

CLINICAL LEARNING EXPERIENCES OF NURSING DEGREE STUDENTS
AT PUBLIC TRAINING HOSPITALS IN THE KHOMAS REGION, NAMIBIA

A RESEARCH THESIS SUBMITTED IN FULFILMENT

OF THE REQUIREMENT FOR THE DEGREE OF

MASTER OF NURSING SCIENCE

OF

THE UNIVERSTY OF NAMIBIA

BY

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APRIL 2023

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ABSTRACT

Clinical placement provides an opportunity for students to be socialised into the health system, achieve clinical skills in a real-life setting and observe the delivery of care by other healthcare professionals. Despite the obvious benefits of placements for students, poor relationships with the supervising nurse, environments that fail to promote belongingness and a lack of supervision hinder learning in the clinical setting. The purpose of the study was to assess the clinical learning experiences of nursing degree students practising in general wards at public training hospitals in the Khomas region of Namibia. The objective of the study was to explore and describe the clinical learning experiences of nursing degree students in general wards at public training hospitals in the Khomas region. The study aimed at answering the following central question: “What are your experiences during placement in general wards of the training hospitals in the Khomas region? The researcher selected a qualitative, explorative, descriptive and contextual design. Fifty-one participants from the undergraduate second, third and fourth years were recruited. Data collection included eleven (11) individual face-to-face interviews and eight (8) Focus Group Discussions. Data was coded and analysed using Tesch’s method of data analysis. Four themes emerged from the exploration and description of nursing students’ clinical learning experiences, namely, a non-conducive learning environment, negative staff attitude, communication barriers and shortage of staff. The results show that there were indeed constraints to learning in the clinical setting across all the years of study. Recommendations were made to the Nursing Education Institution, the training hospitals and the Ministry of Health and Social Services. Further research is needed on the clinical learning experiences of nursing students in other regions, the clinical learning experiences of male nurses and the lecturers’ experiences on clinical accompaniments.

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¹ Focus Group Discussions

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Figure 1.1 Kolb's four-stage cycle of learning

LIST OF ABBREVIATIONS

FGD Focus group discussion

IFFI Individual face-to-face interviews

UNAM University of Namibia

ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to several people who guided and supported me through my thesis writing:

- I am forever indebted to my supervisor, Professor Louise Pretorius, for her support and guidance, and all the knowledge that I tapped from her. This thesis would not have been possible without her support and excellent reviews;
- I was fortunate to have many supportive colleagues during the journey of my thesis. My deepest gratitude goes to Dr Kristofina Amakali for her guidance, support, listening ear and encouragement over the last three years;
- The University of Namibia for approving my study.
- The Ministry of Health and Social Services for permitting me to conduct the study; and
- The 73 students from the Second, Third- and Fourth-year students of 2021, from the Nursing Education Institution, main campus, in Windhoek, Khomas region. Thank you for your participation, precious time, experiences and your unwavering support despite the Corona pandemic and the time when you were preparing for your examinations. You guys made it possible to partake in the study.

DECLARATIONS

I, Joseph Galukeni Kadhila, hereby declare that this study is my own work and is a true reflection of my research, and that this work, or any part thereof has not been submitted for a degree at any other institution.

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Joseph Galukeni Kadhila

April 2023

Name of Student

Signature

Date

DEDICATION

This thesis is dedicated to my daughter, Sacky Panduleni Pomwenepawa Kadhila.

Thank you for always asking dad, “when are you finishing”?

CHAPTER ONE

ORIENTATION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Nursing has been described as a unique and integrated discipline that includes both sciences (e.g. biology, physiology, anatomy) and the arts of humanities (e.g. sociology, physiology, psychology, art, history and language (Mulaudzi, Mokoena & Troskie, 2010). It is a professional career that requires an extraordinary range of knowledge and skills. Nurses are expected to deliver the highest possible quality of care in a compassionate manner to those in need. Therefore, they must access and evaluate extensive clinical information and incorporate it into their daily clinical decision-making as nursing is a clinical practice-based discipline (Kaphagawani & User, 2013). Nursing education must provide nursing students with the necessary skills to help them to offer quality care for patients with complex health problems, through scientific-based clinical learning experiences in clinical practice.

Nursing education in Namibia evolved throughout the years with the contribution of several Christian missions which were established in this country, such as the Renish (1842), Finish (1870), Roman Catholic (1878), Anglican (1924) and Centurum Ontmoeting der Volken (1980). The dream of establishing a nursing school was realised in 1966 with the establishment of a school for auxiliary nurses at the Seminary for community sisters at Khoichas near Mariental. This school became possible through the Nursing Act of 1957 (promulgated on 12 July 1957), which made provisions for the education and training and enrolment of auxiliary nurses and midwives, though such enrolment was not compulsory unless the person practised in

a prescribed area in South West Africa. The proposed nursing school was not a hospital school but was located in a seminary, an educational institution for the preparation of community sisters (deaconesses). Arrangements were made with the hospital at Gobabis to provide the prescribed clinical learning experiences. A clinical instructor would accompany each group of students for clinical teaching and supervision (Van Dyk, 1999).

The first training of assistant nurses took place in 1930 at Onandjokwe Hospital. The aspects of training and education of nurses later became the responsibility of the government with the establishment of hospital training schools. Due to several circumstances, for example, a shortage of finances and personnel, a nursing college was erected in Windhoek only in 1959. By 1960, the need for the training of nursing assistants throughout the country became so great that the administrators of the then South West Africa resolved to provide certificates of completion of training to those who completed the programme (Van Dyk, 1999).

On the 1st of February 1960, the first statutory programme commenced for the education and training of general nurses in Windhoek. In September 1960, the first statutory examinations for nurses in the territory were held. With the opening of Oshakati hospital on the 21st of July 1966, the stage was set for introducing the training for professional general nurses who could register with the South African Nursing Council in South West Africa then, now Namibia was under the rule of South Africa pre-independence. Namibia did not have a regulatory body in place until 1994 when the Namibian Nursing Council was established. Nurse training commenced on the 1st of January 1967 in Oshakati (Van Dyk, 1999).

The University of Namibia's education and training of professional nurses became a reality on 1 January 1986. The integrated four-year Diploma in Nursing (General, Community, Psychiatric and Midwifery) was introduced at both campuses, Main campus Windhoek and Oshakati. The curriculum for the Diploma in Comprehensive Nursing and Midwifery was introduced in 1995 followed by a four-year Bachelor's Degree in Nursing Science in January 2008 (Searle, Human & Mogotlane, 2009). The key to all the pre-registration programmes as indicated, was the clinical practice requirements that a student needed to adhere to in order to graduate as a registered nurse. Ever since, clinical learning experience during clinical practice is considered a core element of undergraduate nursing education as it prepares nursing students to acquire the skills and competencies to provide safe and professional nursing care (Higazee, Rayan, Ades & Alrawashdeh, 2017).

Learning in clinical practice is an important component of nursing education considering that nursing is a practice-based profession (Jonsén, Melender & Hilli, 2013). Clinical practice plays an important role in nursing students' education by promoting different clinical experiences in various locations of the health care settings (Esmaeili, Cheraghi, Salsali & Ghiyasvandian, 2014). While nursing students practice nursing care activities during their clinical rotations, they also get an opportunity to develop effective communication skills and empathetic understanding (Michalec, Diefenbeck & Mahoney, 2013) also state that active involvement and collaboration with clinical staff are imperative to improve students' clinical practices. Clinical placement also provides an opportunity for students to be socialised into the health system, practice clinical skills in a real-life setting and observe the deliverance of care by others. Despite the obvious benefits of placements for students, challenges in terms of poor relationships with the supervising nurse, non-conducive environments that fail

to promote belongingness in the profession and a lack of supervision, among others, prevail (Ulenaers, Grosemans, Schrooten, & Bergs, 2021). The latter has been defined as deliberately planned actions carried out by highly skilled individuals in response to the particular needs of clients.

The clinical setting is one of the most valuable educational resources available to nursing schools and it is also an essential element to the successful preparation of student nurses. The clinical experiences gained in these clinical settings provide nursing students with the opportunity to develop a combination of cognitive, psychomotor and affective skills. It enhances students' professional responsibility, assists them with self-directed learning and facilitates decision-making and problem-solving skills (Abouelfetoh & Mumtin, 2015). Moreover, in clinical placement, students can transfer knowledge from the classroom to real-life situations and apply theory to practice. Additionally, students distinguish between different settings, internalise clinical learning and develop self-monitoring skills (Abouelfetoh & Mumtin, 2015).

Clinical placement experience is an integral aspect of practice development for undergraduate nursing students undertaking a Bachelor of Nursing Sciences degree, for them to acquire competencies and abilities to learn independently, make decisions, and express ethical commitments (Nehrir, Vanaki, Mokhtari Nouri, Khademolhosseini & Ebadi, 2016). The development of nursing practice requires the synchronicity of knowledge application, clinical skills, and the ability to integrate these professional requirements into daily practice. The opposite may result in disappointed employers, frustrated new graduates and dissatisfied patients (Nehrir et al., 2016). Furthermore, in health care settings, it is important to assess the competencies that are essential for

the professional role of nursing students to ensure that they are well prepared for future professional duties.

For student nurses, clinical placements involve being in direct contact with un-well people, studying and learning how to assess and provide nursing care while integrating knowledge, theories and skills acquired in the academic setting. Achieving clinical competence in these placements also involves understanding how to work in teams and how to manage and organise general nursing in healthcare settings (Jacobsen, Onshuus, Frisnes & Conzales, 2020). Clinical training is regarded as the heart and essence of learning and education in nursing (Kalyani, Jamshidi, Molazem, Torabizadeh & Sharif, 2019). Kalyani et al. (2019) further proffer that a clinical learning environment is a combination of several physical, psychological, emotional and organisational factors affecting the students' clinical learning and how they confront the clinical environment. This environment has considerable effects on students' positive learning and emotional well-being. Furthermore, students get acquainted with the realities of their profession and the functions of nursing in this environment. However, the clinical environment has been referred to as a reason for either quitting or continuing with the nursing profession. It is, however, in the clinical arena that nursing students learn to practice the art of nursing.

1.2 BACKGROUND OF THE STUDY

The clinical learning experience is an interactive network of forces within the clinical setting that influences the learning outcomes of nursing students. It includes all experiences that surround students including their professional development in the clinical setting (Papastavrou et al., 2016). The clinical learning of students is generally supervised by clinical instructors, who are there to guide students and to make sure that students implement the right interventions to improve their skills and knowledge

in preparing them to become full-fledged nurses (Tiwaken, Caranto & David, 2015). There is considerable evidence supporting clinical learning as extremely beneficial in familiarising students with clinical judgment and decision-making, stimulating their critical thinking, challenging students to recognise the consequences of their mistakes and exposing them to various socio-cultural, biological, psychological and mental aspects of patient care (Papastavrou et al., 2016).

Much research has been done on nurses' clinical learning experiences. In Norway, half of the students reported that the training sessions in the clinical area are useful and they were confident to master clinical skills during their clinical placement (Solvik & Struksnes, 2018). In Ghana, on the other hand, undergraduate nursing students had both negative and positive experiences during their placements in teaching hospitals. While negative experiences included being made feel isolated, not being taught and branded as theory nurses, inadequate application of the nursing process, and lack of time the positive experiences were guided by that students had the opportunity to see complex medical devices and conditions that are rare in other settings and being empowered (Atakro, Armah, Menlah, Garti, Addo, Adatara & Boni, 2019). In Sub-Saharan African countries, nursing students face different challenges during their training since they are expected to provide nursing care to patients with chronic conditions like HIV and AIDS, Tuberculosis, Cancer and different other serious and often terminal medical and surgical conditions (Rajeswaran, 2016). In South Africa where student nurses perform practical procedures in real-life clinical environments, the students did not always perceive their allocations as conducive to learning; moreover, they even lost compassion for nursing as it was difficult to practice in an environment with a great shortage of clinical resources (Council, 2013; Watkins,

2011). Similarly, during clinical follow-ups, the lecturer realised that Namibia is not exempted at all from negative experiences in the clinical area.

Programmes at nursing education institutions in Namibia are regulated by the Nursing Act, 2004 (Act No 8 of 2004) with applicable regulations. The latter determines that a student nurse must, throughout the course of study, receive both theoretical and clinical instruction while being placed in different health disciplines in the health facilities. The placement is coupled with a certain number of hours. For this research, the focus was on the experiences of student nurses in the clinical discipline of general nursing. The general nursing curriculum at nursing education institutions consists of a theoretical and practical component offered over a period of four years, including clinical education in clinical learning environments. The major part of nursing education in clinical environments in Namibia stretches from semester one and continues until the end of the fourth year which amounts to a minimum of 2800 hours. At least 940 hours thereof consist of general nursing science (Act No 8 of 2004).

Learning in clinical practice provides up to half of the educational experience for student nurses taking the Bachelor of Nursing Science (Tiwaken et al., 2015). The theory and clinical practice equally contribute 50% of a module in general nursing science, having the content covered through theoretical teaching, simulation and real-life clinical teaching (Bevan et al., 2015). Clinical training is further extended into the practical setting during allocation with real patients under the supervision of clinical staff in the health facilities and lecturers from the University of Namibia. The latter implies that students with a Bachelor of Nursing Science spend 50% of their education and learning in the clinical environment.

Nursing students at nursing education institutions are allocated to designated accredited training hospitals, and for clinical nursing practice, student nurses are expected to perform various procedures from the second year of study onwards, after being taught the theory in the classroom. Assessment during the course of studies is imperative to determine their level of competencies in the clinical area. More so, during the Covid 19 pandemic in 2020/2021, the assessment of clinical competencies became a crucial element as the clinical practice of students was interrupted during the pandemic. The School of Nursing and Public Health was compelled to implement additional strategies to ensure that students can fulfil the clinical requirements of their programme.

1.3 PROBLEM STATEMENT

Literature reports that clinical facilities are faced with challenges that could affect student nurses' clinical learning experiences. A report by the Presidential Commission of enquiry into Namibia's Health Services, presented to parliament in march 2013 indicates that the facilities have acute and critical shortages of health professionals and that essential equipment is not available at some facilities. In addition, it was reported that the state facilities are dilapidated and in a decaying state. The Namibian Presidential Commission of inquiry was of the opinion that UNAM's students lack clinical exposure and clinical supervision respectively.

The present researcher has been appointed as a nurse educator at the University of Namibia, School of Nursing and Public Health. One of the tasks is to deal with the allocation of students to general wards at the two training hospitals in Windhoek. During the clinical accompaniment of the nursing students in the Bachelor of Nursing

Science programme, the researcher found it difficult to demonstrate and evaluate nursing students on some of the critical clinical procedures, for example, the aseptic technique due to the shortage of resources at the clinical facilities, which ultimately compromises the quality of demonstrations.

The subsequent overcrowding of the facilities leads to challenges for UNAM nursing students to learn in clinical settings. In an attempt to fulfil clinical requirements, the lack of clinical opportunities causes students to work unsupervised over weekends, public holidays and university holidays, when lecturers and clinical instructors are not available for clinical accompaniment, an approach which compromises the quality of clinical learning for nursing students such as unfavourable clinical experiences, including poor communication, lack of confidence, a failure to apply theory in practice, a failure to develop clinical competencies, and poor nursing care. Clinical learning experiences of student nurses are unknown in the training facilities of the Khomas region. Therefore, the researcher became interested to determine and explore experiences of learning by nursing students during their clinical placement in general wards at public training hospitals in the Khomas region.

1.4 PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the clinical learning experiences of the nursing degree students practising in general wards at the public training hospitals in the Khomas region.

1.5 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Explore the clinical learning experiences of Bachelor of Nursing Science degree students in general wards at the public training hospitals in the Khomas region; and
- Describe the clinical learning experiences of Bachelor of Nursing Science degree students in general wards at the public training hospitals Khomas Region.

1.6 RESEARCH QUESTION

Qualitative research questions are open-ended, evolving, and non-directional (Chih-Pei, 2017). Research questions are important because they help the researcher to set boundaries when conducting the literature review (Smith, 2014).

The study sought to answer the following questions:

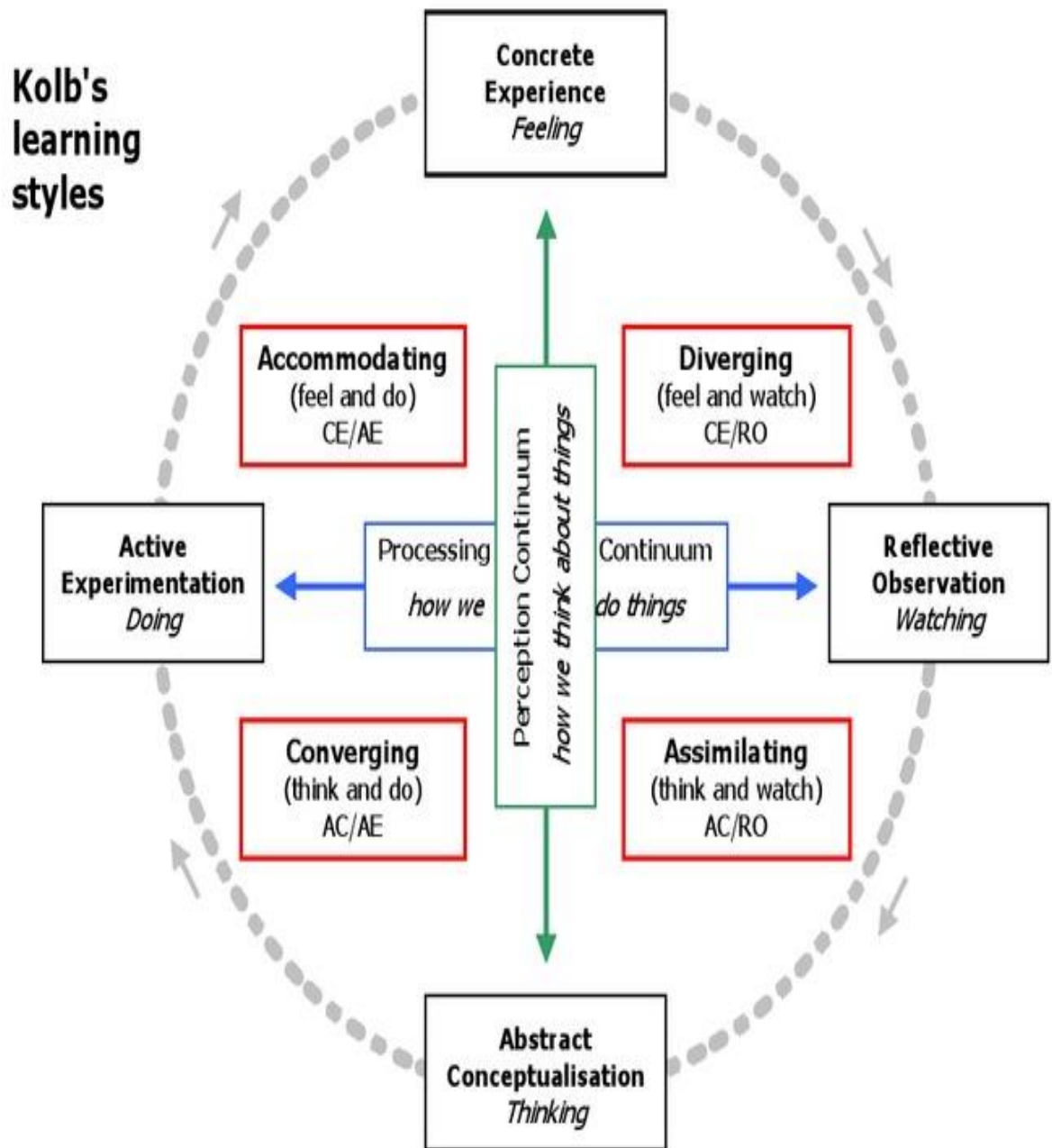
What are your experiences during placement in general wards of the training hospitals in the Khomas region?

1.7 SIGNIFICANCE OF THE STUDY

The significance of the study may be associated with the amount of variance explained and control in the study design to eliminate unexplained variances or the detection of statistical differences (Burns & Grove, 2016). The findings of this study may assist the School of Nursing and Public Health to reconsider the clinical allocation within the programme to some of the general wards. In addition, it will also guide clinical instructors and lecturers on how best they can enhance the clinical learning experience during the clinical placements of nursing students at the public training hospitals in the Khomas region.

1.8 THEORETICAL FRAMEWORK

Recognising that nursing is a practice-based profession, experimental learning theory and service learning emphasise learning by doing and reflecting as discussed by Kolb. Therefore, this study utilised David Kolb's Cycle of Experiential Learning Theory (Kolbs, 1986). A theory is a system of logical statements or propositions that explain the relationship between two or more objects, concepts, phenomena or variables (Lune & Berg, 2017). Kolb's Experiential Learning Theory includes a four-stage cycle of learning and four separate learning styles which concern the learner's internal cognitive processes, which makes it an appropriate and suitable theory to adopt. Kolb thinks that learning involves the acquisition of abstract concepts that can be applied flexibly in a range of situations. In Kolb's theory, the impetus for the development of new concepts is provided by new experiences, in this study referring to the learning that takes place through new clinical experiences. The experimental learning model consists of four stages namely concrete experiences, reflective observation, abstract conceptualisation and active experiment as reflected in figure 1.



© concept david kolb, adaptation and design alan chapman 2005-06, based on [kolb's learning styles](#), 1984
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Figure 1.1 Kolb's-Four stage cycle and four learning styles

The researcher opted for and applied Kolb's 1984 Experimental Learning Theory four stages for this study as he finds it fit for social sciences and natural sciences research; it further offers students a learning environment that provides both reflective

observation and active experimentation. Both concepts are central to learning nursing practice and acquiring nursing skills. Reflection assists students to summarise the learning that took place at the end of each day and further points to what was good and what needs to be improved.

Kolb's stages can be explained as:

Stage 1: Concrete Experience (*Feeling*)

Learning begins in the Concrete Experience stage where learning happens through feeling while the learner goes through a new learning experience. At this stage, the learner experiences learning through visual, audio, or kinaesthetic means. Each nursing student on a new allocation will be delegated to the patient's room every morning where they work hand in hand with a registered nurse. Nursing diagnoses were formulated and a corresponding nursing care plan was drafted accordingly, followed by nursing actions or interventions. By participating in the aforementioned, the student was part of the first stage as discussed by Kolb. This stage laid the foundation for any learning taking place in the new environment.

Stage 2: Reflective Observation (*Watch*)

Following the concrete experience will be the Reflective Observation stage, in which the learner reflects upon the learning experience. This can be acquired through different forms. The student nurse makes sense of and tries to internalise what they have observed in clinical practice within the general nursing environment, and reflects on the clinical experiences encountered. The nursing students were able to reflect more successfully when a senior provides feedback to them. This stage of reflection will assist the lecturer to determine if learning took place and if the student achieved the

objectives set for this encounter. Self-assessment by the student can also be facilitated at this stage.

Stage 3: Abstract Conceptualisation (*Think*)

As the student nurse moves into the Abstract Conceptualisation stage, he/she identifies what needs to be learnt to bridge the gap between what they know and what they still need to learn; to build on existing knowledge and to engage in self-directed learning. For example, reading about each new diagnosis in the ward will enrich learning as the student will holistically understand the condition, plan and interventions better, and will also be able to recall and remember the details of the encounter.

Stage 4: Active Experimentation (*Do*)

In the last phase, the student applies the new construct of the learning and moves into the Active Experimentation stage. The outcome of feedback and self-directed learning helps a student to experiment with a new approach and test it on new experiences. The new experience will generate a new reflection, approach and new experience for the student nurse. During this phase, a student nurse in the clinical setting will do a procedure as they have been encountering and given feedback on demonstrations, as is the expectation after each clinical placement, in this case in a general nursing unit.

In addition, Kolb's learning theory (1974) further sets out four distinct learning styles, which are based on a four-stage learning cycle. Depending on a learner's inclination (what he/she prefers to do) Kolb identifies four types of learners: which are the diverger, the assimilator, the converger and the accommodator. The four types of learners are described in Chapter two.

Kolb argues that learners adopt a learning style contextually and that individual learning style preferences are rather fluid than rigid, changing in response to a situation. They are as follows:

- The Diverger (Reflective observation - Concrete experience)

The Divergers go through the concrete experience and then reflect upon it, attempting to map it to their past experiences (if any) or reflecting on its possibilities. Thus, the Divergers are imaginative, creative, connecting-the-dots kinds of individuals. Within this learning style, people prefer to watch rather than do, tending to gather information and solve problems through imagination. Students with this learning style prefer to work in groups and listen with an open mind. They also prefer personal feedback.

- The Assimilator (Reflective observation - Abstract conceptualization)

The Assimilators too are interested in Reflective Observation but they are also keen on establishing formulae by generalising what they have learned. Thus, they prefer to reduce the clutter of discrete learning and have their generalisations ready. They require a good and clear explanation rather than a practical opportunity. This group of learners are not so much focused on people but rather prefers ideas and concepts, hence they are very effective for science careers.

- The Converger (Abstract conceptualisation – Active Experimentation)

The Convergents wish to go forward and check the veracity/applicability of their

generalisations and thoughts. This group of people can solve problems and they prefer technical tasks. People with a converging learning style like to experiment with new ideas, simulate and work with practical applications.

- The Accommodator (Active experimentation - Concrete experience)

The Accommodators are the hands-on groups who rely on intuition rather than logic. They like to take a practical experiential approach and they are attracted to new challenges and experiences. Accommodators will rely on other people's analysis rather than carrying out their own analysis. Considering the four learning styles puts a challenge on the nurse educator as activities should be designed in such a way that all four categories of learners can be accommodated.

The further application of this theory is explained in Chapter three where the findings are discussed.

1.10 DEFINITION OF TERMS

For the present study, the following terms are defined:

- **Clinical experience** includes the practical knowledge and skills the student acquires through his/her contact with events in the general wards. It further refers to the observation of facts over some time (Cambridge Advance Learners Dictionary, 2013). In this study, clinical experience refers to the knowledge, skills and learning gained by nursing students during clinical placement.
- **Clinical learning environment** refers to a setting where the acquisition of knowledge, skills and values take place. It is further referred to as an essential component that is integral to clinical learning (Bruce & Klopper, 2017).

In this study, the clinical learning environment refers to the general wards of the two training hospitals in the Khomas region, namely the Katutura Intermediate Hospital and the Windhoek Central hospital, where the nursing students are allocated for clinical practice.

- **Clinical practice** is defined as a deliberately planned sequence of activities carried out by highly skilled individuals in response to a particular need of clients (Gaberson et al., 2014). In this study, clinical practice refers to actions carried out by nursing students in the clinical environment to care for patients, as a requirement of training.
- **Student nurse** refers to a person registered as such in terms of section 59 of the Nursing Act 2004 (Act No. 8 of 2004). In this study, the researcher used the term student nurse to refer to a nursing student who is registered for the Bachelor of Nursing Science four-year programme at the University of Namibia, regulated by the Nursing Act, 2004 (Act No.8 of 2004).

1.11 METHODOLOGY

An overview of the research methodology is presented in this chapter. The full discussion thereof follows in Chapter two.

Research design - In this study, a qualitative, explorative, descriptive and contextual research design was followed to explore and describe the clinical learning experiences of students registered for the Bachelor of Nursing Science degree, while on their general nursing placement in the two training hospitals in the Khomas region.

The **population** of this study consisted of all second, third and fourth-year degree nursing students, registered for the Bachelor of Nursing Science programme at the School of Nursing and Public Health at the nursing education institution. The first years were excluded from the study as they would not be able to explain their clinical

learning experiences in the general wards as a result of a limited clinical placement during the first year. However, the second, third and fourth years were included as a result of their extensive placements in the general wards.

Purposive sampling was utilised to select participants for this study. Creswell, (2018) proffers that in purposive sampling, the researcher has the advantage of selecting participants that are knowledgeable and have experience with the phenomena to be researched, and who would be able to contribute rich data to the study. The participants were selected because they met the inclusion criteria, namely that they were in their second, third or fourth year of study. They were considered to be knowledgeable with sufficient experience in general wards, with expected clinical learning during placement in the clinical settings. The first students who availed themselves and agreed to partake per year level were included in the study. The size of the sample for this study was determined by data saturation at 66 participants.

Data were collected through individual face-to-face interviews with 11 participants as well as unstructured focus group discussions with eight groups consisting of at least seven participants. One central question was asked namely to '*describe their clinical learning experiences during the allocation in the general nursing ward,*' followed by probing questions to obtain rich data from participants. Individual interviews lasted up to 20 minutes and the focus group discussions lasted between 35 minutes and 1 hour and 30 minutes. All 11 individual interviews and eight (8) focus group discussions were audio recorded.

Data analysis

Individual interview data were analysed through the 8 steps of Tesch (1992) whereby trustworthiness of the data was ensured, through the criteria of credibility,

dependability, confirmability and transferability (Lincoln & Guba, 1985) as discussed in Chapter two. Subsequently, focus group interviews were also analysed through the 8 steps of Tesch (1992) whereby the trustworthiness of the data was ensured through the criteria of credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985) as discussed in Chapter two.

1.12. RESEARCH ETHICS

Research that involves humans as participants requires adherence to ethical principles to ensure the protection of participants' human rights and dignity (Brink, Walt & Rensburg, 2018). Therefore, the researcher upheld the principles of respect for the person, beneficence, justice, autonomy, privacy and confidentiality at all times. A full discussion on adherence to ethical principles appears in the next chapter.

1.13 CHAPTER SUMMARY

In this chapter, the introduction and background of the study with the problem statement and research question were explained. The purpose and objectives were elaborated on by the researcher. The theoretical framework of choice namely Kolb's Four stage cycle and four learning styles and operational definitions were also explained. The research design and method were briefly touched on but are extensively covered in Chapter two.

The following chapters are to follow:

Chapter two: Methodology

Chapter three: Results, Interpretations and Discussions

Chapter four: Conclusions, limitations and recommendations

CHAPTER TWO

RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

The objectives of this study were to explore and describe the clinical learning experiences of nursing degree students, registered at the University of Namibia, while placed at the public training hospitals in the Khomas region. The previous chapter provided an overview and background of the study. The problem statement, purpose and objectives and significance of the study were also outlined. This chapter described the design and methods utilised to execute the study as well as measures employed to ensure trustworthiness while considering ethical principles.

2.2 RESEARCH DESIGN

A research design forms the blueprint of a study and determines the methodology used to obtain sources of information to collect, analyse and interpret the results (Brink et al., 2018). In this study, the researcher selected a qualitative, explorative, descriptive and contextual design to explore and describe the clinical learning experiences of the students in the Bachelor in Nursing Science degree programme, while placed in the general wards of the public training hospitals within the Khomas region. This design was found to be most appropriate as the students were given the opportunity to elaborate on their learning during their time of clinical placement in general wards.

2.2.1 Qualitative research approach

According to Brink et al. (2018), **qualitative research** is a method of enquiry which focuses on the experience and opinions of the selected participants and aims at understanding the in-depth meanings of a phenomenon from the perspective of the

participants, in an instance where the information is not known. The qualitative approach helps to explore and describe the meaning and provide an in-depth understanding of human experiences (Brink et al., 2018). Therefore, the researcher opted for this approach as this provided rich data on the unknown clinical learning experiences of UNAM Bachelor of Nursing Science degree nursing students placed in the general wards of the public training hospitals in the Khomas region. Clinical placement in general wards is compulsory for all Bachelor of Nursing Science students, as it forms a part of the clinical requirement for this degree. Furthermore, the completion of the required clinical practice is also a prerequisite for registration as a professional nurse at the Health Professional Council of Namibia.

2.2.2 Explorative research design

The **explorative** part of this design refers to the investigation of a phenomenon to identify its variables (Pickard, 2018). This study strove to gain a deeper understanding of the clinical learning experiences of the Bachelor of Nursing Science degree students, while allocated in the general wards of the public training hospitals in the Khomas region. The researcher opted for the general wards as this is the domain where nursing students are allocated throughout their training, hence the opportunity to cover all years of study within this programme, except the first year.

2.2.3 Descriptive research design

According to Gray et al. (2016), a descriptive study is used to describe operational and conceptual definitions of variables identified for the phenomenon explored in the study. The researcher utilised the descriptive design to describe the clinical learning experiences which were explored earlier.

2.2.4 Contextual research design

A contextual design allows a researcher to widen views and perspectives of the research and to prepare well-organised investigations within a certain context (Ellis, 2018). The context of this study can be described as the general wards at the public training hospitals in the Khomas region. The general wards of the two training hospitals in the Khomas region, namely, the Intermediate Hospital Katutura and Windhoek Central Hospital include but are not limited to the medical, surgical, paediatric, orthopaedic, gynaecology, urology, oncology, ophthalmology and, ear nose and throat ward.

The undergraduate nursing students from the School of Nursing and Public Health at the University of Namibia are placed in these two hospitals to gain clinical learning experiences and also to achieve competencies during their training. While students are doing their general nursing rotation, assessments of their competencies are conducted by the University lecturers, clinical instructors and preceptors.

2.3 METHODOLOGY

2.3.1 RESEARCH SETTING

A research setting refers to the specific place (site, location) where the data are collected (Polit & Beck, 2016). The setting for this research study refers to the medical, surgical, orthopaedic and paediatric wards of the two training hospitals within the Khomas region. The UNAM School of Nursing and Public Health allocates less than eight (8) nursing students in the ward per cohort with the assistance of two clinical preceptors for all cohorts and less than 3 professional nurses per ward. Moreover, the two training hospitals also cater for four (4) other nursing training institutions and medical students, utilising one poorly equipped simulation room that is available for all schools in both training hospitals.

2.3.2 POPULATION

A population is the particular type of individuals or elements that is of interest to the researcher and which meets the criteria of the study (Gray, Grove & Sunderland, 2016). The entire population in this study consisted of 312 undergraduate Bachelor of Nursing Science degree students of Namibia's School of Nursing and Public Health, at the main campus of the University of Namibia. This number included 101 second years, 94 third years and 107 fourth years registered within the mentioned programme. This group of students all rotated through the general wards of the training hospitals as part of their compulsory clinical training. As already alluded to, the first years within the programme did not form part of the population.

2.3.3 SAMPLE AND SAMPLING METHOD

Sample

The sample of a study refers to a subset of the population, considered to be representative of the population used in the study (Du Plooy-Cilliers, 2014). The sample size of qualitative data is determined by data saturation, a situation where the researcher experiences repetition of the same findings after all avenues were exhausted and no new findings are emerging from the individual face-to-face interviews and focus group discussions (Maree, 2016). No sample was predetermined; however, data saturation was reached after a total of 11 individual face-to-face interviews and 8 focus group discussions consisting of 6-7 participants.

Sampling

Sampling refers to the process of choosing a representative sample from the population under study in such a way that it represents the population of interest (Brink et al., 2018). The researcher employed purposive sampling for this study, also referred to as

non-probability sampling, based on the judgement of the researcher to select participants who have the most representative attributes to the population, and who are deemed a rich source of data to achieve the objectives of the study (Creswell, 2014). For this study, the researcher chose to include those students considered to be knowledgeable, who would be able to generate appropriate and useful information on the nursing students' clinical learning experiences in the general wards (Gray et al., 2016).

2.3.3.1 Inclusion criteria

Inclusion criteria outline the characteristics whereby subjects will be included in a study (Polit & Beck, 2017). Bachelor of Nursing Science degree students from the main campus, who were in either their second, third or fourth academic year of studies at the University of Namibia was eligible to be included. This applied only to students who were in a particular academic year for the first time, and who were included in the study. The selected students were presumed to have adjusted to the general wards in the clinical learning environment as they completed their first year and therefore would be able to give feedback on their clinical learning experiences.

2.3.3.2 Exclusion criteria

Exclusion criteria is not the opposite of inclusion criteria but rather refers to attributes that prevent a person from being included in the study (Gray et al., 2016). First-year Bachelor of Nursing Science students, nursing students who repeated any one of his/her academic years, nursing students who have transferred from one of the other campuses as well as nursing students who were not willing to sign the informed consent, were excluded from the study.

2.3.4 DATA COLLECTION METHOD

Data collection is the precise and systemic collection of data or information relevant to the purpose, objectives and question of the study (Burns & Grove, 2016). Data was collected through individual face-to-face interviews with 11 participants as well as unstructured focus group discussions with eight groups consisting of at least seven participants. One central question was asked namely to “*describe their clinical learning experiences during the allocation in the general nursing ward*”, followed by probing questions to obtain rich data from participants. Individual interviews lasted up to 20 minutes and the focus group discussions lasted between 35 minutes to 1 hour and 30 minutes. All 11 individual interviews and eight (8) focus group discussions were audio recorded. The researcher used bracketing to mitigate potential deleterious effects of preconception that might taint the research process (Burns & Grove, 2016).

Participants were recruited through their class representatives, focus group discussions and individual face-to-face interviews were audio recorded, with consent from the participants. The interviews and focus discussions were conducted in the Nursing Education Institution’s boardroom. Data collection was conducted from 20 August 2021 until December 2021.

2.3.4.1 Data collection instrument

The main data collection tool in a qualitative study is considered to be the researcher, as he/she formulates meaning through his/her engagement in the study (Botma et al., 2010). Qualitative researchers collect data themselves by examining documents, observing behaviour or interviewing participants. They do not tend to use questionnaires or instruments developed by other researchers (Creswell & Creswell, 2019). The researcher prepared by planning to conduct face-to-face individual

interviews and focus group discussions. Thereafter, the researcher designed an individual interview and focus group discussion guide which was approved by the supervisor. Each focus group consisted of seven participants.

The main question to participants was: “*What are your experiences during placement in general wards of the training hospitals in the Khomas region?*” Probing questions were posed to participants to enrich and complete data. Some of the probing questions included, “Can you explain what you mean by ...” and rephrasing was used to clarify some comments like, “You mentioned that you encounteredduring your experience, can you tell me more?”

2.3.4.2 Data collection process

Face-to-face interviews with individuals and focus group discussions from each of the targeted cohorts of students were conducted until data saturation was reached per year group. The entire process of data collection was explained in detail by the researcher, including the recording of discussions. The researcher and the prospective participants agreed on a suitable date, time and venue for the individual face-to-face interviews and focus group discussions. The interviews were conducted in a quiet place to eliminate distractions, support confidentiality and allow quality audio recording. The researcher and the students were seated at a round table and side by side for the focus group discussions and across the table for the individual face-to-face interview to demonstrate equality and comfort.

2.3.4.3 Face-to-face interviews

Individual interviews are considered to be social interactions based on conversations between the participants and the researcher (Rubin & Rubin, 2011). In this study,

individual interviews were conducted to obtain data from nursing studies regarding their clinical learning experiences.

The individual face-to-face interviews started a day after the pilot study was conducted. The participants were contacted telephonically a day before the interview and again in the morning to confirm attendance. On the day of the interview, the researcher welcomed the participants as they were coming in one by one, introduced himself and explained the study to the participants. Thereafter, the researcher set ground rules and offered the participant the consent form. Once the participant was comfortable and all uncertainties were ruled out, the researcher asked the central question followed by probing questions. At the end of the interview, the researcher asked if there was additional information the participants desired to add or if there were any questions to clarify. Participants were then thanked and allowed to leave.

A total of eleven (11) face-to-face interviews (three in the second year and four in the third and in the fourth year of study) of 10 to 15 minutes were conducted. Before the interviews, verbal permission was obtained from the participants. All second, third and fourth-year undergraduate Bachelor of Nursing Science students were approached in their class during simulation with permission from their class lecturers to invite them for voluntary participation. The participants were interviewed in a quiet, non-threatening and safe environment at the School of Nursing board room main campus UNAM from 10:00 until 15:00 each day.

2.3.4.5 Focus group discussion

Focus group discussions are interviews with a group of five to fifteen people whose opinions and experiences are requested (Brink et al., 2012). Focus groups consist of

six to eight interviewees in each group (Creswell & Creswell, 2019). Focus group interviews are widely used to produce data in qualitative health research (Green & Thorogood, 2014). The researcher opted for this method because of the value it has for sharing experiences while it can generate accurate information in a fairly short space of time (Green & Thorogood, 2014).

Moreover, it provides participants with the freedom to express their experiences and feelings in the presence of others. However, it is acknowledged that a focus group might inhibit participants from sharing information on experiences with their peers. The fact that each group was homogenous and all members were sharing particular experiences, enabled them to interact freely, and also made the environment feel safer for them to share information about the phenomenon under investigation (Burns & Grove, 2016). According to De Vos et al. (2011), homogeneity is important if participants perceive each other as they will spend more time discussing their experiences. Hence focus group interviews remain an outstanding method of data collection because through the group discussion, data are generated from the participants (De Vos et al., 2011) and therefore it was found to be the most appropriate method of data collection for this study.

In this study, a total of 8 focus group discussions, consisting of 6 to 7 students per focus group from all cohorts lasting anything from 40 to 90 minutes, were conducted with the second, third- and fourth-year students of the undergraduate Bachelor of Nursing Science programme. The researcher conducted two (2) focus group discussions with the second years, and three (3) focus group discussions with the third and fourth years till data saturation was reached. A suitable date and time and place

for each focus group discussion were set to suit all the participants. The researcher created a WhatsApp group to facilitate communication with the group. Timely invites were sent to the participants with an additional reminder on the day of the focus group discussion. The students from the individual face-to-face interview were not participating in the focus group discussions.

With each focus group discussion, a brief background of the study was explained to the students. Confidentiality was emphasised by the researcher to encourage them to speak more freely on the matter. Students were further encouraged to seek clarity during the discussion. The researcher prepared the venue by organising chairs around tables in the School of Nursing board room, main campus UNAM. The focus group participants were coded according to the study cohort, and each participant was identified by a number to ensure confidentiality. Participants were informed that they would each have a number for ease of reference during the discussion. The number was key in the identification during the transcribing of the data. At the time of the focus group discussion, the researcher introduced himself and also indicated that the researcher would record the proceedings to avoid omissions. All participants signed informed consent before the procedure.

The researcher further encouraged openness during the discussions and provided clear explanations before the proceedings. Field notes were taken to capture non-verbal and verbal communication and the data collection proceedings were audio recorded with permission from the participants during the interviews.

2.3.4.6 Pilot study

A pilot study refers to a small-scale study conducted before the main study on the limited number of participants at hand (Brink et al., 2018). In this study, a pilot study was carried out with the fourth years from the study population, with the aim of providing the opportunity to make revisions and adjustments to the interview guide, to rehearse the interview activity and also to observe the individual group dynamics. Participants in the pilot study cohort were not included in the main study. Three face-to-face individual interviews and one focus group discussion were conducted on the fourth-year nursing students for the pilot study. No improvement was suggested for the interview guide as the questions were clear to them. All steps to recruit the participants for data collection were followed, and privacy and confidentiality were also upheld during the process.

2.3.4.7 DATA ANALYSIS

Data analysis is conducted to clear and organise data to give meaning to the generated data and present it as a result of a study (Burns & Grove, 2016). In a qualitative study, data collection and data analysis may be overlapping as data is analysed as it is received (Botma et al., 2010). Creswell (2014) explains that data analysis in qualitative research consists of preparing and organising the data for analysis while reducing the data into themes through the process of coding and condensing and the final presentation thereof for discussion.

The data was transcribed verbatim, organised, analysed, and interpreted by the researcher through the eight steps of Tesch's method of data coding process as proposed by Creswell and Creswell (2018) as follows:

- **Step 1** allowed the researcher to get a sense of the whole set of data by reading through all of the transcriptions carefully. The researcher read the entire transcript several times and got the sense from the interview by breaking it into parts and further by going through the field notes. He jotted down some ideas as they came to the margin.
- **Step 2** had the researcher pick one of the shortest and most interesting interviews, searched through it and find the underlying meaning. Relevant parts of the data were identified, analysed and classified.
- In **Step 3** the classified data were arranged into columns of major, unique and “odd” topics. During this process, the researcher made notes in the margins of the transcripts, and similar topics were clustered together in a column as main themes and sub-themes.
- **Step 4** assigned each topic a code that was written next to the appropriate segment of the text to note new categories and also the emerging codes. Similar topics were grouped and given the same codes.
- **Step 5** allowed the researcher to find the most descriptive wording for the topics to be turned into categories. The total list of categories was reduced by grouping topics with the same meaning. The researcher checked and verified all the grouped topics for coherence.
- **Step 6** allowed for a final decision on the abbreviation for each category and alphabetising the codes. To arrive at the final set of categories and codes, the researcher had to go through the materials many times. Columns with themes and subthemes about the findings were created by the researcher.
- In **Step 7** data belonging to each category were grouped into one place and a preliminary analysis was performed. Data reduction, a form of preliminary

analysis, was conducted which sharpened, sorted, focused, discarded and organised data in such a way that conclusions could be drawn and verified.

- **Step 8** allowed the researcher to re-code existing data where the need was identified.

Field notes were triangulated with the recorded data after the researcher listened repeatedly to the recorded data to identify the main ideas and assign codes to similar ideas. Related codes were grouped and themes and subthemes were identified and supported by verbatim quotes from participants. Findings were further presented in the form of in-depth descriptions, supported by relevant literature control. The in-depth data analysis descriptions are presented in Chapter three.

2.3.4.8 TRUSTWORTHINESS

Trustworthiness in qualitative research is a way of evaluating the quality of validity and rigour in qualitative research. Rigour is considered as striving for excellence in research through discipline, adherence to details and meticulous accuracy. In addition, trustworthiness is about accurately presenting, managing and analysing data as they were expressed by the participants (De Vos, 2017). Trustworthiness in qualitative research is about establishing and ensuring the following measures:

2.3.4.8.1 Credibility refers to the truth of the data and its interpretation (Polit & Beck, 2017). It was important that the researcher focused on obtaining the experiences of participants by asking open questions which allowed them the freedom to share their experiences. Therefore, no closed-ended questions that could lead participants to pre-conceived answers were asked. Credibility was ensured by prolonged engagement, member checking and triangulation (Lincoln & Guba 1985).

- **Member checking:** where the researcher shared the findings with the participants to verify accuracy and make sure that he did not miss any information (Creswell & Creswell, 2019). Informal member checking was conducted during the interview through clarification of the questions with the participants.
- **Prolonged engagement:** Prolonged engagement allowed the researcher to have a close association with the participants (Creswell & Creswell, 2019). By spending more time in the field, the researcher develops an in-depth understanding of the phenomenon under study (Creswell & Creswell, 2019). As a lecturer in the School of Nursing and Public Health at the University of Namibia, the researcher was not considered an outsider but rather someone who knows the context of the research and who has also engaged with students in the clinical setting over a long period of time before the research. The researcher spent five (5) months collecting data, and prior to that, the researcher had telephonic and WhatsApp communications with the participants in his capacity as a lecturer.
- **Triangulation:** Triangulation occurs when the researcher uses multiple sources to validate the findings (Polit & Beck, 2017). It is a technique that is used to recognise the complexity of the participants' experiences by the researcher through employing strategies to ensure that the findings are accurate, complete and credible (Creswell & Creswell, 2019). The researcher ensured triangulation by comparing the field notes, transcribed texts and audio recordings to ensure that the researcher had transcribed the recordings accurately and completely.

Additionally, the researcher's supervisor was provided with two transcripts to read and compare with the recorded audios to enhance the quality of the coded and analysed data (Polit & Beck, 2017).

2.3.4.8.2 Transferability is the measure of the extent to which the study can be transferred to other settings or groups (Polit & Beck, 2017). It evaluates if the conclusions of the study can be generalised to other settings (Brink et al., 2018). In this study, findings cannot be generalised as students from different learning contexts may have different experiences regarding clinical learning. However, the researcher provided thick descriptions of the research design, methodology and findings which demonstrated the level of data analysis. In addition, verbatim quotes were provided to support the findings and literature support was added.

2.3.4.8.3 Dependability refers to the consistency of the data over time and conditions, meaning that other researchers should arrive at similar outcomes when research is replicated (Polit & Beck, 2017). The thick and dense description of the research methodology used to conduct the study and description of the sample characteristics, data collection method and data analysis process were detailed with the literature support and an audit trail was also kept to ensure dependability. Peer debriefing is one strategy to enhance dependability (Polit & Beck, 2017). Peer debriefing with experts in the subject matter of methodology during the research process allowed them to evaluate, challenge and propose changes to the research thought process (Polit & Beck, 2017). The researcher briefed the research supervisor regularly and throughout the research process.

2.3.4.8.4 Confirmability refers to the objectivity of the data collected, data analysis and description of the findings (Polit & Beck, 2017). The researcher ensured that the findings, conclusions and recommendations from this study accurately reflect the

experiences and viewpoints of the participants. The researcher further ensured confirmability by keeping a detailed audit trail that he continuously shared with the research supervisor; this audit trail consisted of the researcher’s logic from methodology to the conclusion.

2.3.4.8.5 Authenticity refers to the arrangement of experiences related to phenomena as experienced by different participants and the presentation of research findings (Polit & Beck, 2017). The researcher represented the data by paying attention to any non-verbal cues from the participants’ voices, for example, feelings and emotions, since this information was a valuable contribution to the creation of data and the meaning of the data.

The trustworthiness of this study was therefore ensured by applying the above criteria of credibility, transferability, dependability, confirmability and authenticity (Lincoln & Guba,1985; Sandelowski,1986).

The criteria with specific measures are presented in table 2.1.

Discussion on the criteria and their application to the study follows in Table 2.1

Table 2.1 Measures to ensure trustworthiness

CRITERIA	APPLICATION
CREDIBILITY	
Member checking	The transcribed data and the audio-recorded data were given back to participants to confirm their content in order to avoid misinterpretations of recordings during interviews and group discussions
Prolonged engagement	Prior to the research, the researcher was familiar with the context and participants knew the researcher, which put them at ease to share with him their experiences.
Triangulation	The researcher spent 5 months collecting data.

	<p>The researcher held 8 focus group interviews and 9 individual face-to-face interviews until data saturation was reached.</p>
	<p>Individual face-to-face interviews and Focus group discussions were conducted, audio tapes were recorded and field notes were taken.</p> <p>A literature control was conducted to support the findings.</p>
<p>TRANSFERABILITY</p>	<ul style="list-style-type: none"> • Purposive sampling was used to select participants who had rich data on the study. • A dense description of the research design, methodology, setting, population, sample, data collection process, trustworthiness, findings, and literature control was provided to ensure transferability. • Verbatim quotes were provided to support the findings.
<p>DEPENDABILITY</p>	<ul style="list-style-type: none"> • The researcher was guided by the supervisor and the school’s research committee • A dense description of the research design, methodology, population, sample, data collection process, trustworthiness, findings, and literature support was provided to ensure transferability. • Data was analysed following Tesch’s method of data analysis
<p>CONFIRMABILITY</p>	<ul style="list-style-type: none"> • The researcher kept an audit trail from the methodology to the conclusion as below • Focus group discussions and individual face-to-face interviews were audio recorded and transcribed verbatim, and field notes were written. • All raw data analysed data, and final report were kept in a safe place

	<ul style="list-style-type: none"> • The researcher collected data until saturation was reached.
AUTHENTICITY	Participant quotes were recorded and members checked

2.4 ETHICAL CONSIDERATIONS

All research involving human participants requires adherence to ethical principles so as to provide guidance to the researchers in order to ensure the protection of participants' human rights and dignity (Brink et al., 2018). Therefore, the researcher observed the ethical principles of respect for persons, beneficence, justice and anonymity at all stages of the study.

Permission to conduct research was obtained from the School of Nursing and Public Health Post Graduate Studies Committee as well as the Post Graduate Studies committee of the University of Namibia and the Health and Research Committee (Annex A).

Written informed consent was obtained from each participant before the procedure, and this pertains to either the focus group discussion or interview, which were both properly explained. Adequate information was provided and possible risks were pointed out. Participants had to understand that their participation was voluntary and without any coercion (Polit & Beck, 2017) (Annexure D).

Respect for a person was adhered to by granting students self-determination. Each person was respected and not deceived, threatened or rewarded to ensure their compliance in the study. In addition, the information provided during the course of the study was only revealed to the supervisor of the study. A participant had the right to withdraw from the study at any time without any penalty (Gra et al., 2016).

Avoiding harm and doing good to the participants are referred to as the **principle of beneficence** (Polit & Beck, 2017). There was no immediate benefit to the students as such, but rather to future clinical education and practice. Therefore, **non-maleficence** was adhered to as no risk was posed to any participant during this study (Polit & Beck, 2017). Intrusive questions which may impact participants' career, emotional or psychological well-being were avoided. A counsellor was made available through the office of the Dean of Students (ODS) in case students became emotional during the interviews.

2.4.4 Right to anonymity, privacy and confidentiality

According to Polit and Beck (2017), if anonymity cannot be upheld, then the researcher should make sure that the participants' information remains confidential. Privacy was upheld by holding the interviews in a private place where the participants agreed on the time as well. The researcher further reminded the student participants not to reveal to others their contributions after the interviews or focus group discussions had ended.

2.4.5 Confidentiality

It was maintained during the data collection process, analysing of data and presentation of data. The identity of the students was protected by coding the interview tool. A consent form, field notes and records were kept in the office drawer and work personal computer with a protected password at the University of Namibia and only the researcher had access to them. The researcher's supervisor had access to the hard copies and electronic copies of the collected data on request.

2.5 CHAPTER SUMMARY

This chapter discussed the qualitative, exploratory, descriptive and contextual design of the study, including the population, sample and sampling, whereby clear inclusion and exclusion criteria were set. The data collection process was outlined and data analysis was addressed through the eight steps by Tesch (Tesch, 1992). Ethical measures applied to the study as well as ethical considerations that were adhered to were also presented in this chapter.

CHAPTER THREE

RESULTS, INTERPRETATIONS AND DISCUSSION

3.1 INTRODUCTION

The introduction and methodology of the study were discussed in Chapters one and two respectively. The aim of the study was to explore and describe the experiences of nursing students at the main campus of the University of Namibia, who are registered for the Bachelor of Nursing Science. Only second, third- and fourth-year nursing students at one campus were included in the study. As previously discussed, first-year students were excluded as they were regarded as not in a position to contribute to the study significantly as their general nursing placements experiences were limited at the time of data collection.

The central question asked during the process of data collection was: *“What are your experiences during placement in general wards of the training hospitals in the Khomas region”?*

3.2 PROCESS OF DATA ANALYSIS

The eight steps of Tesch (1992) as described in Chapter two, were used to analyse the data. The researcher colour-coded the data into themes and subthemes, which were confirmed by the supervisor. Data for both the face-to-face interviews and focus group discussions were analysed together.

The discussion of the findings follows, starting with a presentation of demographic data.

3.3 DEMOGRAPHIC DATA

The demographic data as reflected in table 3.1 to table 3.4 below indicates that fifty-seven (57) female and nine (9) male participants participated in this study and their ages ranged between 19 and 35 years of age. The participants for individual interviews were provided with codes as 'IFFI P' meaning, individual face-to-face interview participants and for the focus groups as FGDP standing for focus group discussion participant, to maintain confidentiality.

The female domination in this study was due to the fact that nursing is a female-dominated profession, and the School of Nursing and Public Health was no exception as it had a low intake of male nursing students throughout the years.

Stereotyping and gender bias against men helped to create a less than inclusive, sometimes isolating and challenging experience for men in nursing, who are frequently treated differently from their female counterparts (Ross, 2017).

Table 3.1 gives an overview of the year of study, age and gender of the nursing students who participated in the face-to-face interview. The researcher conducted eleven (11) individual face-to-face interviews, three (3) from the second year, and four (4) interviews from the third and fourth years respectively. Only three (3) males participated in the individual face-to-face interview.

Table 3.1. Demographic data interview participants

Participant	Participant code	Year of study	Age	Gender
1.	IFFI P1	Second year	20	F
2.	IFFI P2	Second year	20	M
3.	IFFI P3	Second year	19	F

4.	IFFI P4	Third year	21	M
5.	IFFI P5	Third year	32	F
6.	IFFI P6	Third year	21	F
7.	IFFI P7	Third year	22	F
8.	IFFI P8	Fourth year	26	F
9.	IFFI P9	Fourth year	23	F
10.	IFFI P10	Fourth year	24	F
11.	IFFI P11	Fourth year	24	M

Interviews were conducted until the researcher reached saturation within the process, the following is the number of the focus groups. The second years had two focus groups consisting of 7 participants each, FGD 1 and FGD 2, thus making it fourteen (14) participants for the two focus groups. The third years had three focus groups, FGD 3, FGD 4 and FGD 7. All FGDs consisted of 7 participants each, thus bringing the number to 21. And finally, the fourth years had 3 focus groups FGD 5, FGD 6 and FGD 8, two FGD consisted of 7 participants each and one FGD had 6 participants, in total they were 20 participants.

The details of the second-year focus groups are reflected in Table 3.2 Fourteen (14) participants one (1) male and thirteen (13) females between the age of 20 to 28 partook in the groups. The numbers under the FGD 2nd Year block represent the focus group number.

Table 3.2. Age and gender of the second-year focus group discussion (FGD)

FGD - 2 nd Year	Participant code	Age	Gender
1	FGD1 P1	20	F
1	FGD1 P2	20	F
1	FGD1 P3	22	F
1	FGD1 P4	26	F
1	FGD1 P5	22	F
1	FGD1 P6	24	M
1	FGD1 P7	21	F
2	FGD2 P8	20	F
2	FGD2 P9	20	F
2	FGD2 P10	22	F
2	FGD2 P11	21	F
2	FGD2 P12	28	F
2	FGD2 P13	20	F
2	FGD2 P14	21	F

A total of 14 second years partook in the focus group discussion on their clinical learning experiences in general wards to form two focus group discussions which were FGD 1 and FGD 2 as indicated on the far left.

Table 3.3 reflects the demographic data of the three (3) third year focus group discussions. A total of 21 students, eighteen females and three male students aged between 20 and 35 partook in the study.

Table 3.3. Third year focus group discussions

FGD- 3 rd Year	Participant code	Age	Gender
3	FGD3 P15	26	M
3	FGD3 P16	21	F
3	FGD3 P17	34	F
3	FGD3 P18	20	F
3	FGD3 P19	21	F
3	FGD3 P20	22	F
3	FGD3 P21	21	F
4	FGD4 P22	22	F
4	FGD4 P23	23	F
4	FGD4 P24	20	M
4	FGD4 P25	21	F
4	FGD4 P26	22	F
4	FGD4 P27	35	F
4	FGD4 P28	22	F
7	FGD7 P43	27	F
7	FGD7 P44	23	M
7	FGD7 P45	24	F
7	FGD7 P46	23	F
7	FGD7 P47	23	F
7	FGD7 P48	23	F
7	FGD7 P49	23	F

The rationale for conducting another focus group with this senior group was to collect more rich data as they were having an extra year of clinical placement.

Table 3.4 represents the demographic data on the fourth-year focus discussion groups, three focus groups participated in this order, FGD 5 with 7 participants, FGD 6 with 7 Participants and FGD 8 with 6 participants. A total of twenty participants (18 females and 2 males) between the age of twenty-one (21) to thirty (30) participated in the focus group.

Table 3.4. Fourth years focus group discussions

FGD 4 th Year	Participants code	Age	Gender
5	FGD5 P29	24	F
5	FGD5 P30	21	F
5	FGD5 P31	22	F
5	FGD5 P32	23	F
5	FGD5 P33	21	F
5	FGD5 P34	30	F
5	FGD5 P35	23	F
6	FGD6 P36	23	F
6	FGD6 P37	22	M
6	FGD6 P38	23	F
6	FGD6 P39	23	F
6	FGD6 P40	23	F
6	FGD6 P41	23	F

6	FGD6 P42	23	F
8	FGD8 P50	23	M
8	FGD8 P51	23	F
8	FGD8 P52	24	F
8	FGD8 P53	22	F
8	FGD8 P54	22	F
8	FGD8 P55	24	F

The demographic data reflects female domination within the interviews, which is probably because worldwide nursing is joined by more females than males. The results further indicate that the focus group discussion in the fourth years had lesser participants as compared to the other groups. The reason for that is that fourth years concluded their examinations and returned to their respective regions which made it difficult to trace them for participation in the focus group discussion.

3.3 THEMES AND SUB-THEMES

Data was collected through face-to-face interviews and focus group discussions up to the point of data saturation, and as already indicated, data were sorted into themes with corresponding subthemes. The following themes and subthemes derived from the analysis are as discussed below and reflected in table 3.5.

Table 3.5. Themes and subthemes

THEME 1	SUB-THEMES
3.3.1. Non-conducive learning conditions	3.3.1.1 Missed learning opportunities due to overcrowding and lack of resources
	3.3.1.2 Short placement
	3.3.1.3 Sending students for personal errands
	3.3.1.4 Unprofessional behaviour
	3.3.1.5 Unfamiliar with the role of preceptors
	3.3.1.6 No orientation or delegation
	3.3.1.7 Coerced evaluations by lecturers and preceptors
	3.3.1.8 Use of cell phones during evaluations
	3.3.1.9 No correlation with theory and practice
	3.3.1.10 Effects of Covid 19
THEME 2	SUB -THEMES
3.3.2 Negative attitudes	3.3.2.1 Negative attitude towards teaching and demonstration
	3.3.2.2 Taking of short cuts

	3.3.2.3 Name calling and comparing students from UNAM
	3.3.2.4 Harassment by male nurses
	3.3.2.5 Favouritism
	3.3.2.6 Unapproachable nurse

THEME 3	SUB-THEMES
3.3.3 Communicating barrier	3.3.3.1 Use vernacular language
	3.3.3.2 Shouting
THEME 4	SUBTHEMES
3.3.4 Shortage of staff	3.3.4.1 Compromised time for teaching
	3.3.4.2 Overworked students
	3.3.4.3 Lack of supervision

A discussion of each theme follows, supported by relevant subthemes and supporting literature.

3.3.1 THEME ONE: NON-CONDUCTIVE LEARNING CONDITIONS

A conducive clinical learning environment can help to reduce some of the anticipated challenges that students meet in the clinical area. Such challenges hinder positive student learning which is detrimental to the field of nursing practice (Chiona, 2020).

Most students felt that their clinical environment in general nursing was not conducive to learning. The following sub-themes emerged from the study results, namely, overcrowding in the wards, lack of equipment, less placement time, sending of students unnecessary, no orientation, no delegation, the role of preceptors not known,

and use of cell phones during evaluations. A conducive clinical environment for students in clinical placements is dependent on the engagement and collaboration between preceptors and academic nurse teachers (Ekstedt et al., 2019).

The same was observed by Rajeswaran (2016) in a study done in Botswana stating that ward atmosphere directly influences students learning as it determines their perception of whether the clinical area is suitable for their learning. This concrete experience would directly influence the learning of the student (Kolb, 1986) as it will influence the second phase of reflection about the clinical experience. The diverger will most probably not benefit from such a situation as the latter prefer to watch rather than do. Insufficient equipment, theory-practice gap, confusion, stress, and anxiety may encourage the students to practice shortcut methods to complete their tasks quickly, rather than to focus on the competency. Jamshidi et al. (2016) state that nursing students' exposure and preparation to enter the clinical setting are some of the important factors affecting the quality of clinical education.

Since an optimal clinical learning environment has a positive impact on nursing students' professional development, a poor learning environment can have adverse effects on their professional development process. During such an experience, it is important for the student to be guided to optimise the opportunity. Kalyani et al. (2019) also concluded that factors causing problems between students and the department staff include a lack of correspondence between education and treatment, rejection of criticism, insufficient equipment provided to students and failure to consider the students' list of responsibilities.

This theme is corresponding with Kolb's theory (1986), which indicates that learning is a cognitive process that involves constant adaptation to and engagement with one's

environment. The environment thus has a very important role to play in the learning of the student. As indicated earlier, an introduction to the environment is imperative. For meaningful learning to take place, the learning environment should be friendly to the nursing students.

3.3.1.1 Sub-theme: Missed learning opportunities due to overcrowding and lack of resources

The increased intake of nursing students in nursing colleges has led to overcrowding and lack of resources in public academic hospitals, thus negatively influencing their learning experiences and the availability of clinical learning opportunities (Motsaanaka et al., 020), especially for the convergers in Kolb's theory, as they would focus on the ideas and not on the people which might compromise patient care. In addition, such overcrowding will influence the reflective observation stage of learning and ultimately what the student will observe to reflect on from such an overcrowded situation may be minimal. This will result in a student focusing on finishing a log book rather than being concerned with learning from the placement.

Most participants agreed that there was overcrowding and a lack of resources in the wards which led to missed learning opportunities, scrambling for rare procedures and frustration from both students and nurses. This is illustrated below:

“The Universities are a lot, and the wards are always overcrowded; we have a shortage of staff also sometimes getting demonstrations is very hard for the staff members as they are always overworked”. (IFFP 2)

“We were many students meaning we were more than the patients so when you go to a certain room everything is done, so at some point, there is basically nothing to do you have to read through the files and make yourself available,

but still the senior sisters will be screaming on you that you have to do something and ABC.” (FGD P 3).

“We end up a lot in the wards and then some sisters feel so frustrated, say for example you have 20 first years in the ward you need to give them special attention and also special attention to the patient and some wards are overcrowded with patients so I think it also brings stress to the sisters and also to us students because you really don’t get to learn a lot of things cause the students are a lot and the sister will not get time to teach” (FGD P33)

“The nurses hide gloves in the lockers and tell us there is nothing. Some nurses don’t want us to wear gloves and aprons because we are a lot, and they say we must buy gloves” (FGD14).

“One other thing is that there are never materials in the wards which limits your learning because you would want to see the thing, you would not want to hear. You want an ideal situation we don’t want shortcuts at the end of the day I am disadvantaged I don’t really know how to do the things as I am supposed to do” (FGD P8)

“Lack of equipment like gloves, aprons, dressing packs that is causing the nurses to take second options, because if there are no dressing packs obviously I cannot leave the patient to be there if the dressing is not done, it will negative input on the wound and it can cause wound infection the lack of resources also lead to wasting of resources, for example, using sterile gloves on unsterile procedure”. (FGD P 30)

“I feel we have too many students in one place or department. I will talk about where you have more than 5 students in a room, whereby any procedure to be done on a patient, the patient won't be comfortable”. (FGD P21)

Kalyani et al. (2019) in a study on how nursing students experience the clinical learning environment reported that nurses found the physical space to be inappropriate for the number of students in the department. These results were further supported by Ali and Ali (2017) who contended that crowded clinical training places because of large numbers of students impede effective clinical learning and learning chances and self-confidence which leads to students not being competent in some remedial tasks when completing training hence being unable to provide quality care. In a study done by Motsaanaka et al. (2020) in Gauteng, it was revealed that nurses had difficulties in managing a large number of students in clinical settings and students were competing for clinical procedures, thereby compromising the active experimentation stage in Kolb's learning cycle. Convergers will also face some difficulties to learn in such a situation as this group of learners prefers to be involved in technical tasks.

Ziba et al. (2021) state that overcrowding in the clinical setting is a major challenge to clinical teaching and learning. Overcrowding in the wards makes it difficult for nurses and students to engage meaningfully. When students are high in numbers, the physical space cannot accommodate them and it becomes very difficult for staff to even assist them to learn clinical skills.

In a study done by Rajeswaran (2016) in Botswana, it was also concluded that the lack of resources negatively impacts students' teaching and learning. It is further argued that the lack of facilities and the unavailability of the needed equipment does not only lead to waste of time and delays in patient care, but it creates an unpleasant educational

environment for the students (Kalyani et al., 2019). The lack of resources was one of the most important factors that cause students to learn in a difficult way (Kaphagawani & Useh, 2013; Moyimane et al., 2017).

McMahon et al. (2020) state that the world's wealthiest countries have been gripped by resources shortage, including a shortage of personal protective equipment (PPE) and ventilators during the pandemic. Governments around the world are bargaining share in a global strangled supply chain. Though the pandemic had devastating effects on the world, training of nurses continued to take place, and this was seriously affected by the shortage of equipment.

UNAM's School of Nursing and Public Health places nursing students on a two-week rotational basis in the nursing clinical departments, in this case referring to general wards, but due to the fact that there are students from other nursing training institutions in the clinical settings, overcrowding has become a serious clinical learning burden affecting all year participants in the study. Although the students raised concerns about the shortage of resources in the clinical setting, the Ministry of Health and Social Services has the obligation to ensure that the hospitals and wards are well stocked with equipment and supplies, to enable safe nursing practice and nursing care. However, that is not the reality on the ground as one will still find some shortages of resources in the clinical settings due to the strangled supply chain and delayed orders.

Active experimentation allows learners to apply newly acquired concepts and ideas in practice, however, when the wards are overcrowded, learning, as per Kolb (1986), cannot take place as expected due to limited learning opportunities.

3.3.1.2 Sub-theme: Short placement

Limited educational opportunities were experienced by participants during their time in clinical settings. The main reason cited for this problem was the short duration of the clinical education in different wards, the large number of students in each clinical education group and the lack of diverse cases in the wards (Mamaghani, 2018).

The participants in this study highlighted that they were placed for a short period in the general wards, and hospitals in general, and wished for longer placement periods. The participants mentioned that the two weeks period was not sufficient for learning as in the first week they still had to find their way around the ward and the clinical requirements are many to finish in two weeks. The participants expressed their views below:

“I don’t understand the time you get mainly you get allocated to a department for just a week, and you are expected to finish procedures there, the first day you are oriented and you do nothing much how do you expect me to finish all activities there in just a week?” (FGD P 31).

“We are really placed for a very limited time and we do not learn much” (P 41).

Most students complained about the inaptitude of hours allocated for clinical learning and time schedules. Some authors state that among the important effective factors in students, clinical learning is the unsuitability of the number of hours and time schedules assigned for clinical learning (Ali & Ali, 2017). Gilbert and Brown (2012) emphasise that a short placement period can result in a decreased sense of belonging and limited learning opportunities for student nurses due to the time required setting. In a study by Silva et al. (2012) done in Sri Lanka, the authors also admitted that the

majority of students were unable to finish all their procedures within the allocated time due to short stays in clinical settings.

The School of Nursing and Public Health places nursing students on a two-weekly clinical rotational basis. The students raised concerns about the period of allocation as it was not enough for clinical learning and the completion of log books. UNAM through the School of Nursing has received recommendations from the stakeholders on how to mitigate the situation and improve clinical placements. It is envisaged that a student, during his/her two weeks of placement will be able to go through Kolb's cycle of learning (Kolb, 1986), starting with a concrete experience and ending with active experimentation. However, this is not a given, considering the multiple factors that have an influence on the learning that takes place during such placement.

3.3.1.3 Sub theme: Sending of students for personal errands

Mamaghani et al. (2018) report that when health personnel and clinical instructors try to forcibly impose their demands on nursing students and forcing student nurses to perform basic and routine tasks that were not deemed by the student as important educationally was a form of bullying. This caused students to believe that they were wasting their educational time and negated from them the value of clinical education.

Most participants cried foul at the nurses sending them all the time and unnecessarily even for their private things and they then come and use it against them if they refuse to be sent hence they are regarded as being unprofessional. The participants further stated that the nurses don't give them time to learn in clinical and work on their practical books. Going out of the ward on a regular occasion will interrupt the learning cycle for these students at any stage (Kolb, 1986). These quotes were captured from the Focus Group Discussions:

“The sisters will send you for her personal reasons, but when you refuse and bring your book later they refuse to sign because you did not go where she was sending you before. It is not supposed to be like that because I cannot be sent around every day; it is my right to refuse the request made by a sister sending me for her personal things”. (P29).

“The other thing is that you are sent to escort patients to other hospitals the whole day and you miss out on practical learning for the whole day” (FGD P9).

“To add on to what student 29 has said about the sending, the nurses really send students a lot and the students will not even get the time to learn anything but at the end of the day they will say they will not sign for you because you told me that you don’t want to go to the pharmacy or to the gate to buy fat cakes, you will just end up crying it is emotionally draining it is very bad”. (FGD P 32).

The students argue that one of the most unprofessional behaviours of nurses with the students was to ask them to do things which are not particularly defined as their tasks. The findings of this study were also supported by the findings of Jamshidi et al. (2016), which show that students had missed opportunities for clinical learning when they were sent to perform other equally important errands, including going to the laboratory and x-ray, among other things instead of learning in the ward.

3.3.1.4 Sub-theme: Unprofessional behaviour

Professional behaviour, an inseparable part of the nursing profession, is a set of values and norms suitable for profession-related behaviours which are acquired through the knowledge, attitude and skills that result in a commitment towards a specialised field

(Mousaviasl et al., 2019). Some nurses were upset by the students' entrance to the clinical wards because they believed that nursing students were the cause of clutter and disorganisation in the clinical setting (Mamaghani, 2018).

Some of the students felt that some nurses lacked professionalism and that they could not be their role models as they behave in an unacceptable manner. This is illustrated by the following quote:

“The nurses lack professionalism because we need role models, we need to have someone to look up on to, cause our lecturers are not always around. They don't do things professionally it is just chaotic in the wards you are supposed to have role models and say I want to be like a certain sister but at the end of the day, you really don't see whom to follow because everybody does the things differently just chaotic there is no professionalism. For example, let me say you are going to do a procedure as a nurse you are supposed to have a trolley packed with your instruments, but for them, they don't take a trolley they just have their needles in their hands which is not professional they are supposed to have trolley and do everything in order”. (FGD P 40).

“The nurses should stop saying: I also suffered for signatures, there is just this thing of I can't sign your book, I also suffered for signatures, why shouldn't you, it is like they don't want you to finish or graduate - it is not easy and it is unprofessional”. (FGD P 27)

The nurses in the clinical wards have all gone through nursing training, whereby ethics was a compulsory module as a way to reinforce professional conduct and instil discipline in the workplace among the nurses. It is therefore hard to comprehend this kind of behaviour.

Student nurses described professional nurses as knowledgeable, approachable, skilful, excellent communicators, reflective practitioners and having a positive attitude (De Swardt, 2019).

A non-supportive learning environment combined with unwelcoming clinical staff, clinical instructors with a lack of expertise, and a lack of sense of belonging among nursing students are a few key challenging factors with a negative impact on students' learning in the clinical learning environment. Understanding these factors is essential to take appropriate action to overcome the challenges (Panda et al., 2021).

3.3.1.5 Sub-theme: Unfamiliar with the role of preceptors

The School of Nursing and Public Health has, since 2017, managed to recruit preceptors on part-time contracts, for supporting the lecturing staff in the clinical follow-up of students. The role of a preceptor extends beyond the technical aspects required of a supervisor in the clinical environment to also involve the social aspects of caring for preceptees' wellbeing (Quek & Shorey, 2018). The education of the future generation in nursing is dependent on the availability of qualified preceptors and appropriate clinical sites. Students need extensive real-life patient care experiences with knowledgeable and dedicated preceptors to achieve competency for practice (Tenfelde & Fantasia, 2018).

Asif et al. (2021) state that students also have a variety of concerns about precepted clinical experiences and perceived barriers reported by students have included concerns about the competition at clinical sites and the inability to find preceptors in speciality practice. Some participants questioned the role of the preceptors as the preceptors only came to take attendance and do examination evaluations in the wards. The participants mentioned that the preceptors need to be visible in the wards all the

time to guide and observe if the students are carrying out their skills correctly, and assisting students in all clinical procedures. The constant support and observation of the student in the clinical area are important to determine what learning style the student follows, and to support the student where necessary, to learn. And not just coming to take register but assessing them on clinical procedures as supported below:

“The only time we see our preceptors and lecturers was time for OSCE or evaluations or when we go to the University for class. I feel like we missed out on information that could be important due to Covid 19”. (FGD P 35)

“Talking of preceptors, I don't know the role of preceptors; the only thing they do is come to the wards they just go to simulation and then they ask you to go there to sign sending messages (P36).

Rajeswaran's (2016) study findings revealed that clinical tutors were only seen in the clinical area when they came to evaluate students. The same evidence was pointed out by Ekstedt et al. (2019) in Sweden, that students' dissatisfaction with clinical learning was not only associated with having limited preceptors, but also with the preceptor's attitude and approaches. College instructors and preceptors should design a programme for accompaniment and avail themselves in clinical settings on a continuous basis to guide student nurses. The authors further indicated that a supervision model for students, based on peer learning with students in dedicated rooms with many preceptors, can be more satisfying than a model with traditional supervision where each student is dependent on a single preceptor. These findings are also congruent with those by Kaphagawani (2016), who acknowledged that in the absence of nurse educators in the clinical area, students were not able to integrate theory and practice.

Kolb (1984), through his learning cycle, argues that a student needs reflective observation. The student nurse makes sense of what they have observed and reflects on the clinical encounter. In the absence of clinical preceptors and lecturers in the wards, the students are denied this opportunity of reflective observation in clinical learning and they miss out on important clinical learning experiences as nobody can guide them during the process. Reflection is important for the student to remember the situation and to do or actively experiment afterwards.

The lecturers, as academics, are responsible for the organisation, planning, coordination, implementation and evaluation of learning and teaching aspects of the students. They are responsible for ensuring the efficient and effective implementation of the curriculum and ascertaining that students have achieved the set learning objectives, through theoretical and practical teaching and evaluation of students. Additionally, preceptors are complementary/supporting staff responsible for the accompaniment of students during clinical practice to mentor and guide students' nurses towards professionalism and providing clinical teaching, bedside teaching and simulations to ensure the clinical competencies for students.

3.3.1.6 Sub-theme: No orientation or delegation

To optimize teamwork, there is a need to have a shared mental model in performing basic nursing care tasks, mutual support for workload management, better delegation practices, enhanced interpersonal relationships and better team orientation (Goh et al., 2020).

Some participants expressed that they did not receive any orientation until their fourth day of work or that there was no orientation at all. As such, they were working without delegation which led them to get lost in the wards and find it difficult to find certain

equipment in the ward. The participants felt that if orientation and delegation were done, this could have made their clinical placement in the general wards worthwhile for learning.

“My clinical learning experience was terrible we were not oriented and therefore got lost in the wards and there is a shortage of staff meaning that the staff members did not have time to teach”. (IFFI P9)

“Also, maybe they need to orientate us before because one needs to know where to find specific equipment and so on”. (IFFI P4)

“The sisters really have a lot of work to do you will be lucky if they orientate you on the first day you come. I remember being oriented on the fourth day, how do you orientate me on the fourth day I already know what is being done”. (FGD P 34)

Cowen (2016) states that delegation promotes efficiency and flexibility, and it allows for work to be done by different people in different ways thereby ensuring a high level of success and achievement of objectives. This also results in a balanced workload and the promotion of effective communication.

This finding is analogous to those by Kalyani et al. (2019), that there was no clear description of the tasks for nurses and students, which was why they were irresponsible, for instance, causing a negative attitude towards nursing and general confusion about nursing. The main reason for orientation is to enhance the skills and knowledge of the new graduate, facilitate the integration of theory and practice and ease the new graduates' transition from university life to the clinical setting (Lortan & Maistray, 2019). This first day in the ward would fit into the concrete experience of Kolb's cycle, which is important for learning to take place. If the student is not properly

orientated into the context of his/her clinical placement, his/her concrete experience and subsequent reflective observation will be affected. The students who are divergers will particularly be influenced by this lack of orientation since they learn from direct observation and reflection.

3.3.1.7 Sub-theme: Coerced evaluations by lecturers and preceptors

Some participants raised a concern about how preceptors treat them unfairly, stating that lecturers and preceptors do not care if they are ready for evaluation or not. What they care most about was with regards to their marks. This experience made the students uncomfortable as illustrated by the students' views below:

“I was evaluated on a certain procedure I was not even given enough time to adjust to the wards because what they only think is for their procedure to be done as long as they obtain their marks you know for their Continues assessments. they not putting in consideration that okay this student are they ready for evaluations”. (FGD P38)

“Preceptors are supposed to view students differently. They are not there to scare students and make them uncomfortable like when it comes to evaluation” (P 36).

“Imagine you are evaluated by a rude clinical preceptor, that is a failure and it affects your mental health” (P, 35)

This finding coincides with those from the study by Kaphagani and Useh (2013), arguing that clinical nurse educators' role is to enhance learning through the provision of opportunities for learning, support, guidance and conducting timely and fair evaluations. However, in the current study, students felt that this role was not filled as

lecturers, clinical instructors and preceptors took more time in evaluating than teaching.

This observation was supported by the findings from Tiwaken et al. (2015), who state that unfamiliarity with procedures is another factor that makes the student nurses tremble. The researchers further added that students were concerned about the manner in which faculty staff interact with them, as they believe themselves to be worthy of respectful treatment.

The lecturers and preceptors are supposed to prepare students well in advance for their clinical evaluations. Clinical evaluations are a delicate task for nursing students as the practical component contributes 50% to the passing marks.

3.3.1.8 Sub theme: Use of cell phones during evaluations

The use of mobile phones by nurses for personal purposes while on duty is unequivocally considered unprofessional and often risky behaviour. If not used with discretion, smartphones can have serious consequences both on patient safety and on how healthcare professionals approach the risk of dehumanisation care (Osorio-Molina et al., 2021).

The participants expressed their frustration with the fact that some lecturers, clinical instructors and preceptors use their cell phones during evaluations. The participants alluded that such behaviour leads to preceptors having divided attention and ending up failing students as per the verbatim quotes below:

“As much as we are not allowed to use phones at work, there are some preceptors who use their phones, they are receiving calls during clinical evaluation. Imagine how distracting that is for me personally when I was

evaluated a particular person that was evaluating me received 3 phone calls and later on when we had to go through after evaluation she is telling me you did not do that and that I was like I did how do you expect to get everything if you are on your phone". (FGD P38)

"We are afraid of failing the lecturers do not give us enough attention as they are busy on their phones" (P40)

This finding resembles those by Wu et al. (2012), that student learning is hindered by teachers' unclear and non-useful feedback or teaching without a respectful attitude.

Fiorinelli et al. (2021) concluded that mobile technology can improve nurses' performance and the quality of care, provided they are used with discretion. However, the application of regulations and policies by health facilities is desirable to avoid the inappropriate use of these devices by nurses.

In an official circular (no 85 dated 05 September 2016), the Executive Director in the Ministry of Health and Social Services stated that usage of cell phones during official working hours is prohibited for all staff of the hospitals, health centres, clinics and outreach facilities (MOHSS, 2016). However, it is observed that this circular does not prevent staff from using their phones, nor are there any sanctions, should a staff member not comply with that. The use of cell phones during nursing interventions not only compromises safe nursing care but also interferes with the entire learning cycle of the student. The initial CE must be a lively encounter that involves all students. What is unprofessional conduct and contradicting to safe patient care may be differently perceived by the student during Kolb's learning cycle. Kolb (1986) suggests that learning styles are part of an individual's personal identity, though the change in style is inevitable so as to produce a more balanced learner. Therefore, the

clinical staff, preceptors and lecturers should assist students in circumstances where their learning may be hampered, and a variety of teaching methods may assist in this regard.

3.3.1.9 Sub-theme: No correlation between theory and practice

Transferring theory into practice in a structural manner requires professional support in the workplace, trust and the opportunity for direct experience, using valid and up-to-date knowledge by clinical staff and bridging the simulated situations with real-life scenarios (Hashemiparast et al., 2019).

Some participants felt that they were having difficulties adjusting in the wards, as what they were taught in class differed from what they were taught in practice. The participants further raised their concern about a difference in the way things were done in the two training hospitals and as such, they had to keep on adjusting to new skills or different skills from either hospital.

“When you are taught theoretically compared to how it is done practically it is always a challenge, because in the theory you are expected to see in that sense that you understand it theoretically, it is a challenge because you imagine it like when you are taught theory, but when you have to do it is so different and also the way they do procedures from hospital to hospital is a challenge one has to keep on adjusting even the soaping differs and one has to be adjusting with clinical rotation”. (IFFI P 4).

“We are not confident in carrying procedures basically turning theory into practice, we know the theory but difficult to carry it out” (FGD P13).

“We went with theory to practice although at school we are taught with equipment which is not the case in the ward, because most equipment is not in the ward”. (IFFI P9)

“We don’t have equipment and resources, humidifiers, hand disinfectants, gloves there is nothing plasters no dressing packs what you are taught in the class is different from what you find in clinical”. (FGD P 28)

Saleh (2018) indicates that the primary purpose of theory in nursing is to improve practice by positively influencing the health and quality of life of patients. The relationship between theory and practice is reciprocal. Practice is the basis for the development of nursing theory whereas nursing theory must be validated in practice.

It is further argued that the nursing profession is composed of two parts, the theoretical part which reflects knowledge which is conveyed in the classroom and the practical part which focuses on improving skills in the clinical area and prepares student nurses to be able of doing as well as knowing (Saifan et al., 2015). As can be seen from the quotes above, there is a challenge for nursing students in general wards to apply their theoretical knowledge to the execution of clinical skills in practice.

Motsaanaka et al.’s (2020) study also supports the findings that placing a large number of students in the clinical setting leads to overcrowding thereby creating challenges for students to integrate theory into practice. Students become anxious and confused if they practice something different from what they learn in the classroom (Kaphagawani & Useh, 2013).

The participants’ experiences indicated that there was a theory and practice gap as what was taught in class was not what was practised in the wards, thereby creating uncertainty around what exactly would be the right way to do things. This gap was

already pointed out by the relevant stakeholders during consultations with UNAM's School of Nursing and Public Health, especially during the process of curriculum review and transformation. During the latter, strategies to strengthen the closure of the theory and practice gap in the School of Nursing and Public Health were discussed in order to prepare nurses for the public market.

3.3.1.10 Sub-theme: Effects of Covid 19

Globally, the Coronavirus disease had negative consequences for higher education such as universities closing in response to lockdown measures. The School of Nursing and Public Health at the University of Namibia was no exception.

The highly contagious and fatal nature of the Covid 19 continued to place immense pressure on hospitals and the psychological well-being of healthcare workers, including student nurses who had to continue with clinical practice in order to comply with their training regulations. Therefore, this pandemic continues to affect the clinical education for nursing students whose programme is already known to be highly stressful even without additional challenges presented by Covid 19. The Corona virus disease led to fears and increased stress levels among nursing students who strive to acquire the requisite skills and competencies necessary for patient care (Baluwa et al., 2021).

The researcher collected data amidst the pandemic; some students stated that their clinical learning was negatively affected by Covid 19 for the year and a half prior to data collection, as they were withdrawn from the clinical practice and the lecturers and preceptors were also absent from clinical settings due to the fear of contracting Covid 19. The negative impact of the latter was that students missed out on important clinical learning opportunities. Some of the participants had this to say:

“My clinical learning was also affected by Covid 19, so since Covid -19 came we were withdrawn from clinicals and we were unable to go to work for almost half a year and so on and we were also not allowed to work in other departments since they were either turned in Covid wards or something like that this affected our teaching and experiences.” (FGD P 53).

“It is really a struggle especially now that there is Covid 19, we had theatre allocations. People in theatre don’t want a lot of students as it is overcrowded now. We must hope to make our own way to complete because it is not easy.” (FGD P34)

“Third year with Covid 19 we were really under pressure, I think I really missed on what I needed to learn because I was just pushing to finish my log book because the University was on our case saying if you are not finishing the books you are not going to the next level.” (FGD P41).

“The nurses were helpful but we had limited learning because it was Covid 19 we were basically just doing basic nursing care because the wards were full of Covid 19 patients. I just feel we could be placed back to go learn on the missed opportunities and learn more”. (FGD P23).

Triemstra et al. (2021) state that the Covid 19 pandemic forced learners and educators to rapidly adapt within their altered clinical learning environments through personal separation, social distancing, organisational changes and the shift from physical to virtual learning environments, which significantly disrupted the status quo. The Covid 19 pandemic has affected and will continue to affect the delivery of knowledge at all levels of education including nursing (Hoofman & Secord, 2021).

In an attempt to cope with the pandemic, after a state of emergency was called by the country's President, the School of Nursing and Public Health initially withdrew nursing students from practice for a period of two months, which was done to allow the School to cater for the necessary protective clothing. Parents and guardians got anxious and they threatened to take their children out of the training institution. Measures were put in place for the students to be granted an extension on the log book requirement, in an attempt not to miss out on clinical requirements.

Agu et al. (2021) state that the impact of Covid 19 on developing countries may be greater than in developed countries due to some disparities. Online learning has become the solution to complete the curriculum. However, it does not address the clinical component. For the School of Nursing and Public Health at UNAM, after a state of emergency was declared on 13 March 2020, online learning was a huge challenge and even more so for the nursing students who had connectivity challenges at the residences they were occupying. Ulenaers et al. (2021) state that according to students, the clinical placement during the pandemic was more demanding than usual, and they expressed this using various terms such as: busy, insecure, hectic, difficult, rare, overwhelming, heavy, stressful, weird, unsafe and psychologically stressful.

3.3.2 THEME TWO: NEGATIVE ATTITUDES

The nursing staff's negative attitude towards students and clinical instructors was one of the major factors that caused inappropriate interactions including poor communication skills and the short duration of clinical experience (Mamaghani et al., 2018). Most of the students across all years of study in the clinical learning experienced negative attitudes from the clinical staff and clinical supervisors during their clinical placement, in this case, in general wards. This was also shown by emerging sub-themes from the study: nurses refusing to teach, the name-calling of

students, the comparing of students from different universities, male nurses harassing female students, shouting at students, and favouritism.

This finding is similar to a study done by Rajewaran (2016), specifically in Botswana, which argued that a lack of harmony, communication, and interpersonal relationships between the educator and the student negatively affected clinical learning. The attitude, approach, interpersonal relationship and neutrality of the lecturers create trust among students, and 75% of students raised concern that their learning was compromised due to the lack of organisational support. This finding is supported by Kalyani et al. (2019), that the interpersonal relationship between the instructors and clinical nurses and students plays an important role in the development of students' personal and professional identities. The authors further add that hopelessness was another psychological reaction which was created under the influence of nurses' attitudes.

As previously indicated, the first stage in Kolb's cycle consists of the first concrete experience (CE), especially in the clinical context. This is what will guide the learners' reflective observation (RO) and ultimately direct their abstract conceptualisation (AC) and active experimentation (AE). While students are in the clinical area, the moulding of future professional nurses, among others, takes place. It is therefore imperative that negative experiences as explained under theme two be redirected by the lecturer or clinical staff who accompanies the students, to bring perspective and corrective measures to the RO.

3.3.2.1 Sub-theme: Negative attitude towards teaching and demonstrations

The concept of academic incivility does not seem to be completely established yet, but it is characterised by a violation of the norms of mutual respect in interpersonal

interactions among faculty members, administrators and students. Academic incivility hinders teaching and learning activities between faculty members and students, which puts the purpose of higher education institutions at risk (Park & Kang, 2021).

Most participants raised concern about nurses that refuse to teach them and also to sign their log books in the clinical settings, saying that it was not part of their duties. The negative attitude negatively affects the students' learning as the students find it hard to learn on their own without demonstrations. The findings are stated below:

“Sometimes, some of the nurses are just rude, keeping information to themselves and they don't like helping by giving demonstrations and teaching students, and they don't like signing also. Sometimes you work with them but at the end of the day when you have to give feedback they will say, ‘I never saw you, where did you work such things and it is not really good when someone is answering you like that’”. (FGD P17).

“Okay I also had a bad experience in the ward whereby some of the nurses were refusing to teach us because it is apparently not their responsibilities to teach us, it is supposed to be our clinical preceptors and lecturers”. (FGD P31)

“I also had a similar experience to the one of my fellow students whereby I worked the night shift. The sister was sleeping the whole night and I did all the vitals in the ward and nursing care. When it was time to sign, the nurse was refusing to say it was time for them to go”. (FGD P 28).

The most important obstacle against clinical education is associated with nurses with inadequate knowledge and skills and the uncooperativeness of the personnel (Shadadi et al., 2018). Kaphagawani (2016) proffers that the clinical staff did not want to teach

or assist students because they were not being paid for supervising students, were overloaded with work and they were not employed to teach students, which was perceived as the duty of the Nurse Educator. In a study by Jamshidi et al. (2016) student nurses were particularly dissatisfied with the lack of feedback they received in the ward, the lack of opportunities to practice a particular skill, and insufficient exposure to learning opportunities. However, it is one of the instructors' and nurses' important obligations to provide nursing students with training and support on entry into clinical environments and help them to accept their role as nurses (Kalyani et al., 2019).

It is further argued that nursing behaviour, attitude and willingness to teach have an important influence on the learning of students. If students do not feel wanted, trusted, respected or supported, or feel bullied, intimidated or treated unprofessionally, the workplace culture causes them to lose confidence, which hinders growth, thereby resulting in inadequate preparation for professional nursing practice (Webster, 2016) as per Kolb's cycle in the discussion above.

Ziba et al. (2021) state that in Ghana, it was regarded as the responsibility of every registered nurse or midwife to provide teaching or guidance for students who work with them on their shifts. The registered nurses supervise students and do not receive payment from any of the institutions for this service. Equally so is the expectation of the registered nurses in public hospitals in Windhoek. However, as alluded to earlier, there are factors like overcrowding of the ward that compromise this expectation. Ultimately, it is the student nurse who is negatively affected by the situation.

3.3.2.2 Sub-theme: Taking shortcuts

Workers in health care organisations develop workaround behaviour in response to the four factors they perceive: prevent or weaken the care they provide to their patients, are not in the best interest of their patients, make the realisation of their job difficult or longer or potentially threaten professional relationships. Workarounds are created under pressure to respect rules or meet other work demands. They can also have negative consequences such as medical errors which can subsequently lead to injuries (Mansour & Tremblay, 2019).

Safe and timely patient care also requires optimal coordination of staff, resources, equipment, schedules and tasks. However, healthcare workers encounter barriers when implementing these standards and engaging in workarounds to overcome these barriers (Mula et al., 2019).

Some students from the study felt that some nurses were taking shortcuts and they were not willing to demonstrate the actual procedures. This is evidenced by the quote below:

“Some nurses do shortcuts, so you will end up doing shortcuts as you see them doing. They don’t want to demonstrate because they don’t want us to know the shortcuts”. (FGD P13)

“One is taught something else and when you are practically doing it, it is like kind of different as nurses are doing it differently in practical” (P5)

“One thing is that there are no materials in the wards which limits your learning because you would want to see the things you would not want to hear. We don’t want shortcuts at the end of the day as the nurses do”. (P8)

Student nurses described the challenges they experienced when observing risks to patient safety. Registered nurses request students to engage or conspire in unsafe practices, leading them to experience discomfort and yet they have to remain silent. Students acknowledged that they frequently remain silent due to the fear of negative consequences (Fagan et al., 2020).

3.3.2.3 Sub-theme: Name calling and comparing students from UNAM

Obvious signs of bullying of student nurses from some institutions in the general wards are evident. Signs of bullying include the excessive blame of students because of little mistakes, continuous monitoring of students without specific reasons by irresponsible staff to try to mock or hassle students, and students' humiliation for their choice of profession and the mistakes they make. The author further mentioned that it also included workplace violence, which refers to verbal violence including insults, ridicule and contempt (Mamaghani, 2018).

“Nurses eat their young ones” is an unfortunate idiom which is understood and used by nurses internationally. Dishearteningly, the idiom has been in use for over 30 years. Nurses eating their young does not literally refer to being cannibalistic with other nurses but refers to the bullying behaviours experienced by nurses (Gillespie et al., 2017).

Most participants experienced name-calling and ill-treatment by the nurses during their clinical placement in general wards. The negative experience makes the student nurses feel hopeless and demoralised, thereby leading to poor learning outcomes and a feeling of wanting to quit. This experience was mostly encountered by the second and third-year groups, as fourth-year participants were most likely to be respected as they were seniors. The participants further felt downgraded and demotivated by

belittling from nurses in the wards as they always compare them to other institutions also training nurses. Discriminatory behaviours and an unsupportive atmosphere in clinical environments as well as the negative attitude towards nursing students in clinical departments and society, caused an inferiority complex and a sense of humiliation or deficiency in self-confidence in students, as is evident from the following verbatim quotes:

“The nurses blame you for things that they did when you were not there. You come in the morning then you are blamed for something that you don’t know. That causes a very uncomfortable situation for us. (FGD, P36)

“They will either call you stupid or incompetent but what they don’t understand is if you want your student to know something teach them on the first and second day but they don’t do that, they rather ridicule us, make fun of us, say the meanest things to us and they demoralise us. So, when they want you to do something, we are not even comfortable because you know if you do something in a wrong way they will judge you saying what do they teach you in UNAM, you guys are just useless”. (FGD P5)

“The nurses are rude they don’t communicate well to students, they embarrass you and do not include you in the team” (FGD, P7)

Kaphagawani’s study (2016) concurs with the present findings, that some staff would talk down on students in the presence of patients by calling them names. As a result, patients sometimes refuse to have some procedures being done on them by students. In addition, students in most cases receive destructive feedback. Students were reprimanded in the presence of patients, other staff and students. Owing to some mistakes made, they are humiliated, insulted and laughed at in the presence of

guardians, which makes the students seek to withdraw from the clinical learning site. Such types of feedback instil fear and cause students to refrain from performing any procedures in case they can make some mistakes thereby causing them to lose opportunities for clinical learning.

Also, it is further confirmed by Kalyani et al. (2019), that clinical nurses' negative relations with the students and the behavioural and verbal aggression towards students are a major factor in the development of stress in students, thereby creating a sense of inefficiency and this can become the basis for disqualification. An authoritarian and uncivil approach to nursing students is a major source of stress for nursing students and it negatively affects their learning (Yen, 2012).

A moderate to high prevalence of clinical violence towards nursing students during clinical placements is documented. The findings show that the prevalence of and negative impacts from verbal abuse were significantly higher than physical violence. The study revealed that the experiences heightened students' intentions to leave the nursing profession. The nurses in the clinicals are supposed to be friendly, accommodating and welcoming rather than rude to students. Friendly nurses are perceived to be the best at passing on knowledge to nursing students (Cheung et al., 2019). The senior students in their final year are often less exposed to name-calling and labelling than their juniors as supported by the following verbatim quotations:

“In the fourth year, the sisters are treating us with respect because we are seniors now” (FGD-P 37).

“The other experience that is not so nice is when the moment you go to some wards and sometimes the nurses there have kind of discrimination what so not. Sometimes you find students were already working there and instead of

accommodating us, the students that are coming just that time and letting us get to know the ward they discriminate against us and always be like categorising students by institution saying this institution is not good because the students are like whatever. For instance, if you find an institution where they compare you not knowing that they have been there for a long time and we haven't. Sometimes they say all sorts of bad things which is emotionally draining” (FGD 8, P36)

“The experience that made me uncomfortable is the stereotype, stigma and discrimination against UNAM students from the staff. The nurses are not respectful they end up shouting and dehumanizing you in front of patients” (FGD 8, P 38).

“There was a time that we were with the other university and the nurses where like they don't want UNAM students, they are so rude what not we only want the other university students”. (FGD 2, P13)

“Some nurses don't want us to wear gloves and aprons because we are a lot” (FGD 2 P14)

“There is this thing of nurses, I don't know if I could say stereotyping but I don't know how to call it, but those nurses who are not UNAM products they are against UNAM students. One day I was standing in the coat with other students from other institutions but the nurse just started shouting, ‘you UNAM students are lazy and always coming late, but we were not the only students there which is bad” (FGD P13).

It is reported that many of the students complained of staff discrimination between them and other trainees in the clinical settings (Ali & Ali, 2017). Some nurses have

negative attitudes towards the students' presence in the department, coupled with the lack of support by nurses, and patient mistrust which is caused by an unsupportive atmosphere in the clinics, which was very unpleasant to the students (Kalyani et al., 2019). The findings are similar to those from a study by Jamshidi et al. (2016), that many students complained about the staff's discrimination between them and medical students. The comparison between nursing and medicine and regarding medicine as a superior major violates nursing students' personal dignity and gives them a sense of professional inferiority.

UNAM's School of Nursing and Public Health is the mother school in the training of health workers. The Department of Nursing is one of the oldest and first departments to train nurses in Oshakati and Windhoek, Namibia, since 1986. The School was absorbed into the stream of Higher Education and it continued to train nurses first with a comprehensive diploma and thereafter the Bachelor's Degree in Nursing Science was introduced. Currently, nurses are trained at four campuses across the country. Therefore, it is the opinion of the present researcher that the School of Nursing and Public Health staff should continue to contribute efforts to boost the positive image of the institution at large.

3.3.2.4 Sub-theme: Harassment by male nurses

The prevalence of sexual harassment against female nurses is high. Some female nurses are sexually harassed by patients, patients' families, physicians, nurses and other co-workers. The harassment is affecting the mental, physical, emotional, social and psychological health of female nurses (Kahsay et al., 2020).

Some female students articulated their distress at being harassed by male nurses if they refused to play along with their advances. The students felt that they had to learn to

deal with the harassment which resulted in them focusing less on learning as illustrated by the following quotations:

“The male staff members, when they feel like they like you, you also see in the way they treat you, that is also where favouritism starts from. You will be doing the least but they will still sign and they will let you get away with anything, but the moment they ask for your number or visitation outside the clinical environment and you turn it down, you become a problem, you will no longer get signed, it goes beyond criticism. Even for things you do, they no longer get signed for. You become a problem child all because you don't want to entertain their advances” (FGD P 38).

“The male nurses ask for personal numbers and start texting after hours making one uncomfortable and stressful” (P4)

This finding supports the study by Al Rahman (2017) in Egypt indicating that 88% of nursing students experienced bullying behaviours in the clinical setting, which leaves them feeling powerless and frustrated, and this creates a hostile environment. Kahsay et al. (2020) indicate that some female nurses were harassed verbally, got unwanted emails, were blackmailed or got some telephone calls for sexual relations, they asked about their private matters, and they were asked for sexual relationships even though they clearly showed that they were unwilling to have such, and they were asked to do something sexually in exchange for favours.

In a study by Siuta and Bergman (2019), it was clear that sexual harassment is common enough to be concerning to organisations. Additionally, it is damaging to the targets' well-being. Sexual harassment is also damaging to organisational productivity. Sexual harassment is a gendered experience. People who have more minoritized demographic

markers are more likely to experience sexual harassment. Workplace sexual harassment among nurses was high and affected the job satisfaction of nurses that may have a negative impact on the nurse working force. Verbal sexual harassment was the main form of harassment, while other forms were also reported (Maghraby et al., 2020).

Healthcare workers who experience sexual harassment experience aversive feelings and some experience harmful health- and employment-related harms. Recipients of sexual harassment engage in a wide variety of passive and active coping strategies. (Drauker, 2019).

The clinical learning setting must be a conducive environment to promote teaching and learning, and not be a sexual harassment ground where students experience hostility. Nursing students should know their rights including guidelines to combat sexual harassment. The workplace procedures for reporting sexual misconduct should be in place and policies should be available to guide managers on how to intervene and charge those found guilty of sexual harassment.

3.3.2.5 Sub-theme: Favouritism

An uncivil clinical environment behaviour can have a detrimental effect on the nursing student's morale, thereby adversely affecting their motivation and ability to learn (El Hachi, 2020). The participants experienced a feeling of victimisation and discrimination in the wards by the nurses, as some nurses were having their favourite students or they were favouring some students from other institutions. The nurses were choosing whom to work with, whom to teach and whom to sign for without the person doing the actual procedures. The following quotes provide some evidence for the above:

“In some wards, there are some nurses who only want to work with specific students from a specific University”. (FGD P10)

“The heart-breaking moment is how they refer to our institution. I feel like most of the nurses don't like us because of the institution we came from, and the nurses are favouring some students. If there is a procedure to be done, the nurses are calling their favourite students and it is demotivating for us. They say to a specific student come do this procedure and if you don't know any nurse you go home without a procedure”. (FGD P 41)

“I want to add on favouritism, some nurses go to the point of signing for student procedures that were not done. I feel the students need to learn because they are putting the lives of patients in danger”. (FGD P40)

It so happens in the clinical environment that some of the doctors and nurses can show more attention to medical students than other students from the health sciences including nursing students and this leads to the negative attitude of other students. This can have some negative effects on the creation of learning opportunities and it can reduce learning motivation (Farzi et al., 2018).

Similarly, Abdel-Samea Hagrass et al. (2020) reveal that students experienced favouritism between college and university students during their clinical placement as more attention was given to college students.

These results are further in agreement with the results from a study done by Mwai (2014), which found that the majority of student nurses did not feel welcomed by the nursing team and even many of them did not feel accepted.

3.3.2.6 Unapproachable nurses

Incivility in nursing education is a persistent global problem that threatens the psychological and physiological health of faculty and students. Incivility in nursing education is defined as a range of disruptive behaviours or failure to take action when action is warranted. These behaviours and inactions may result in psychological or physiological distress for people involved and if left unaddressed, it may progress into threatening situations (Urban et al., 2021).

Most participants experienced unapproachable nurses in the clinical setting (general wards), where nurses are always angry and they respond to students inappropriately. This experience makes the students feel unwanted and they become afraid of asking questions for them to learn clinically:

Sometimes you will be in a ward and they won't even listen to what you have to say. They will really downgrade you, really demotivate you that you won't even want to come to that certain ward the next day". (FGD P 31)

"There are certain wards where the nurses are rude such that the students are afraid to ask questions on the things they don't understand; they are even afraid of putting theory into practice because they know that if they make a simple mistake the nurses are going to shout at them". (FGD P 2)

This result coincides with results from a study by Yen (2012), where student nurses described the uncaring behaviours of instructors such as the lack of interest in student nurses, being unapproachable, refusing to give clarification on student nurses' questions, openly criticizing student nurses in front of others and being rigid. This uncaring behaviour leaves the student nurses feeling powerless, intimidated, and angry and it interferes with their learning.

This finding supports the results of a study by Chapman (2002, as cited by Tiwaken et al., 2015) which emphasised that a nurse and clinical instructor should display personal characteristics such as being supportive, encouraging, resourceful, confident, approachable, friendly, available, and helpful. Understanding, welcoming and having students' interests at heart were all important aspects that the students perceived as enhancing their clinical performance. The findings are also in agreement with the results from Kalyani et al.'s (2019) study, where participants expressed a feeling of missing out on many training opportunities because of the authoritarian and intimidating instructors who were unapproachable, difficult to communicate with and sarcastic.

THEME 3: COMMUNICATING BARRIERS

Communication among health workers is important in order to provide quality nursing care to the patient. Some participants reported that language barriers impeded their learning in the clinical setting of general wards. As much as English is the official language, some nurses were teaching and reporting in their native languages, which made others to feel discriminated against as those who could not understand the language were excluded from the report giving or teaching. A lack of common language between the clinical mentors and students made the clinical practice rather frustrating at times. The opportunity to observe and learn clinical procedures was most of the time missed because the students were busy trying to understand the language rather than clinical procedures (Mwai, 2014).

3.3.3.1 Sub-theme: Use of vernacular language

Nursing students with a native language other than that of the majority of their peers might face an additional challenge when it comes to communication skills, as language competence is described as a prerequisite for good communication skills.

Internationally, good communication skills are described as an important part of the nurse's core competencies, which is crucial for nursing practice and patient-centred care (Furness, Kvaal & Haye, 2018). Students acknowledged seeing disadvantages and limitations in their learning possibilities because of their different cultural backgrounds. Furness et al., (2018) further state that it was a serious challenge because language competence and good communication skills are crucial in enabling successful outcomes that lead to positive experiences in the clinical learning environment (Hagqvist et al., 2020).

Some participants felt that they faced discrimination, racism, neglect and isolation from the nurses in the wards. This feeling leads to the loss of learning opportunities as some students did not understand what the nurses were reporting or teaching fellow students as the teaching was being done in a non-official vernacular language rather than in English. The students had this to narrate.

“Language usage in certain wards where we go, I will say certain sisters, and will just blame one tribe, most of the wards where we go the sisters think all students know how to speak local, even when they are handing over they do it in a local language and some of us don't understand and that makes us feel left out so it is better if they start using English as it is the official language for everyone, for all to be accommodated”. (FGD P7)

“There are these nurses that speak their mother tongue ... or ... because sometimes there is this majority group and they just decide let me speak ... and ... and then me as a student that speaks another language I don't understand what they are really saying and I don't feel like comfortable asking what they are saying because I don't know their reactions.” (FGD P12)

“My experience is that we students face discrimination and racism from the nurses, especially the ... speaking nurses, they don’t want to communicate in English or to participate or work together with students that are from other tribes. The nurses only want to work with ... students maybe because they are comfortable to work with them because they speak the same language”. (FGD P 26)

“I also had an experience where the sister only wanted to teach in ... and then for me as a non ... speaking I just had to stand there and since they were signing student books I just had to give my book to be signed because I also want to finish but I don’t know the things”. (FGD P28)

Wyman (2018) argues that language barriers and cultural differences can become detrimental and stumbling blocks barring the way to clinical learning success. A language barrier can make the delivery of high-quality healthcare very challenging. It has a negative impact on the quality of healthcare, patient safety and the satisfaction of medical professionals and patients (Al Shamsi et al., 2020).

In another study, a student stated that with documentation, giving and receiving a report to and from clinical staff was challenging because even if they knew what they wanted to say, they couldn’t express it completely in the Finnish language. Students with a good command of the Finnish language seemed to settle into their clinical environments easier (Baraz, 2015; Mwai, 2014).

It was also pointed out that professional communication between the instructors and nursing personnel with the students is important so as to facilitate the learning and socialisation of nursing students.

3.3.3.2 Sub-theme: Shouting

Nursing students mentioned shouting, isolation, humiliation and being assigned work below their competency level as their commonly experienced bullying behaviours. The majority of the students shared that they experienced shouting and described it as a bad experience that should be stopped.

Some participants felt that some nurses are rude as they don't know how to approach and reprimand students; they just shout in front of other students, thus making others look useless and making them feel hopeless:

“The general nursing lecturers and nurses don't have the heart of speaking to students without freaking them out and showing them some love. They will come to you in a way that no-one wants to be approached, you cannot come to a student shouting in front of the other students. The other preceptor shouted at a student saying you cannot dress like that you look like an ambulance driver”. (FGD P40)

“Some nurses shout at us for small mistakes, they should take students aside and correct them there”. (FGD P 35)

This finding relates to a report by Abd El Rahman and Abou Shousha (2013), that students reported being yelled at or being shouted at or behaving towards students in an inappropriate, nasty, rude or hostile way, or they were belittled or humiliated. Ali and Ali's (2017) study findings agree with the findings from this study where students complained about poor communication between students and clinical staff. Moreover, cooperation was barely existing with each other, which inevitably leads to frustration and demotivation, thus negatively affecting students' learning and the acquisition of knowledge and skills. Ali and Ali further state that proper communication between

key stakeholders can support and simplify the clinical learning community and help to illustrate the roles of both students and clinical nurses.

THEME 4: SHORTAGE OF STAFF

Staff turnover is a challenge in the provision of affordable and high-quality healthcare services as it exacerbates the worldwide shortage of nurses. Furthermore, the loss of trained and expert nurses affects positive patient outcomes (Falatah & Salem, 2018).

As the Covid 19 pandemic continued to spread worldwide, there has been a dire need for more hospital beds to cater for the increasing number of patients requiring hospitalisation. This has created a severe burden on healthcare systems and the healthcare workforce. Together with expanding healthcare facilities, the demand for more nurses has also risen (Couper et al., 2022).

Most if not all students felt that there was really a shortage of staff in the clinical setting and the shortage affected their clinical learning in a negative way as the students were forced to work beyond their time with no supervision and the sisters did not have time to teach and demonstrate to them, thereby leading to exhaustion and missed clinical learning opportunities. Some students indicated that there was a shortage of staff in the wards, which was aggravated by the Covid 19. This is evidenced by the following quotes:

“Sometimes the sisters are overworked and they don’t have enough time to attend to students, especially in the Covid 19 situation, there are many critically ill patients in the wards and some sisters also contracted Covid 19 and got sick, so there is a shortage of staff in the wards”. (FGD P50).

“If there is a shortage of staff there is a negative impact on us because nurses will beg us to extend so that we can help them out because the work is too much and also they give us less attention because she is the only one and she needs to finish her work that needs to be done in the ward because if she does not finish it the matrons will be on her”. (FGD P31)

“When I speak of being taught or shown about a procedure the nurses are overworked and they are very few in the department whereby they cannot pay attention to us”. (FGD P 21)

“We are really missing out on learning opportunities because of the shortage of staff”. (FGD P41)

Nursing shortage can lead to errors, and higher morbidity and mortality rates, and in hospitals with a high patient-to-nurse ratio, the nurses experience burnout and dissatisfaction (Haddad et al., 2020). Nursing shortages have a high impact on working environments, patient outcomes and the long-term health of nurses, thereby leading to longer shifts and higher nurses to patient ratios. This shortage increases stress, fatigue and the risk of injuries to nurses, but it can also reduce patient care (Gianni, 2021).

3.3.4.1 Sub-theme: Compromised time for teaching

As previously explained, nursing education was disrupted by Covid 19. To protect the public from Covid 19, clinical settings quickly reduced their availability for non-person nursing student clinical placement. Limited in person clinical opportunities reduced spontaneous teachable moments between nurse educators and their students, resulting in lost opportunities to reinforce their learning of didactic content in the clinical setting (Smith et al., 2022). Clarke et al. (2018) state that the preceptors failed

to use teachable moments in the clinical settings and repeatedly humiliated the students. Calling a student stupid was counterproductive and destabilising.

The participants in this study felt that there were not enough professional nurses to pass on knowledge as there was a shortage of staff in the wards. It is noted that staff in the clinical area preferred to perform procedures themselves so as to save time rather than leaving it to students to practice. However, students were not getting help when needed and they lacked support in their clinical learning environment. In such situations, the students were mainly with clinical staff who were not willing to teach and help them. This contributed to students' failure to practice some skills (Kaphagawani, 2016).

The following quotes support the above:

“As there are many students in the ward from other institutions and there is a shortage of staff, having now this few nurses in the ward to teach us they don't have enough time to teach us everything in the ward”. (FGD P 41)

“It will be nicer if the nurses are more interested in the students because yes we have our lecturers they come but most of the time we spent it with the nurses and they are unwilling to teach.” (P 8)

“Sometimes some nurses are just rude and don't like helping giving demonstrations, teaching students and they don't like signing also.” (P 9)

Rajeswaran (2016) states that teaching and guidance is an important component that should be provided by the lecturers, preceptors and clinical nurses in nursing education. It was also noted that the nurse educators would only come for the

orientation of students during a new clinical allocation, for clinical assessment and sometimes for the evaluation of their case studies. However, students were not guided or observed by the clinical staff when doing procedures so that they could know if they were doing the right thing and that learning was taking place (Kaphagawani, 2016).

Clinical nurses have the obligation of teaching and doing some demonstrations under their scope of practice but due to the high workload and the shortage of nurses, this is sometimes not possible as they are overwhelmed by their clinical duties and responsibilities. According to Kolb's (1986) theory, learners create new knowledge from direct experience rather than from receiving instructions; meaning that nurses in the wards should make time to teach nursing students. However, when a ward is extremely busy, it is expected for learning to be compromised as students may not have the time for RO and AC. In nursing, these are very important when competencies should be attained in nursing practice. Students should be having the time to reflect on their own actions and think about whether that was the right way to do some or not, and if not, how it can be corrected.

3.3.4.2 Sub-theme: Overworked students

Nursing education is acknowledged as a challenging and stressful field of study. Nursing students usually experience considerable academic stress including class assignments, clinical reports and examinations. Chronic exposure to academic stress may lead to academic burnout in nursing students. Academic burnout can be defined as a state in which students are faced with increased emotional exhaustion (Wei et al., 2021).

The participants stated that they had to assist the nurses as their work load was just too much, compared to the number of staff, which led to long and extended working hours.

This experience compromises the participants' learning in the clinical setting, especially the fourth year of study as they had other important school chores like research that they had to attend to:

“Some wards are really understaffed and that puts pressure on the students because they have to work through lunch and extend because you find only one registered nurse and two enrolled nurses and the rest are just students”. (FGD P7)

“The nurses are trying to take advantage when in clinical, they might have staff shortages now that they see nursing students around they will try to abuse them by overworking them while they are relaxed”. (FGD P13)

“My clinical learning has been good but I feel that hospitals are under pressure because the nurses are under staffed, they put more pressure on us, they make us work more just to relieve them, and they also teach less because there are less registered nurses”. (FGD P24)

The shortage of staff leads to nursing students covering the shortage of staff instead of learning as they were assigned to work as similarly to qualified nurses (Gemuhay et al., 2019). Students articulated that heavy workloads compromised their clinical learning. Gemuhay et al. (2019) further mention that participants agreed that in their initial clinical practice they felt loaded, overburdened and stressed due to the clinical demands and requests from the clinical instructors such as patient assessment, daily records and nursing care plan and others (Rajeswaran, 2016).

The nursing students are indeed overworked by the nurses as there is a nursing shortage in the hospitals. This can lead to students getting fatigued, as well as having a lack of concentration and loss of precious time to carry out other important educational issues.

3.3.4.3 Sub-theme: Lack of supervisors

Clinical supervision is beneficial to the student, firstly by directly overseeing students in the clinical facility and as such a supportive relationship is built between the clinical supervisor and student. The benefit of this supportive relationship is that it optimises teaching and learning. Secondly, clinical supervision strongly influences the student nurses' professional development. Negative clinical supervision or the absence thereof could result in negative attitudes of the student towards the profession (Van der Heever, 2018).

Working unsupervised is a risk in nursing. Some participants stated that they had to work unsupervised in the wards due to the fact that nurses were busy attending to other equally important nursing duties. Some participants confirmed that they had to take risks and carry out certain procedures on patients without guidance:

“If there is too much workload in the ward, the nurses are not supervising, there is no monitoring of students, and sisters don't get to see how a student did a certain thing and the student ends up doing procedures they are not allowed to perform”. (FGD P3)

“As a student, you are supposed to be helping, then you find yourself in a situation where you have to give medications, which is a medical hazard on its own, then it does not feel good. But then the sister will say you don't want to do that but you also just want to cover yourself”. (FGD P8)

“The other thing is that the nurses in the ward leave you to be in charge of things that they literally know they need more attention, making you feel

uncomfortable even though students are not blamed but it works on your conscience if anything happens". (FGD P 28)

Gemuhay et al. (2019) indicate that the supervision of nursing students in clinical practice by nurses is essential as it can strengthen nurse-student relationships and develop or build confidence and competence among nursing students. A particular good learning environment is found in wards with an explicit structure for receiving students, offering supervision from more than one preceptor, and a pedagogical atmosphere where staff are generally interested in supervising students and are easy to approach (Ekstedt et al., 2019).

A similar sentiment is shared by Kaphagawani (2016), that students were learning without support and guidance, and students were sometimes left alone in wards or units even in placements which require them to be under strict supervision, including the labour ward and the intensive care unit (ICU). As a result, they would be stranded if a patient's condition changes. Consequently, the lack of supervision leaves students on their own without achieving any clinical learning and the safety of patients is compromised.

3.5 CHAPTER SUMMARY

This chapter presented the themes and subthemes derived during the analysis of the data. The latter was collected through face-to-face interviews and group discussions. The themes and subthemes were supported through relevant literature. The researcher also reflected on and applied Kolb's theory during this discussion. Chapter four presents the conclusion, limitations and recommendations of the study.

CHAPTER FOUR

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In the previous chapter, the findings of the study were discussed and literature control was done. In this chapter, the researcher presents the conclusions derived as well as the limitations experienced. Recommendations are also formulated.

The main aim of the study was to explore and describe the clinical learning experiences by nursing degree students in general wards at public training hospitals in the Khomas region of Namibia. The main focus was on UNAM second, third and fourth-year degree nursing students at the main campus. The following objectives guided the study, namely to:

- Explore the clinical learning experiences of nursing degree students in general wards at the public training hospitals in the Khomas region; and
- Describe the clinical learning experiences of nursing degree students in general wards at the public training hospitals in the Khomas region.

The researcher used one central question which is: *“What are your experiences during placement in general wards of the training hospitals in the Khomas region?”* This was followed by probing questions to clarify answers. Data were analysed by way of Tesch’s method of data analysis, and the findings from the study were confirmed through literature control.

4.2 CONCLUSION

Clinical placement experiences form an integral aspect of practice development for undergraduate nursing students undertaking a Bachelor of Nursing Sciences degree to acquire competencies and abilities to learn independently, make decisions, and express ethical commitments (Nehrir et al., 2016). This study focused on the clinical practice of the second year, third and fourth-year nursing students at the University of Namibia. The conclusions of the study are presented according to the two objectives formulated for the study:

4.2.1 Objective One: Explore the clinical learning experiences of Bachelor of Nursing Science degree students in general wards at the public training hospitals in the Khomas region

Clinical learning experiences in the Bachelor of Nursing Science degree in general wards at the public training hospitals, in the Khomas region, were explored by conducting focus group discussions and face-to-face interviews with the concerned group of students.

It can be concluded that there are limited learning opportunities for nursing students in the clinical setting at all levels of year studies. The study revealed that students encountered several constraints during their clinical placement that negatively affect their clinical learning during their placement. Some of the negative experiences included overcrowding in the wards, resulting in reduced learning opportunities and frustrations in the clinical setting during placement. The participants also mentioned that there was a shortage of equipment and manpower in the clinical setting, which affected their learning as the procedures were not done up to the expected standard and there was nobody to monitor when procedures were performed clinically.

It was further revealed that students felt victim in the clinical setting by the nurses as they were called names, were bullied and were compared to other training institutions. They also encountered favouritism and faced a language barrier, as a result of the use of local languages instead of English, which was declared as a national language in the country.

The participants from the study also mentioned that they missed out on important learning opportunities due to the Covid 19 pandemic as they were withdrawn from the clinical setting by the university due to the concern for their health safety in the clinical setting, or they were either confined to a few wards as other wards accommodated Covid 19 patients and there was no learning taking place.

4.2.2 Objective two: Describe the clinical learning experiences of Bachelor of Nursing Science degree students in general wards at the public training hospitals in the Khomas region

The description of findings was in Chapter three. The researcher presented the demographic information regarding the participants in table form. Qualitative findings were presented in themes and subthemes. The four main themes deduced from the data analysis were non-conducive learning conditions, negative attitudes, communication barriers and a shortage of staff.

It was noted that across all the years of study, all the participants from the IFFI and FGD experienced a non-conducive clinical learning environment (Theme 1), due to the fact that there was overcrowding, less placement time, no orientation on placement and delegation in the clinical environment which led to students competing for procedures among themselves to learn and complete their log books.

The participants also felt that they were getting lost in the wards as they had nothing to do because there was no orientation and delegation and many a times, they were just expected to be ready for evaluations without much learning that took place. The participants further mentioned that there were discrepancies between what is taught in class and what is practised in the clinical settings because of the lack of equipment and other consumables in the clinical area. This finding also provided evidence that the preceptors were forcing students to do practical examinations without prior preparation. Students felt very uncomfortable as they were working under pressure and they did not feel that they are learning.

The participants also agreed that staff shortage (Theme 4) affected nursing students negatively as all participants mentioned that they were not taught, or demonstrated to and were working unsupervised. They also felt overworked as a result of extended working hours on request by registered nurses. The participants agreed that this experience made them work under fear of making mistakes and risking their own education as they had minimal skills to practice. The participants also felt that the shortage of staff led them to become fatigued and therefore less functional, thereby leading to poor concentration, poor learning and less productive to carry out nursing care.

As much as the students were concerned about clinical learning the attitudes (Theme 2), some of the nurses in the clinical preceptors and lecturers were not welcoming towards students. This was noted by all year levels revealing that they were called names, comparing them to students from other training institutions, shouting at them and refusing to teach them. That experience made them feel useless and demoralised, and some mentioned that they felt like quitting. The female participants also expressed

their uncomfortable clinical learning experiences whereby some male nurses were proposing to them in the clinical area which leads to hostility and favouritism, and some of the nurses refusing to sign their books if their advances are rejected or disapproved.

Some participants agreed that there was indeed a communication barrier (Theme 3) that was caused by the fact that some nurses refused to communicate in the official language and they only communicated in their native language, which will then benefit only certain groups of students. In the same vein, the students also showed their dismay due to the fact that some nurses don't know how to communicate at all and only shout and scream in the clinical area which affects their clinical learning in a negative way. This is because they missed out on important morning reports and teaching opportunities that were done in a non-official language. The experience made them feel isolated, discriminated, demoralised and unwanted in the clinical setting.

The researcher decided to take Kolb's learning cycle and learning styles (Kolb,1986) as the study's theoretical framework because the key of learning by experience fits in the context of clinical learning of nursing students on clinical placement. However, from the data analysis of this study, it transpired that those students need substantive support while in the clinical area for them to learn through the stages of Kolb's learning cycle. It further indicates that the lecturer should employ a variety of teaching methods in order to reach all students who may have different learning styles. Nurse educators should be aware of common learning strategies that can be executed in the clinical area to facilitate the learning of students, for example, small group teaching, reflective sessions, and return demonstrations among other.

4.3 LIMITATIONS OF THE STUDY

Limitations are regarded as the influences, short comings or conditions that the researcher cannot control but which can place restrictions to the study (Polit & Beck, 2017). The following were identified as limitations during the study:

- The researcher as an academic the students might have reservations to express themselves or either preferred to offer information that pleases the researcher because of the academic relationship. The researcher deals with 1st years and thus has no direct contact with the other academic years. The researcher further used bracketing.
- The study was further limited to two training hospitals in the Khomas region, namely, Windhoek Central Hospital and the Intermediate Hospital Katutura and thus findings cannot be generalised to other hospitals.

Notwithstanding its limitations, this study has provided important information regarding the clinical learning experiences of nursing degree students at the public training hospitals in Windhoek, Khomas region, Namibia.

4.4 RECOMMENDATIONS

There is considerable evidence supporting clinical learning as extremely beneficial and important in familiarising students with clinical judgments and decision-making, stimulating their critical thinking, challenging students to recognise the consequences of their mistakes and exposing them to various socio-cultural, biological, psychological and mental aspects of patient care (Papastavrou et al., 2016).

Based on the findings from the individual face-to-face interviews and focus group discussions in this study, the researcher made some recommendations towards the School of Nursing and Public Health, and the Ministry of Health and Social Services

as the custodian of clinical placements, as well as some recommendations for further research.

4.4.1 Recommendations to the School of Nursing and Public Health

Clinical learning is the main part of nursing education in Namibia and it forms 50% of the curriculum. Therefore, exposure to the clinical learning environment is one of the most important factors affecting the teaching and learning process in clinical settings (Jamshidi et al., 2016). Clinical placements where students learn clinical practice should allow students to acquire nursing skills and competencies, as well as clinical reasoning, while simultaneously providing room to develop as professional nurses (Gemuhay et al., 2019).

Kolb (1984) states that experimental learning is learning from experiences and mainly in the active sense and it is the cornerstone of nurse development. Clinical learning is a large component of undergraduate nurse training, and it is a planned and supported process for the nurse to experience increasingly challenging situations whilst developing knowledge and skills.

It is therefore recommended to the School of Nursing and Public Health that:

- Lecturers and clinical preceptors should be made aware of the different stages of experiential learning and how students should be supported to facilitate learning;
- The lecturers and preceptors must ensure that nursing students are accompanied in the clinical area on a daily basis;
- The clinical department in the School of Nursing and Public Health must ensure that the students are placed for a period which is sufficient for learning in the clinical setting;

- Lecturers and preceptors must ensure that demonstration teaching is carried out in a clinical setting when students are fully prepared;
- The clinical department must ensure that a reasonable number of students are allocated in the clinical setting to avoid overcrowding and promote learning. This can only happen when discourse is held with other institutions to find a balance in the allocation of students; and
- The researcher, when he shares his findings with his colleagues, should also encourage colleagues to utilise simulation teaching where possible to cement certain competencies. The latter will facilitate the learning of students in the clinical unit and reduce the stress and frustration of students on clinical placement.

4.4.2 Recommendations to the Ministry of Health and Social Services (MoHSS)

As nursing students in training are mostly allocated to facilities of the MoHSS, the researcher deemed it necessary to recommend to the MOHSS the following:

- It is essential for all clinical units, including the general wards to utilise a delegation book for the delegation of duties of all staff on duty but specifically for nursing students in the ward. This is needed as a way to provide some direction to the student as to where s/he should be focusing;
- Registered nurses should focus on teachable moments as the clinical learning modality to teach students. It is essential that this be introduced to nurses at the ward level, so as to understand how it affects the method of teaching;
- The Ministry of Health and Social Services should strive to improve the working conditions at the ward level, especially in the provision of equipment and consumables. Not only will that improve patient care, but this will also

facilitate student teaching. It is highly recommended that the MoHSS considers appointing clinical staff per ward complex so as to focus on the teaching of all students. This is to eliminate discrimination among institutions and also get standardisation in nursing care; and

- In-service training needs to include the aspect of experiential learning so professional staff may understand the effects of different circumstances on the learning of the students.

The role of the researcher in the above would be to share his findings with the relevant ministry and also to avail himself in the execution of the recommendations. Close collaboration between the training institution and the clinical entity is of utmost importance.

4.4.4 Recommendations for further research

The researcher disclosed that the context of his research did not cover other campuses of the institution and therefore the following recommendations are made for further studies:

- As the context of all regional and district hospitals are different, it is worth to exploring student nurses' clinical learning experiences in other hospitals that provide clinical learning in other regions;
- It would be beneficial to the recruiting and training of nurses in the country to explore and describe the clinical learning experiences of male students in training; and
- Lecturers' and preceptors' clinical accompaniment experiences should be explored to find depth in some of the information that was revealed by the nursing students during this study.

4.5 CONTRIBUTIONS OF THE STUDY

The findings from this study provide important information which was not explored before, regarding the clinical learning experiences of nursing degree students in the general wards at the training hospitals in the Khomas region. The recommendations are aimed at the University, the training hospitals and the Ministry of Health and Social Services, to ensure that there is a conducive environment for the students' clinical practice and learning.

4.6 CHAPTER SUMMARY

Clinical learning cannot be overemphasised because it is through clinical learning that nursing students learn how to apply abstract concepts in clinical settings. The study achieved its aim of exploring and describing the clinical learning experiences of nursing degree students at the public training hospitals in the Khomas region using Kolb's Experimental Learning Theory as the theoretical framework. The participants from individual face-to-face interviews and the focus group discussions were consulted to answer the central open-ended question that was: *Tell me about your clinical learning experiences during your placement in the general nursing wards of the two training hospitals in the Khomas region?*

The findings from this study add knowledge to the nursing profession and the education of the nursing students in Namibia with regards to nursing students' clinical learning experiences. This finding will be made available to the University of Namibia, the School of Nursing and Public Health and the Ministry of Health and Social Services so that it can guide lecturers, preceptors and nurses on how best to enhance clinical teaching in the Bachelor of Nursing science students' clinical practice, with

the aim of producing competent and practice ready nurses on completion of their four year programme as recommended by the stakeholders.

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ANNEXURE A: ETHICAL CLEARANCE



ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: SON/615/2021 **Date:** 17 August, 2021

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: Clinical Learning Experiences Of Nursing Degree Students At The Public Training Hospitals: Khomas Region, Namibia

Student: JOSEPH GALUKENI KADHILA

Student Number: 200906895

Supervisor(s): Prof L. Pretorius

SCHOOL OF NURSING

Take note of the following:

1. Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the DEC. An application to make amendments may be necessary.
2. Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the DEC
3. The Principal Researcher must report issues of ethical compliance to the DEC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by HREC-H
4. The HREC-H retains the right to:
 - i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
 - ii) Request for an ethical compliance report at any point during the course of the research.

HREC-H wishes you the best in your research.


Prof. C Wilders (Chairperson)


Pamela Claassor (Secretary)

ANNEXURE B: REQUEST TO THE MOHSS FOR PERMISSION TO A RESEARCH STUDY

University of Namibia, Private Bag 13301, Windhoek, Namibia
340 Mandume Ndemufayo Avenue, Pioneerspark
☎ +264 61 206 3111; URL: <http://www.unam.edu.na>



From: Mr. Joseph –Galukeni Kadhila
School of Nursing; Faculty of Health Science; University of Namibia
P.O. Box 978; Windhoek

To: The executive director
Ministry of Health and Social Services
Private bag 13198
Windhoek

Dear Mr B. Nangombe

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I, Joseph Galukeni Kadhila is a registered student at the University of Namibia, pursuing a Master of Nursing Science under the School of Nursing. Student number 200906895

I am hereby seeking permission to conduct research on my proposed topic which is:
Clinical Learning Experiences of Nursing Degree Students at the Public Training Hospitals: Khomas Region, Namibia.

I believe that the findings of this study might assist the nursing schools to improve clinical teaching through consideration of some of the general wards for clinical allocation of the nursing students for quality learning. Moreover, the study findings will provide information to guide clinical instructors and lecturers on how best they can enhance clinical learning experience by students nurse during the clinical placements at the public training hospital in Khomas Region.

I undertake to adhere to and apply the ethical principles during the course of the study. In addition, ethical principles of respect for a person (inclusive of obtainment of an

informed consent, privacy, anonymity, confidentiality) justice, beneficence and non-maleficence will be maintained towards the study participants.

For enquires or further information contact me on the following email: jkadhila@unam.na , phone: 0812495831 or the study supervisor Prof L. Pretorius at lpretorius@unam.na, phone: 081 249 5933

Attached receive a copy of the research proposal as was approved the UNAM Health Research and Ethical Committee (HREC), Ethical Clearance Certificate by HREC and the MoHSS's form for **REGISTRATION OF A RESEARCH PROJECT**.

Thanking you in advance for your usual support

Yours Sincerely

Joseph-Galukeni Kadhila

Signature

Date

**ANNEXURE C: PERMISSION LETTER FROM THE MINISTRY OF
HEALTH AND SOCIAL SERVICES**



REPUBLIC OF NAMIBIA

**MINISTRY OF HEALTH AND SOCIAL
SERVICES**

Ministerial Building
061 -203 2507
Harvey Street

OFFICE OF THE EXECUTIVE DIRECTOR TCI: No:

Fax No: 061-222 558

Private Bag 13198, Windhoek

Ref: 17/3/3/JGK

Andreas.Shipanga@mhs

Enquiries: Mr. A. Shipanga

Date: 05 November 2021

Mr. Joseph G. Kadhila
PO Box 978
Windhoek

Dear Mr. Kadhila

**Re: Clinical learning experiences of Nursing Degree students at the Training
Hospitals: Khomas Region, Namibia.**

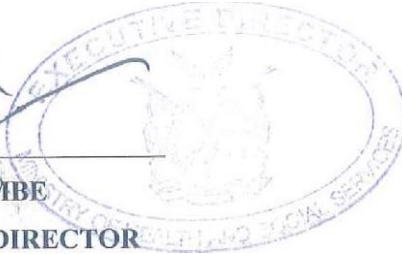
1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit,
3. Kindly be informed that permission to conduct the study has been granted under the following conditions:
 - 3.1 The data to be collected must only be used for academic purpose;
 - 3,2 No other data should be collected other than the data stated in the proposal;
 - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
 - 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
 - 3.5 Preliminary findings to be submitted upon completion of the study;


- 3.6 Final report to be submitted upon completion of the study;
- 3.7 Separate permission should be sought from the Ministry for the publication of the findings.
- 4. All the cost implications that will result from this study will be the responsibility of the applicant and not of the Mol-ISS.

Yours sincerely,



BEN NANGOMBE
EXECUTIVE DIRECTOR



All official correspondence must be addressed to the Executive Director. 

ANNEXURE D: PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM



TITLE OF THE RESEARCH PROJECT:

CLINICAL LEARNING EXPERIENCES OF NURSING DEGREE STUDENTS AT THE TRAINING HOSPITALS: KHOMAS REGION, NAMIBIA

REFERENCE NUMBER :

PRINCIPAL INVESTIGATOR : Mr J Kadhila

ADDRESS : PO BOX 978 WHK

CONTACT NUMBER : 0812495831

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Research Ethics Committee at The University of Namibia and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Namibian National Research Ethics Guidelines.

1. What is this research study all about?

- a) Where will the study be conducted; are there other sites; total number of participants to be recruited at your site and altogether.*

The study will be conducted at the two public training hospitals general wards; the population will be 312 nursing bachelors' students.

- b) Explain in participant friendly language what your project aims to do and why you are doing it?*

The project aims to explore and describe nursing degree student clinical learning experiences in general wards at training hospitals Khomas Region, Namibia

- c) Explain all procedures.*

The research will be a qualitative explorative descriptive and contextual study that will make use focus group discussions to collect data.

d) Explain any randomization process that may occur.

Not applicable to this research study

e) Explain the use of any medication, if applicable.

No medications will be used in this study.

2. Why have you been invited to participate?

a) Explain this question clearly.

You have been invited to this study because you are a UNAM Nursing Bachelors Students who conduct your clinical learning in the general wards of the two training hospitals Khomas Region and is believed that you can provide rich data on the research.

3. What will your responsibilities be?

a) Explain this question clearly.

If you agree to participate in this study, you are expected to participate in a group of 7 or more participants and your duty will be to share your clinical learning experience during your placements in general wards of the two public training hospitals Khomas region with the rest of the group.

b) Explain the duration the participant is expected to participate in the study (i.e. 2 hours, 4 days, etc.)

The discussion will last for about 1 hour depending on how the focus group participates.

4. Will you benefit from taking part in this research?

a) Explain all benefits objectively. If there are no personal benefits, then indicate who is likely to benefit from this research e.g. future patients.

There will be no direct benefits from the research but there might be benefits to the Faculty of Health Sciences specifically the School of Nursing with value of information for students to use and help with clinical teaching.

5. Are there in risks involved in your taking part in this research?

a) Identify any risks objectively.

There are no foreseen risks from the research but if emotional risks occurred, support will be provided by the Dean of students counselling office.

f) Explain all procedures.

The research will be a qualitative explorative descriptive and contextual study that will make use focus group discussions to collect data.

g) Explain any randomization process that may occur.

Not applicable to this research study

h) Explain the use of any medication, if applicable.

No medications will be used in this study.

6. Why have you been invited to participate?

b) Explain this question clearly.

You have been invited to this study because you are a UNAM Nursing Bachelors Students who conduct your clinical learning in the general wards of the two training hospitals Khomas Region and is believed that you can provide rich data on the research.

7. What will your responsibilities be?

c) Explain this question clearly.

If you agree to participate in this study, you are expected to participate in a group of 7 or more participants and your duty will be to share your clinical learning experience during your placements in general wards of the two public training hospitals Khomas region with the rest of the group.

d) Explain the duration the participant is expected to participate in the study (i.e. 2 hours, 4 days, etc.)

The discussion will last for about 1 hour depending on how the focus group participates.

8. Will you benefit from taking part in this research?

b) Explain all benefits objectively. If there are no personal benefits, then indicate who is likely to benefit from this research e.g. future patients.

There will be no direct benefits from the research but there might be benefits to the Faculty of Health Sciences specifically the School of Nursing with value of information for students to use and help with clinical teaching.

9. Are there in risks involved in your taking part in this research?

b) Identify any risks objectively.

There are no foreseen risks from the research but if emotional risks occurred, support will be provided by the Dean of students counselling office.

10.If you do not agree to take part, what alternatives do you have?

c) Clearly indicate in broad terms what alternative treatment is available and where it can be accessed, if applicable.

Not applicable

11. Who will have access to your medical records? (Where applicable)

a) Explain that the information collected will be treated as confidential and protected. If it is used in a publication or thesis, the identity of the participant will remain anonymous. Clearly indicate who will have access to the information.

The information shared during the focus group discussion will only be accessed by the researcher and supervisor before the data is analyzed and presented for the purpose of confidentiality. The identity of participants will be protected by assigning numbers for purpose of anonymity. Before publication the participants will be quoted and allocated.

12. What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study?

- a) Clarify issues related to insurance cover if applicable. If any pharmaceutical agents are involved will compensation be according to ABPI guidelines? (Association of British Pharmaceutical Industry compensation guidelines for research related injury which is regarded as the international gold standard). If yes, please include the details here. If no, then explain what compensation will be available and under what conditions.

The will be no foreseen harm or injury to the participants but if emotional risk occur the student will be provided with support through the dean of students counselling office.

13. Will you be paid to take part in this study and are there any costs involved?

The participants will not be paid to take part in this study participation is voluntarily and free and they will also not be expected to pay to participate.

10 Is there anything else that you should know or do?

- a) You should inform your family practitioner or usual doctor that you are taking part in a research study. (Include if applicable) N/A
- b) You should also inform your medical insurance company that you are participating in a research study. (Include if applicable) N/A
- c) You can contact Prof L Pretorius at 081 249 5933 if you have any further queries or encounter any problems.
- d) You can contact the Centre for Research and Publications at +264 061 2063061; pclaassen@unam.na if you have any concerns or complaints that have not been adequately addressed by the investigator.
- e) You will receive a copy of this information and consent form for your own records.

11. Declaration by participant

By signing below, I agree to take part in a research study entitled (*insert title of study*).

I declare that:

- a) I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- b) I have had a chance to ask questions and all my questions have been adequately answered.
- c) I understand that taking part in this study is **voluntary** and I have not been pressurized to take part.
- d) I may choose to leave the study at any time and will not be penalized or prejudiced in any way.
- e) I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 2020.

.....
Signature of participant

.....
Signature of witness

12. Declaration by investigator

I *Joseph Kadhila* declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. (*If a interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) on (*date*) 2020

.....
Signature of investigator

.....
Signature of witness

ANNEXTURE E: INDIVIDUAL FACE TO FACE INTERVIEW GUIDE

INDIVIDUAL FACE TO FACE INTERVIEW GUIDE

TITLE: CLINICAL LEARNING EXPERIENCES OF NURSING DEGREE STUDENTS AT THE TRAINING HOSPITALS: KHOMAS REGION

MAIN QUESTION

Please tell me about your clinical learning experiences in all disciplines, kindly provide as much information as possible.

PROBING QUESTIONS

1. Please tell me more of what you have said
2. Could you please tell me about your clinical experiences that gave you most new knowledge and that you will never forget?
3. What clinical experiences you mentioned made you feel uncomfortable

ANNEXTURE F: FOCUS GROUP DISCUSSION TOOL

FOCUS GROUP DISCUSSION TOOL

MAIN QUESTION

Please tell me about your clinical learning experiences in all disciplines, kindly provide as much information as possible.

Probing questions

1. Please tell me more of what you have said
2. Could you please tell me about your clinical experiences that gave you most new knowledge and that you will never forget?
3. What clinical experiences you mentioned made you feel uncomfortable

THANK YOU

ANNEXURE G: INDIVIDUAL FACE TO FACE INTERVIEW

Date: 06 September 2021

Time: 14h39

R-Researcher

P- Participant

INDIVIDUAL FACE TO FACE INTERVIEW 2ND YEAR

R So today 06 September around 14H39, I am going to hold an interview with a second year nursing student. Good afternoon mem

P Good afternoon sir, how are you doing?

R I am doing very fine, so how are you feeling today?

P Mmh anxious

R Please don't be anxious it is just an interview

P Okay

R My name is Mr Kadhila and I am a masters of nursing student with the University of Namibia and I am doing research on clinical learning experiences of nursing students in the hospitals.

P Okay

R Mmh so you are a second-year nursing student?

P Yes sir

R Thank you so much for participating in my study and I guess you have signed the consent form.

P Yes

R Before we start we are going to have ground rules, we are not going to mention any staff name or hospital name and we will use the code provided.

R Any question before we start?

P No

R Okay please tell me more about your clinical learning experiences in the general nursing wards, please provide as much information as possible.

P Okay my clinical experiences have been challenging at first as I did not have much knowledge on how to do things practically. We did theory before but applying it in practice was a bit of challenge or it was interesting. The interesting part was like having to do things yourself like feeling independent like probably knowing how to soap a patient you feel more independent and you feel more curious on doing it and the challenge was I will say the challenge was of the signing of procedures.

R Okay

P The nurses were stubborn actually they will not sign they were strict on signing although you do the procedures they wouldn't sign. The biggest challenge was the that some will say no I will sign tomorrow either they don't show up and have to come back to the same ward to find the nurse.

R So the nurses were strict, what do they do?

P So you will be doing a procedure and probably the nurse will ask you to say do what can I say may be wash a patient, then you wash the patient then do the soaping and all that and then they will keep sending you at around at the pharmacy, at the end of the day the same nurse will not want to sign it is either they don't want to sign or they say that will sign tomorrow it is why missed out on a sign out.

R You also mentioned on theory?

P Yes when you are taught theoretically compared to how it is practically it is anyways a challenge because in the theory you are expecting to be in that sense that you understand it. Theoretically it is challenging because you imagine it like when you are taught theory but when you have to do it is so different, let's say dressing, in dressing you have to do it aseptically but when you have to do in the clinics they use other instruments to replace something that is not there some for example we won't use cotton because there is a shortage of cotton, so nurses won't use cottons they will use gauze so there where it comes in as a bit of challenge. You are taught something else and when you are practically doing it. It is like kind of different so then you have a kind of more than you have practically vision of it but it does not correlate with what you are taught theoretically.

R Okay what do you mean by they have shortage of equipment also?

P Yes they don't carry out procedures as supposed to and also the way it is been done from hospital to hospital, challenge one has to keep on adjusting even the soaping is different like from hospital to hospital and so you have to adjust clinical allocation changes right. So say you were at specific hospital and they

do the soaping differ, say for instant they do the vitals different, the vitals are done at eleven o'clock and then you leave out assessment and planning and that is where the challenge comes in and then you go to the other hospital and then at that hospital you do it is kind of that you have to adjust to it constantly, that is also a challenge again.

R Do you want to add more?

P No

R So what nature of clinical learning do you usually receive in the clinics?

P We receive demonstrations, we also receive mmmh they also do teaching and explain more in detail, I will say like we actually learn more in practice than in theory because the nurse there have more knowledge on it and you can ask questions so forth. It is just like 5% of nurses that won't teach us much especially in some wards they don't have time to teach and they are more strict. That is a challenge. Some are giving demonstration and explain to you, sometimes they will even give you ah explanation of let me say you are only expected to know a certain how I say they go into more detail they tell you the doctors do this and that, while us nurses we are just supposed to do this, they go in too much details.

R Okay thank you, so tell me about clinical learning that gave you most new knowledge and that you will never forget.

P Okay mmmh it was clinic, I will say in my second year where we inject that is my new knowledge and that is when I actually got my confidence because nurses repeat and give you an opportunity to do it yourself.

R Thank you. What clinical experience you mentioned made you feel uncomfortable.

P Having to nurse the other gender male. They make me uncomfortable.

R How is the experience now, are you getting use to?

P Yes now I am getting used to. Or when you have to do invasive procedures on a known patient positive is it also uncomfortable procedure because you will never know when you will prick yourself and further.

R Thank you. What can you suggest for any improvement or recommend?

P I will say nurses programme or specific day for nurses to give demonstrations and I feel like it will help more the quarrelling and signature will end there should be on programme where in the mornings you get there the nurse sign the in and 30 minutes before and the nurse sign the out when you have to leave then there is no quarrel or nurse to tell you come back tomorrow because they give medications around four when it is time to knock off on demonstration there should be a specific day for demonstration for example Tuesday, Wednesday for demonstration when you miss those days there should be no negotiations because it was specifically said Monday, Tuesday demonstration then Friday you give feedback because some students I won't do it on time but it there is pressure I will finish my procedure so when the nurses.

R Thank you. Any recommendation?

P No

R Thank you so much. All the best with the exams.

P Thank you.

ANNEXURE H: FOCUS GROUP DISCUSSION 4TH YEARS

DATE: 7 SEPTEMBER 2021

TIME: 14H36

DURATION: 1 H 47: 12

R-Researcher

P- Participant

R Today on the 5th September 2021 around 14H36 we are going to hold our sixth Focus Group Discussion with the fourth year bachelor of nursing students in the UNAM board room. Good afternoon.

P Good afternoon sir

R How are you today?

P We are fine

R Okay my name is Mr Kadhila and I am a masters' students with the University of Namibia, doing research on the clinical learning experiences of UNAM Nursing students. Thank you, guys, for agreeing to participate in my study and I hope all have signed the consent form.

P Yes, we did

R So you guys are fourth years' bachelor's nursing students in your 9 month?

P Yes Sir

R Okay before we start we are going to have ground rules we are going to talk one at a time, all the points are valid and we are not allowed to mention any

name of a sister, student or ward name, we have to participate equally and we will use our codes to refer to each other, is it okay.

P Yes sir.

R Any question before we start?

P No sir

R The first question will be please tell me about your clinical learning experiences in the general nursing wards please provide as much information as possible, who wants to go first?

P 34 My clinical learning from first year it was great. In the first year it was good, the nurses were helpful and they are willing to teach us, but from second year they were not supporting as usual. Preceptors and lecturers come in recording attendance in the third year we had to learn on our own as we were seniors. We were to learn from YouTube, from textbooks, we were to learn on ourselves because the lecturers were not coming to the hospitals but just that the classes were cancelled. The only time we saw our lecturers was time for OSCE and evaluation or when we go to the university for classes specific class but other than that I feel like we had missed on information that could be important due to Covid-19 that they could provide in clinical and I feel like we are in fourth year and we missed out on some information or you find that the nurses in the hospital will ask you to do something and then you are confused or you know how to do it but unsure then the nurses in the wards will say how are you a fourth year and you don't know how to do things because we missed out on things that we were to learn in simulation or in clinical settings with our lecturers and the nurses will not give us all the information because they are

under staff and if you find that there are a lot of patients in the ward the nurses are not keen on teaching us, because they are saying your seniors were supposed to know that, those that are keen on teaching us will come on certain days. If you are lucky enough on the first week, you'll get taught and on your second week you are on your own and going to the general wards. Some sisters are very good at teaching, some not, some don't even want to be asked question, some don't even want to sign our things or sign procedures. You will find that 3 days go by without a single procedure because they will say I was not there when you were doing your things. They were rude towards us, they were not respectful towards us in the wards and they blame us for things that they did. You were not there, you come in the morning then you are blamed for something that you don't know, because of uncomfortable environment. For us they will either compare us to the other institutions or they will call us stupid or incompetent but what they understand is if you want your student to know something on the first two days orientate and them. On the third day then you can expect what you want you teach them but they don't do that they us they make fun at us. They are very rude and they say the meanest things to us and they demoralize us, so when they want us to do something we are not even comfortable because you know if you do it the wrong way then they will judge you saying what do they teach you at UNAM, IUM is better than UNAM or Welwitschia students are better than UNAM. You guys are just useless. That is what the nurses say to us in the wards.

P In our fourth is actually better now because you are a senior and they respect you here and there even the performance is not like first and second year but the nurses are still respectful to teach it is the teaching that is a problem.

- R You mentioned something on preceptors coming with attendance.
- P 34 Preceptors first year they use to come every day. Second year some days, third year they don't want to come to you which is not a problem but they are leaving the wards early and the wards are too full and the only time you get time is after 12 or past lunch time and then tomorrow you find a preceptor that says if you did not sign when I saw that means you are absent and that doesn't make sense and they don't come in the wards and if they come and you have complained, I don't think they will solve the complains. Sisters are rude and they don't want to do something and they will just be like okay tomorrow is the same situation again.
- R Okay. Student 34 tell me more of what you have just said.
- P 34 Mmmh the preceptors just come take attendance and only teach certain things that you are evaluated on. Apart from that they don't teach unless have a question or something than they can teach but I feel like they should initiate teaching, just to give us the basics when we come to a ward then we will know how to go about it and they expect us to know things from the first year but we missed out on those teachings you don't they know we learn from colleagues but the colleagues just teach you what they also know.
- R Thank you who want to go second?
- P 35 My experience from first year it was welcoming. The thing is, I was excited I found sisters, clinical instructors, lecturers very helpful and then though out my second year here are up and downs. It was somehow in my third year I just realized that you have to be on your own and ask the sisters to give demonstrations. There finally in the final year things are going better and I feel

like I don't know much and not ready for work because somethings that I am learning are things that I was supposed to learn in first year and I feel like I have missed out on important things. The sisters are very helpful. We are learning a lot and I just feel like the learning process from first year to final year is changing and becoming different every day we step our foot in the hospital. It is a new day to learn something and I just feel like it is nursing and then at the bed side I somehow fail to understand the clinical preceptors I don't know what their job is. Is their job to teach us or just to give clinical attendance so to me it seems that their job is just to give attendance list and that is that and then to tell you tomorrow you have an evaluation because the lecturers teaching you that subject is the one to come and give you a demonstration to learn something. I never learned much from the clinical preceptors. I never really learned like anything important.

The bad experience with the sisters let me not say much about them because they help us however they expect us to do more than we are expected. The most of them comparing us to other institutions doing nursing and it really put me down like I don't know anything but instead of them bringing you up upgrading you but also they fail to understand that us students we are not the same. We don't learn at the same pace. Some are slow students; some are fast students so somehow, they need to improve.

R Okay preceptors don't teach they just come for attendance also.

P I can't really remember catching everything important from them. All I can remember is signing the attendance.

R Thank you student 35. Okay student 38

P 38 For me my clinical learning experience has been okay I did not have much of problems. When I was first year everything was new and I was trying to adapt I did not get-tough time from the nurses or preceptors in the hospital and in my first year I remember the preceptors were helpful. It was not only about attendance. I remember them coming in the ward and even look at you as the student how you put on your uniform and correct you here and there and they will ask you about your concern, what do you think is bothering, what do you want, they can even ask you if you are in this ward, what type of ward is it, and what do you want to learn. They give you that freedom to question them and the second year I enjoyed my clinical. Preceptors will come and sign our attendance. About the teaching in second year I can't really recall but the preceptors are helpful, whatever question you post to them they will be able to answer and if you have any problem with the sisters, are you harassed, they really care they ask that. Coming to third year for me Covid came but it was not really a problem because I got an opportunity to go work in the region and I learned a lot. I was expose because here in Windhoek you are just in Katutura Intermediate and Windhoek Central Hospital but when I went to the regions you get to learn a lot as you are exposed. The problem with Windhoek the students are a lot, sometimes we say the sisters are rude to us but not really. They are just overwhelmed because of the many training institutions and all want to be taught but in the regions they are teaching. In my final year I don't really have much complains but the problem that I have like my experience is still good but still learning. The sisters in the wards are still demonstrations. The only problem is with the preceptors they only give demonstrations on procedures that are for evaluations just that is the only thing and then when it

comes to evaluations especially us that started late in NGN. General nursing, we have a problem with preceptors because personally me when I was evaluated on a certain procedure. I was not even given enough time to adapt to the ward because what they only think is for procedures to be done as long as they obtain their marks you know for their CA. They are not putting in consideration that okay these students are they ready for evaluation, are they used to the ward, sometimes you just say things and you really don't know because you only gotten ward today, tomorrow is evaluation and when one busy with the evaluations, there are some preceptors as much as we are not supposed to have our phones at work, then they are having their phones and they are receiving call during evaluations imagine how distracting that is like for me personally when I was evaluated that particular person that was evaluating me received calls three times and later on when we had to go through after evaluation she is telling me you did not do that and I was like I did. How do you expect to get everything if you are on your phone and dividing attention but overall I don't think they are bad people. They are good.

R Thank you. Please say more on region placement

P Us student on main campus we are just between the two hospitals. I was permitted to work in the regions. There I was involved and I had a good experience.

R So region placement is helpful?

P Yes really helpful and I will recommend that students be sent on region placement.

R Who wants to add more

P 38 In my first year we use to get our attention. We had lovely lecturers and they taught us in simulation very well. She groomed us so well in the first year. Second year I had a big problem with the nurses, General nursing department I have a problem with the preceptors as well reason being that they speak on the phone. The general nursing lecturers, nursing is kind and caring but the general nursing lecturers don't have that heart on speaking to students without freaking them out and show than some love. They will come to you in a way that you don't or nobody needs to be approached, you cannot come to a student and you are shouting and insult them in front of the other students and everyone. I also encountered when a preceptor shouted at a student saying that you cannot dress like that, you look like an ambulance driver in front of everyone else. It is not kind we have others in nursing and we know the principles that we have to as nurses or student nurses. We must have this mindset that nursing is not just about serving the patient but also about upholding each other.

R Thank you. You mentioned time, say more.

P Sometimes you are given a big procedure to complete so you are forced to rush and complete this book and neglect all other aspects in the wards, which is not good

R What you basically saying is time is not enough?

P Time is not really enough at all

R Thank you. Participant 41

P 41 Okay so my first year was positive new environment, excited all that. Second year a bit challenging you encounter really rude nurses. They expect you to

know everything at times, you might have missed it in the first year as a sister in the ward you are at least to and groom students and teach the most. The heart-breaking experience is they referred to our institution. I feel like most of the nurses in the wards don't like us because of the institution we came from. They compare us to the other institutions. The lecturers teach a lot; they are present most of them. The preceptors I won't say much on them because you won't see much of them, you only see them here and there not so many times. They teach you on the procedures the book. Sometimes so big and sometimes you won't understand what is in the book. It as there are many students in the wards from other institutions and to do here is shortage of staff so having 110 how this nurse in the wards to teach us, they don't have enough time to teach us everything so it is also of our preceptors to teach us but they don't do that. So, from my side nurses in the wards are really helpful in of the cases. I have learned from the nurses in the wards and lecture theory in most of the time I have failed to apply theory in to practical. I don't know I think it is also about the time and not holding much of the nurses don't come to us because they have so much to do. I remember this year where we had to be sent to the private sector, that was very good and I have to applaud the University for that because when we went there the nurses there are on top of their they really required to but being in private sector, they teach you a lot and we learn a lot. Third year with Covid we were really under pressure, I think I really missed on what I needed to learn because I was just pushing to finish my log book, because the university was on our case saying if you are not finishing the books you are not going to the next level. On that so we were forced to finish the log book and not really to learn and I think it is going to be difficult for me. As a registered

nurse I just did things for the sake of finishing the log book but not because I to learn.

R Tell me more about the rude nurses.

P 41 The rude nurses sometimes you will be in a ward and they won't even listen to what you have to say they will really down grade you really so they demotivate you that you won't even want to come to that certain ward the next day because of how they speak to you. As a student I don't know but I really say there are students that approach nurses in a way that is not appropriate but my side I don't think there was a day that I approached a nurse in a bad way but they will just come to you, I don't know whether they come with frustrations from home. They will just shout at you and throws words to you. You won't know why, sometimes it is something simple. They tell you do this then you tell them, sister I don't know how start shouting and throwing rude words and sometimes it is in front of the patients, of other junior students. Sometimes I just feel like how we were taught in ethics as colleagues we need to correct each other in private address the mother so that I know what to do next time. They just shout at you there at the nursing station and I feel it is not really good.

R Thank you so much. Student 37

P 37 So from first year to second year the lecturers and preceptors really did their work. So first year we were babies that's why they were coming too much. Second year it was more like you are on your own but my experience I never really like had any problem. Third year came and there was corona and we had like 3 months without being taught anything and we went back to the hospital

and actually I didn't see any lecturer or preceptor because I understand they are more prone to complications and they were but we were also going to the hospital putting our life at risk. In our fourth year the sisters are treating us with respect because we are seniors. And also, the private hospital thing it was a good initiative from UNAM. The private sector really teaches things that one understands. Also, in our June Holiday they should try to send students to the regions because they can finish their procedures and we are also overcrowded. There are student doctors and other students from the other institutions that are also trying to get procedures.

R Thank you, Participant 36

P 36 In my first year it was a good experience because we were new to the sisters, lecturers and preceptors were really helping us. In my second year the nurses were comparing us to the other institutions, saying you are a whole second year and you know nothing, but we were not taught before placement, so I suggest after examinations so when you are placed in that department. In my third year it was corona when we went back to practical so we were just on our own and nobody was helping us and we were on pressure because the time was not on our side. So, we have few time in different department and we try to finish our log books. We did not see the preceptors, lecturers we only use to see them online classes and so when you do online you really don't attend classes, you don't ask questions. It was really not a good experience and this year the sisters are helpful because they think we are about to become colleagues with them. Talking of preceptors I don't know the role of preceptors the only thing they do is come to the wards they just go to simulation and then they ask you to go there to sign sending messages on, sometimes you don't even have data when

you come tomorrow you find a cross on your name like because you did not see if preceptors are there so I think they should also be coming in the wards and teach us and give us demonstrations because all they do is give us demonstrate on things we need for evaluations and I also think the university need to allow students to work in other regions, just familiarize with other hospitals

R Thank you so much guys, what nature of clinical learning do you receive in your fourth year. Participant 40

P 40 We receive demonstrations and that is our lecturers evaluate so they can give us our evaluations. We also have demonstrations that we have to do in our, so that we can give feedback on what we have learned.

P 41 Being fourth year, we required to know more of things in the ward nurses' rounds and doctors' rounds. You are to know all administrative. The nurses will want you to know all in running a ward.

R Thank you. Participant, 38

P 38 I feel like this year we concentrate on administration and also there is none of preceptors teaching, we seniors and we are teaching others but we are expected to write what we were teaching us in different and you also medication was mentioned already, we are more like doing everything from first year to fourth year now you are like you are in charge of the ward. Everything you have to check you don't wait for the sister to say go get the medication, you just do things on your own. You don't wait for someone to order you around.

R Any addition

P 37 In our fourth year we work with less supervision now you delegate students and administrative work and managing a ward.

R Thank you P 37. Participating 35

P 35 This year I am serious. I go early to work to get report so that I can give it to the others, this year you don't expect to be told to do things you have to lead on your own because you know is something you need to do and you don't wait to be told I feel that this year is my reach year for nursing.

R Thank you. Participant 36

P 36 We are more on teaching and administration, this year and I work on my own. We are also encouraging our juniors to take their learning serious.

R Thank you P 36. Any addition. Now participants could you tell me about your clinical experience that gave you more experience and that you will never forget. Participant 38

P 38 My experience was in the ICU. I was taught a lot and also CPR. How to do CPR

P 36 I learned how to a tracheostomy and how to change it. I was really taught.

R Participant 35

P 35 The ICU, the tracheostomy care, managing a ward and managing an emergency.

R Thank you. Participant 34

P 34 My clinical that gave me new knowledge is CPR. I will never forget and also mental health and the act of kindness, being loving to the patients.

R Participant 38

P 38 One of my best experience is doing soaping because I like learning what the patient has to say and I advocate for them.

R Thank you, any addition

P No

R Moving to the next question. Participants tell me on the clinical learning that made you uncomfortable. Participant 41

P 41 In the ward, the nurses are favouring some students. If there is a procedure to be done, the nurses are calling their favourite students and it is demotivating for students. They say students who, who come do this procedure and if you don't know any nurse you go without procedures but I didn't really experience it because we are different students but I felt bad for those that were experiencing it because they feel demotivated they cry and go to the tea room and then they miss out on a learning opportunity.

P 40 I want to add on the point of favouritism. Some nurses go to the point of signing for students on procedures that were not done, but I feel like the students need to know because they are putting people's lives on risk.

R Participant 35

P 35 The experience that made me uncomfortable was working at paediatric and I was carrying this little baby and the nurse started shouting at me and I started crying because maybe I don't like to be shouted at. The nurses leave you alone at night while they go sleep but if anything happens I know the students are not hold accountable but deep inside you will feel guilty.

R Student 35 you mentioned shouting, tell me more about it.

P 35 The nurse found me holding the baby, she just started shouting but she didn't even teach me how to hold the baby properly first.

R You also mentioned sisters sleeping

P 35 Yes the nurses sleep at the nurses' station.

R Participant 38

P 38 For me this was when I was allocated at mental as I said it is not just UNAM students there, there are also other institutions but there is this thing of nurses I don't know if I should say stereotype but I don't know how to call it but those nurses that are not products of UNAM, they are against UNAM students. The other day the nurse found us standing at the with other students from other institutions she just started shouting you UNAM students are crazy and always coming late but we were not the only ones there, which is bad. Also the other thing is favoritism, there are these students that know that sister who is like this or Mr who is like, so they will act in a manner to be favored in their presence then later they just give their book and it is signed. When you go there the sister will not sign because you don't impress them. I am not there to impress them but to work and care for patients. Then they say I did not see you working but they sign for others. The problem is favouritism and also saying UNAM students, UNAM student it is not fair.

R Thank You P 38. Participant 34

P 34 My experience that made me uncomfortable is the stereotype, stigma and discrimination against UNAM students from the staff. Just for being UNAM

students and not for doing anything. The rude comments for being a slow learner. Now for me personally I have clinical anxiety triggered by the clinical setting, because you find you are not a fast learner and you want the sister to repeat when they tell you something. If you ask the sister can I do it like this, they will say I told you long time ago but you just slow. But I just want to learn that I do it the right way so that you also make you ask that you don't do things wrong. The nurses are not respectful they end up shouting and dehumanizing you in front of patients and colleagues it makes you feel like you are stupid like you don't know anything, even your colleagues will end up saying that one is stupid even in the wards she doesn't know anything. It is not that you are stupid, it is just that you are trying to be sure of what you are doing. The favouritism part is you work fulltime in the ward than a student that only comes in the morning disappear then appear in the afternoon gets more signatures, without doing anything because they know a sister in the ward that favour them. Now you are left to struggle for signatures and it is sad and makes you feel like why should I put in effort if others just come smile and get their things done and even time to look for signatures they first rude and say all mean things to you before they sign so that is one of the things that made us students uncomfortable and also the staff the moment they see you are a UNAM student they don't to learn. The other thing is nurses don't like students that are outspoken, students who really know how to explain what is what, students who are vocal about issues that are expecting them or the treatment they receive from them, for them if you question them, it is disrespect but if you don't question them it is like you must just work and not rest until you go to your house, if you question then why you don't have to rest they becomes

disrespectful and label you as bad. I feel like we should be accorded space where we can verbalize our feelings on how we are treated. My other uncomfortable situation is not being signed for if you don't give a number or if you are not being nice to someone or if they say hi can we go out, can I have your number if you say no from there on, you are labelled as the problem person you will be lucky if you get a signature from someone you don't know. What they tell the colleagues from there on you don't really get anything signed because you turned down advances from a staff member and that change their perception from than and that is really uncomfortable for one.

R Tell me more of number giving?

P The male staff members when they feel like they like you, you also see the way they treat you that is also where favouritism starts. From you will do the least but they will still sign but the moment they ask for your number or ask for visitation outside clinical environment and you turn them down, you become a problem you will no longer get signed for. You become a problem child all become you don't want to entertain their advances.

R Thank you, any addition. Okay participants can we suggest any recommendation for improvement.

P 34 Clinical preceptors can they please teach and orientate students in the wards, our lecturers also to come teach us because theory is different from practice. For example, if drawing blood, this is a procedure not just verbally because we just following the textbook when you go to practice is totally a different thing.

R Tell me more on the orientation

P 34 Yes the sisters do have a lot of work to do you will be lucky if they orientate you on the first day you come. I remember we were orientated on the fourth day. How do you orientate me after four days I already know what is being done? There is no need, if the preceptors can take that pressure from the sisters it is going to be great. Like on the first day they should talk of what to expect in a certain ward and basics.

R Okay thank you. Participant 38

P 38 Me, the recommendation is that for our names to be send to the wards before we go there. Like other institutions they send their list of students before time, so that when we come the sisters are expecting us you know like it is so bad you get there and asked who said that you are there. The other thing is there someone you can talk to here. One thing I noticed is the other thing regarding absenteeism at clinical. We know clinical is 100% but the only thing they ask is your medical report or death certificate but some things are not medical related. I just had a mental break down and I needed to talk to someone but there are really times students are suffering. Even wise I don't know how it will be for but can the lectures just create a room and not just to punish us when absent, adding a to the stress that I already have and you didn't talk to you.

R Thank you. Participant 41

P 41 For me the shortage of staff. The university places us in the two hospitals but I feel like the university must place us in regions. Our colleagues have asked for it before but the answer given was that they cannot look after us when we are there but we have hospitals like Oshakati who are training nurses. Why can't they have connection with them, because now that we are just in these

two hospitals the nurses become overwhelmed. Imagine now our two hospitals are always preoccupied and our books are supposed to be signed by a registered nurse. We need to start giving medication in a ward that has 40 patients or more so she will start in the morning hours and only finish at 4 hours even if we have to extend until seven she also has to knock off and rest to start another shift the next day. There is really not enough time. We are missing out on learning opportunities because of a shortage of staff. I think sending us out will be best.

R Thank you.

P 35 My recommendation for preceptors is that they are supposed to view students differently. They are not there to scare students and make them uncomfortable like when it comes to evaluations. Some students are afraid to be evaluated by some preceptors because some preceptors are just rude. They are not understanding they should at least be kind and understanding. We come from different backgrounds at home you are being treated badly and again at the hospital. It is very stressful. We all know that failure is something we don't like; imagine you are evaluated by a rude clinical preceptor as a failure and it affects your mental health. They should try to be polite.

R Participant 36

P 36 Exposure the students need to be sent to private hospitals because when we complete we are afraid to work in private because we are not exposed and we are also afraid. I think holidays we are working from January to December, we don't even get enough rest anymore. We are still working on school things and public holidays if we are placed and don't work we are expected to work in the hours, but it is not our fault. The university should start considering those

things. They also need to consider the mental health of the students; it doesn't mean if the student has money they don't have problems. It is not just about the money.

P 40 About the cell phones from the preceptors. Our cell phones are supposed to be on silent. If you are evaluating a student and it is urgent and you cannot mute your phone, then you have to pose the student whom you are evaluating and apologize because you are disturbing and it is disrespectful to have your phone while you are evaluating me because how will you feel if my phone rings while you are evaluating me, you will want to disqualify me. If we had to have phones on us we do it in a proper manner.

P 41 They usually communicate on WhatsApp but as students, we are not allowed to work with phones. Then the nurses in the wards will be like UNAM students are always with their phones but they communicate via phones so I think we should try and use other means of communication.

R Thank you guys for participating in my study. All the best with the examinations and your research.

P- Thank you, sir.