • Teaching students (Doc 1), (Doc 2) • Lack of knowledge professional nurses (Doc 2) • Clinical supervision (Doc 1), (Doc 2) 	<ul style="list-style-type: none"> • Retired nurses in practice (Doc 2) • Assessment of student nurses (Doc 1) • The availability of different career paths (Doc 2) • No referencing system related to medication (Doc 1), (Doc 2) • Force to work without scope of practice (Doc 1) • Generation gap (Doc 2) • Equipment in the ward – managing (Doc 1), (Doc 2) • Gender (Doc 2) 	<ul style="list-style-type: none"> • Attitude towards research (Doc 2)
<p>Emotions experienced [EMO]</p> <ul style="list-style-type: none"> • Frustration/ discouragement (Doc 2) • Emotional maturity (Doc 1) • Suppress emotions (Doc 1) • Dealing with emotional issues (Doc 1), (Doc 2) • Rejection (Doc 2) 		
<p>Ethical values [ETH VAL]</p> <ul style="list-style-type: none"> • Caring / Uncaring behaviour (Doc 1), (Doc 2) • Work for money (Doc 2) • Role model good/poor (Doc 1), (Doc 2) • Personal background / values problems (Doc 1), (Doc 2) • Image of a professional / student nurse (Doc 1) • Respect (Doc 1), (Doc 2) • Ethical / professional behaviours (Doc 1), (Doc 2) • Work ethics (Doc 1), (Doc 2) • Minimum standards (Doc 1) • Dress code (Doc 1). (Doc 2) 		
<p>Factors related to the ward environment [FAC WARD ENV]</p> <ul style="list-style-type: none"> • Student / professional nurse responsibility (Doc 1), (Doc 2) • Supportive / Unsupportive environment (Doc 1) • Orientation (Doc 1), (Doc 2) 		

Preliminary analysis of sample A (Professional nurses)		
Major topic	Unique topics	Left overs
<ul style="list-style-type: none"> • Different nursing education institutions (Doc 2) • Teaching the student nurse (Doc 1), (Doc 2) • Communication (Doc 1), (Doc 2) • Workload (Doc 1), (Doc 2) • Teamwork / involvement (Doc 1), (Doc 2) • Resources (Doc 1) • Off duties (Doc 2) 		
<p><i>Factors related to student support [FAC SS]</i></p> <ul style="list-style-type: none"> • Coaching (Doc 1), (Doc 2) • Corrective interventions (Doc 2) • Collaboration between NEI and hospital (Doc 2) • Mentor (Doc 1), (Doc 2) • Clinical accompaniment (Doc 1), (Doc 2) • Acknowledgment (Doc 1) 		
<p><i>Attitudes of student nurse [ATT SN]</i></p> <ul style="list-style-type: none"> • (Doc 2)Attitudes professional nurse [ATT PN] • Negative perceptions of student nurses - delinquent, hatred (Doc 2) • Bad (negative) / good attitude (Doc 2) • Attitude towards students from different institutions (Doc 2) • Relationships (Doc 1), (Doc 2) • Approachable (Doc 2) 		
<p><i>Factors related to the nursing profession [FAC NP]</i></p> <ul style="list-style-type: none"> • Career choice (Passion/calling) (Doc 1), (Doc 2) • Perceptions of the nursing profession (Doc 1) • Student selection (Doc 2) • Role model (Doc 1), (Doc 2) 		



FAX: 011 726 2619

Private Bag 40

TEL (011) 644-8900

01. 06.2011

ENQUIRIES

Ms. N. NTSELE

Tel. (011) 644 8903

nompie.ntsele @gauteng.gov.za

RE- PERMISSION TO CONDUCT A RESEARCH PROJECT AT [REDACTED] NURSING COLLEGE

**RESEARCH TOPIC: GUIDELINES FOR PROFESSIONAL SOCIALIZATION OF
STUDENT NURSES**

Thank you for submitting the research proposal to the research committee.

The committee has approved the proposal without reservations. However, the following conditions for approval apply:

- You will be expected to present the research project in two (2) stages during the college's research days i.e. the research proposal, research findings and the recommendations
- You are also required to donate a copy of the completed research project to Ann Latsky Nursing College Library
- Inform the research committee about the research journal where the research project will be published.

Kind Regard

Nompi Ntsele (Chairperson – Research Committee)





UNIVERSITY OF [REDACTED]
Campus



Nursing Science Department
Box 142 [REDACTED]
TEL NO.: (012) 521-4664/4305
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E-MAIL: Joyce.Mokoena@ul.ac.za
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0204
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[REDACTED]
Tel: 012 - 521 4000
Fax: 012 - 560 0086

Mrs H.C. de Swart
Tshwane University of Technology
PRETORIA
0001

Dear Mrs de Swart

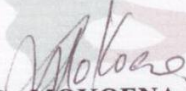
**RE: PERMISSION TO CONDUCT A RESEARCH STUDY ON: GUIDELINES
FOR PROFESSIONAL SOCIALISATION OF STUDENT NURSES**

Thank you for considering to involve the staff of our department in your research project. The title of your study is of special interest to us as a nursing department engaged with the undergraduate student nurses in the B. Cur programme.

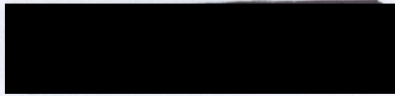
It is our pleasure to give you permission to conduct your data collection with us. We trust that you will be so kind as to share with us your findings at a later stage.

Thanking you in advance.

Sincerely


J.D. MOKOENA (DR)
SENIOR LECTURER : ACTING HEAD OF DEPARTMENT
NURSING SCIENCE

May 10, 2012



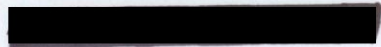
Research Ethics Committee

The TUT Research Ethics Committee is a registered Institutional Review Board (IRB 00005968) with the US Office for Human Research Protections (IORG# 0004997) (Expires 19 Jan 2014). Also, it has Federal Wide Assurance for the Protection of Human Subjects for International Institutions (FWA 00011501) (Expires 31 Jan 2014). In South Africa it is registered with the National Health Research Ethics Council (REC-160509-21).

June 4, 2012

Ref #: REC2012/05/006Q(2)
Name: De Swardt HC
Student #: UNISA

Ms HC de Swardt



Faculty of Science

Dear Ms de Swardt,

Decision: Final approval

Name: Ms HC de Swardt



Proposal title: Guidelines for professional socialisation of student nurses

Qualification: Doctoral study in Health Studies at UNISA

The REC has perused your response letter dated May 19, 2012 to the [REDACTED] REC regarding our recommendations in respect of your application for permission to distribute a questionnaire amongst TUT staff members. The applicant has adequately addressed the REC's recommendations and requirements.

Note that the REC's suggested changes to questionnaires items are hereby waived due to project-specific practical considerations despite the items' inherent shortcomings as indicated in the formal [REDACTED] REC letter dated May 18, 2012.

The study is **approved**.

The proposed research project may now continue with the proviso that:

- 1) The researcher/s will conduct the study according to the procedures and methods indicated in the approved proposal, particularly in terms of any undertakings and/or assurances made regarding informed consent and the confidentiality of the collected data.



We empower people

Tel. 0861 102 422, Tel. (012) 382-5154, Fax (012) 382-4409, [REDACTED] The Registrar, Private Bag X680, Pretoria 0001

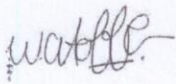
2) The proposal (inclusive of the applicable information leaflet/s, informed consent document/s, interview guide/s and/or questionnaire/s) will again be submitted to the Committee for prospective ethical clearance if there are any substantial changes from the existing proposal, particularly if those changes affect any of the study-related risks for the research participants.

3) The researcher will act within the parameters of any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.

Note:

The reference number [top right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants

Yours sincerely,



WA HOFFMANN (Dr)

Chairperson: Research Ethics Committee

[Ref#: REC2012=05=006Q=DeSwardtHC(2)]



We empower people

Tel. 0861 102 422, Tel. (012) 382-5154, Fax (012) 382-4409, www. [redacted] The Registrar, Private Bag X680, Pretoria 0001

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Navrae / Enquiries:

☎ : (012) 354-2125

☎ : (012) 354-1490

✉ : nursing@medic

Private Bag X323 ARCADIA 0007 Pretoria – Republic of South Africa
Web: <https://> Tel: (012) 354-2125 Fax: (012) 354-1490

4 May 2012

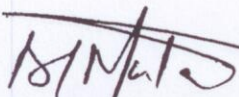
Mrs R de Swardt
Tshwane University of Technology
Private Bag x 680
Pretoria 0001

Dear Mrs de Swardt

STUDY: PROFESSIONAL SOCIALIZATION

I hereby wish to grant you permission to continue with the second phase of your study.

Kind regards



Prof FM Mulaudzi

Head: Department of Nursing Science



GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA



[REDACTED] NURSING COLLEGE

Private Bag X 05 Tel: (011) 983-3000
Bertsham Fax: (011) 983-3091
2013

From: Mrs S Peters

Principal: [REDACTED]

Private Bag X 05

BERTSHAM

2013

For Attention: Ms Rina de Swardt

Lecturer: Adelaide Tambo School of Nursing Science

Tshwane University of Technology

Private Bag X680

PRETORIA

0001

Fax: +27 (0) 0865554974

E-mail: deswardtr@tut.ac.za

**SUBJECT: PERMISSION TO CONDUCT RESEARCH AT [REDACTED]
[REDACTED] COLLEGE**

Correspondence dated 17/04/2012 is hereby acknowledged.

Permission is hereby granted to conduct research at the institution. The date for you to see the lectures/tutors will be on the 18th May 2012, Friday at 10h30.

I wish you success with your studies.

Kind regards,

Mrs S Peters

(College Principal)

cc: Chairperson: Research Committee

10/05/12.



UNIVERSITY
[REDACTED]

FACULTY OF HEALTH SCIENCES
ACADEMIC ETHICS COMMITTEE

AEC24-01-2012
25 May 2012

TO WHOM IT MAY CONCERN:

STUDENT: DE SWARDT, HC
STUDENT NUMBER: -

TITLE OF RESEARCH PROJECT: Guidelines for professional socialization of student nurses

DEPARTMENT OR PROGRAMME: Nursing

SUPERVISOR: Prof GH van Rensburg UNISA CO-SUPERVISOR: Prof M Oosthuizen UNISA

The Faculty Academic Ethics Committee has scrutinised your research proposal and confirm that it complies with the approved ethical standards of the Faculty of Health Sciences; University of [REDACTED]

The AEC would like to extend their best wishes to you with your postgraduate studies.

Yours sincerely,

Dr R Razlog (Acting)

Chair : Faculty of Health Sciences AEC

Nursing Education

School of Therapeutic Sciences – Faculty of Health Sciences – 7 York Road, Parktown 2193,
Tel: + 27 11 4884272 – Fax: + 27 11 4884195 – Email: Patricia.Apfel@wits.ac.za
Website: www. [REDACTED]



Mrs. HC de Swardt
UNISA
Department of Health Studies
P O Box 392
Pretoria
0003

14 May 2012

DOCTORAL STUDENT: HC De SWARDT DATA COLLECTION

Permission is hereby granted for the abovementioned candidate to collect data in the Department of Nursing Education, School of Therapeutic Sciences, Faculty of Health Sciences.

Yours sincerely

A handwritten signature in cursive script that reads 'JE Maree'.

Professor JE MAREE (LIZE)
Head: Department of Nursing Education

RESTRICTED

1MH/302/6

Tel: 012 314 0487
Facsimile: 012 314 0623
Enquiries: Prof / Lt Col
M.K. Baker



██████████
Private Bag X1026
Thaba Tshwane
0143
22 June 2011

**CLINICAL TRIAL APPROVAL: “GUIDELINES FOR PROFESSIONAL
SOCIALISATION OF STUDENT NURSES”**

1. The ██████████ Research Ethics Committee (1MHREC), adhering to GCP/ICH and SA Clinical Trial guidelines, evaluated the above-mentioned protocol and additional documents.
2. The following members approved the study:
 - a. Lt Col M.K. Baker: Neurologist, male, chairman 1 MHREC.
 - b. Lt Col C.S.J. Duvenage: Specialist physician, female, member 1 MHREC.
 - c. Lt Col L.M. Hofmeyr: Otorhinolaryngologist, male, member 1 MHREC.
 - d. Lt Col D. Mahapa: Dermatologist, female, member 1 MHREC.
 - e. Lt Col A.D. Moselane: Urologist, male, member 1 MHREC.
 - f. Lt Col E.J. Venter: Periodontist, male, member 1 MHREC.
 - g. Lt Col T. Deo: Gynecologist, female, member 1 MHREC.
 - h. DR T.J. Marè: Advocate, independent of the organization, male, member 1 MHREC.
 - i. Mrs. C. Jackson: Layperson, independent of the organization, female, member 1 MHREC.
3. The following documents were evaluated:
 - a. Study protocol dated 13 February 2011: “Guidelines for professional socialisation of student nurses”
 - b. Letter “Request for permission to conduct a research study at the SAMHS Nursing College” dated 02 May 2012
 - c. Information Leaflet and informed consent
 - d. Questionnaire
 - e. Curriculum Vitae Mrs. H.C. de Swart
4. The recommendations are: The study was approved on 22 June 2012. The principal investigator Mrs. H.C. de Swart will be supervised by Prof G.H. van Rensburg. Report backs are to be made to the 1MHREC six monthly, in the event of any serious adverse events or termination of the study. A copy of the completed thesis should be submitted on completion.

A handwritten signature in black ink, appearing to read 'M.K. Baker'.

(M.K BAKER)

**CHAIRMAN ██████████ RESEARCH ETHICS COMMITTEE:
LT COL / PROF**

Rina de Swardt

From: Maureen Venter [Maureen.Venter@[REDACTED]]
Sent: 24 May 2010 08:47 AM
To: Rina de Swardt
Subject: Application to conduct focus group Interview with the 4th year [REDACTED] student

We acknowledge receipt of your ethical approval documents from your University and the Informed consent from that will be completed by the student.

We hereby give your permission to conduct research and we will appreciate it if you can provide us with the report once your research has been completed.

Kind regards

Prof FM Mulaudzi

Mrs Maureen Venter
Secretary: Department of Nursing Science
Tel (012) 354-2125
Fax (012) 354-1490
E-Mail [nursing@medic.\[REDACTED\].ac.za](mailto:nursing@medic.[REDACTED].ac.za)

GDHSD RESEARCH PROPOSAL EVALUATION FORM

(UNDER AND POST GRADUATE RESEARCH PROPOSALS)

For approval by Director: Policy, Planning and Research



GAUTENG DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT (GDHSD)

Vision of the Department

“To be the best provider of quality health and social services to the people in Gauteng”

POLICY, PLANNING AND RESEARCH (PPR) DIRECTORATE

Enquiries: Sue le Roux or Siviwe Mkoka

Tel: +2711 355 3212/3249

Fax: +2711 355 3675

Email: Sue.LeRoux@gauteng.gov.za / Siviwe.mkoka@gauteng.gov.za

SECTION A

Researcher/ Investigators Name	Principal	Hester Cathrina de Swardt
Physical Address		745, Bates Street, Moreletapark, 0181
Postal Address		745, Bates Street, Moreletapark, 0181
Telephone Contacts		+2712 993 3938 (Home), +2712 382 5034 (Work), +2772 518 8003 (Mobile)
Email Address		deswardtr@tut.ac.za / rina.deswardt@gmail.com
Institution		University of South Africa
Research Topic		Guidelines For Professional Socialisation Of Student Nurses
Date Received by the Directorate	PPR	03 May 2010
Date Received Reviewer		03 May 2010
Final Review Date		04 May 2010
Date Submitted to Director	PPR	04 May 2010
Research Site(s)		1 Hospital in Gauteng (Steve Biko Pretoria Academic Hospital) and; 7 Nursing Educational Institutions within Gauteng.
Type of research		Exploratory Sequential Mixed Method Study: Qualitative (Focus groups in Hospital and focus groups with students in colleges) and Quantitative (Questionnaire Interviews with educators)
Supervisor		Prof GH van Rensburg and Prof MJ Oosthuizen

SECTION B: PROPOSAL REVIEW

	YES	NO	Comments
1. Is this research project within the scope of the Department of Health key policy priorities/directives?	√		The department has committed itself to improving the quality of nursing care that is provided to patients. SANAC and other observers have cited degeneration of certain values and principles amongst nurses as core reason for the poor attitude towards patients and appalling service from nurses observed in many facilities. Retired nurses are being brought in, not only to increase workforce but to impart those values and principles upon the new cadre of nurses. The study will explore various professional socialization issues for nurses and propose guidelines for institutions that train nurses.
2. Content of Research:			The study will examine the various professionalization issues for nurses in South Africa and propose guidelines for effective promotion of optimal professionalization of student nurses.
▪ Original work	√		
▪ New facts, ideas	√		
▪ Confirmation of uncertain data		√	
▪ Repetition of known data and consequently of limited importance		√	
▪ Insufficient research information	√		
▪ Confusion of topics/questions		√	
3. Is the title of the research project suitable?	√		The title of the study is: "Guidelines For Professional Socialisation Of Student Nurses"

	YES	NO	Comments
4. Writing style			
▪ The text of the proposal is clear	√		Excellent written proposal with exhaustive literature review and a lucid argument articulation.
▪ The nomenclature used is correct	√		
▪ The references used are relevant, comprehensive and accurate (corrected)		√	
▪ The spelling and grammar are correct	√		
▪ The language needs improvement		√	
▪ The research proposal needs restyling and rewriting		√	
5. Are the research methods appropriate to the study	√		
6. Does the study have ethical approval? If yes, name the ethics committee	√		Yes Officially granted ethics approval on 17th of February 2010 by the University of South Africa's Health Studies Research and Ethics Committee (HSREC). Project Number: 3135 840 3 The ethics approval certificate is attached.
7. Is data collection method in line with study design?	√		
8. Is time frame of the proposal adequate to meet the objectives?	√		

	YES	NO	Comments
9. Is it stated in the proposal the method of dissemination of the results of the research project?	√		Research outputs will be disseminated as report to all organisations involved in professional socialisation of nurses (hospitals included) as well as the central office of the Gauteng Department of Health and Social Development.
10. Is the possible conflict of interests clarified?	√		
11. Are financial implications and financial support transparent?	√		There is no financial implication of this study for GDHSD.

SECTION C - SUMMARY OF THE RESEARCH PROPOSAL

This is a proposal for a research study which will be conducted in fulfillment of requirements for the degree of DLitt et Phil in the subject of health studies at the University of South Africa. The study will explore the issues that surround the process of professional Socialisation of Nurses in South Africa. It is the ultimate aim of the study to develop some guidelines for educators and clinical mentors alike which will promote better methods of professional socialisation of nurses. The subject is interesting and has relevance for service delivery, SANAC and others have recently lamented the degenerating professional conduct of nurses which affects patient care and service delivery.

The objectives of the study are:

1. Explore and describe the perceptions of professional nurses regarding their role in the professional socialisation of student nurses;
2. Explore and describe the experiences of student nurses regarding their socialisation as members into the nursing profession;
3. Determine how nurse educators facilitate and teach professional socialisation in student nurses who followed the four-year integrated nursing programme in Gauteng;
4. Develop guidelines to assist nurse educators and professional nurses in the process of professional socialisation of student nurses.

Ethics clearance certificate was obtained from University of South Africa's Health Studies Research and Ethics Committee (HSREC). The study is potentially not harmful in any way to participants and the researcher has obtained permission from the Steve Biko Academic Hospital to access the hospital and this will be coordinated by the researcher and management of the facility involved. The researcher, in conducting her study will abide by the conditions provided in the attached agreement which will be signed by her and submitted to the central office of GDHSD.

Permission to enter educational institutions and interview students and educators will be obtained from respective institutions heads or principals.

There are no financial implications relating to the study for the GDHSD to incur.

SECTION D - RECOMMENDATION AND approval

Reviewed by:



Mr. Siviwe Mkoka

Deputy Director: Policy, Planning and Research

Date: 04/05/2010

Approved by:



Ms. S. le Roux

Director, Policy, Planning and Research

Date: 07/05/2010
