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Values, Assumptions, Behaviours, and Practices Influencing the Professional Development of Nursing Students Within Acute Care Practice Environments in Rwanda: A Focused Ethnographic Study

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Abstract

The future of the nursing profession in Rwanda in large part depends on the nursing students who join the workforce and the training they have received. Preparing them to enter the profession with the necessary clinical competencies, values, and attitudes requires practice-based learning environments to become more supportive of facilitating their professional development. The current learning environments experienced by nursing students in Rwanda, and the values, assumptions, practices, and behaviours of different stakeholders involved in preparing them to enter professional practice, have not yet been explored.

The aim of this study was to address that knowledge gap by exploring the values, assumptions, practices, and behaviours within acute care practice environments and an educational institution within a resource-limited context like Rwanda and how the cultural aspects of these environments influence the development of nursing students as future nurses in professional practice. Guided by a constructive lens, this study used focused ethnography to explore the values and assumptions co-constructed by multiple stakeholders involved in the professional growth of students, particularly from the perspective of students, staff nurses, clinical instructors, and nurse leaders. Individual interviews, observations, and document reviews were used as data sources.

Findings from this study revealed that the acute care practice learning environment is a multifaceted entity influenced by interconnected sets of values, assumptions, behaviours, and practices that intersect at institutional, unit, and individual levels. Nurturing, professional gatekeeping and engagement emerged as positive values and assumptions that guided clinical settings and academic program members in their behaviours and practices to nurture and support nursing students as they develop into

future nursing professionals. On the other hand, collaboration, structural, and interpersonal barriers prevented the acute care practice environments and the academic institution from enacting these positive beliefs and values. This disconnect between values and the actual enacted practices and behaviours within acute care practice units and by individuals constrained practice environments and academic programs from creating and sustaining enriched and positive environments conducive to preparing students for professional practice.

The findings of this study illuminate that building and sustaining a nurturing and positive learning environment that fosters the professional development of nursing students requires a multifaceted approach that engages every concerned stakeholder in "*co-creating*" a learning culture to close the existing gap between the desired learning environment and the actual unit practices and individual behaviours. Recommendations related to policy, education, practice, and research have been formulated and addressed in this dissertation.

Keywords: Nursing students, professional development, acute practice learning environments, focused ethnography, Rwanda

Summary for Lay Audience

Nurses constitute the majority of health professionals in Rwanda, yet, the country still face a significant nursing shortage. Educating future nurses required to mitigate this shortage and provide effective patient care requires the practice-based learning environments within which nursing students acquire necessary skills, attitudes and values to be more supportive and empowering. To date, how these environments facilitate or hinder nursing students professional development in Rwanda has not been researched.

The aim of this study was to explore how the current practice-based leaning environment in Rwanda support or hinder the professional development of nursing students. A qualitative, focused ethnographic approach was used and the study was conducted in three practice settings and an academic setting. Individual interviews were conducted with 38 significant people involved in the development of nursing students, namely students themselves, clinical instructors, staff nurses, and nurse leaders from both the practice and the academic settings. Observation of learning activities, and review of documents related to practice-based learning supplemented data from interviews.

Findings from this study revealed that professional development of nursing students is facilitated by positive values and assumptions of nurturing junior students, a shared professional responsibility to develop nursing profession, and individual, units, and institutional commitment. These values guided staff nurses and clinical instructors to nurture, care for, welcome, role-model, guide, integrate, respect, involve, and support nursing students' development into future nursing professionals. However, the enactment of these positive values into practices and behaviours within units was hindered by different barriers- collaboration, structural, and interpersonal barriers. These barriers constrained practice environments and academic program from creating and sustaining

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enriched and positive environments conducive to preparing students for professional

practice.

Recommendations from this study suggest that building and sustaining a positive

learning environment for nursing students requires a collaborative approach that engages

every concerned stakeholder in "*co-creating*" a learning culture that reduce the identified

barriers and enhances the positive values. This will result in shaping the proficient,

effective, and caring future nursing workforce required to deliver safe patient care in the

predominantly nurse-based Rwandan healthcare system.

Co-Authorship Statement

This dissertation has been developed in collaboration with my supervisor, Dr. Yolanda Babenko-Mould, and my committee members, Dr. Sandra Regan, Dr. Beverly Leipert, and Dr. Michaela Hynie. It includes three manuscripts: Chapters Two, Four, and Five. I, Umubyeyi Benoite, made the primary contribution by framing the research question, constructing the theoretical background, performing the literature review, determining and describing the methodology, performing data collection and data analysis, and writing the manuscripts. The contributions of the dissertation supervisor and committee members consisted of supervision, guidance, reframing of the chapters, and contributing intellectual insights and editorial input for the manuscripts. They will be the co-authors of the manuscripts originating from this dissertation.

Dr. Susan Ray, who was a member of my committee until her sudden and tragic death. Dr. Ray will be deeply missed, and I am forever grateful for her initial insights that helped shape the rest of the dissertation.

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To my family, this dissertation and my doctoral journey were made possible thanks to your constant support, encouragement, and belief in me. I got married and became a mother during my doctoral journey, and this would not have been possible without the understanding of my husband Emmanuel. His love, care, and belief in me carried me through this process. In addition, he shared with me his graphic skills and his

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Chapter 1: Introduction

Background

Practice-based education is an important component of nursing education as it enables students to integrate the theoretical knowledge acquired in the classroom setting with hands-on practice to expand their knowledge base and refine their clinical skills (Gaberson & Oermann, 2010; Lee, Clarke, & Carson, 2018). Real-world experience in the practice setting offers opportunities for significant hands-on experience and knowledge and skill acquisition, which increases the self-confidence and critical thinking abilities nursing students need when faced with challenging situations, thus supporting them in their development into effective professional nurses (Benner, Sutphen, Leonard, & Day, 2010).

Professional development (PD) encompasses the process through which individuals accumulate knowledge, judgement, attitudes, and skills relevant to the profession, as well as the way they understand and perform their practice (Benner, 2004; Dall'Alba & Sandberg, 2006). During a nursing education program, changes in knowledge, skills, attitudes, and values are acquired through formal education and an embodied understanding developed through practical experience in the practice-based learning environment (PLE) (Dall'Alba & Sandberg, 2006). The experiential learning that students gain from interacting with people in PLEs heavily influences their professional growth (Benner, 2004; Gaberson & Oermann, 2010).

The PLE includes various elements that surround the nursing student in the practice setting, such as the psychosocial and interactional factors of the people in the environment, the physical characteristics of the setting, and the organizational culture of the practice setting (Flott & Linden, 2016). All these elements can come together to

shape an empowering learning environment where students feel welcome and are motivated to engage in developing their knowledge, skills, attitudes, and judgement as future nurses (Flott & Linden, 2016; Papp, Markkanen, & von Bonsdorff, 2003).

The beliefs, values, and assumptions embedded within the PLE define the ways in which professionals within that environment act, think, and perceive (Taplay, Jack, Baxter, Eva, & Martin, 2014). Such beliefs and values hold the potential to influence how teaching and learning are fostered in that practice environment, how necessary resources are allocated to achieve their priorities, and how key members of the environment collaborate and engage in how nursing students develop as professionals (Henderson, Briggs, Schoonbeek, & Paterson, 2011; Saarikoski, Warne, Kaila, & Leino-Kilpi, 2009). When effective teaching and learning activities have been embedded within PLE practices, students are encouraged and involved in learning activities that promote critical thinking, problem solving, and decision making (Henderson et al., 2011; Walker, Cooke, Henderson, & Creedy, 2011). Within such a learning culture, student accomplishments are recognized, which increases their motivation, self-efficacy, and preparedness for professional practice (Babenko-Mould, Iwasiw, Andrusyszyn, Laschinger, & Weston, 2012; Bradbury-Jones, Sambrook, & Irvine, 2010).

On the other hand, if effective teaching and learning have not been integrated into core values embedded within the PLE, the learning environment can be perceived as unwelcoming and unsupportive, with staff nurses who are less receptive and unwilling to teach and clinical teachers who are inaccessible and have unrealistic expectations of students (Chuan & Barnett, 2012; Reeve, Shumaker, Yearwood, Crowell, & Riley, 2013). Consequently, unsupportive environments may result in lost student learning opportunities, create a sense of vulnerability among students, increase student anxiety,

and lead to a sense of detachment and disengagement in learning, which may hinder the PD of students as well as negatively affect the provision of effective nursing care (Anthony & Yastik, 2011; Melincavage, 2011).

Several studies have identified the attributes of PLEs that influence the creation of a supportive learning environment for nursing students, such as the supervisory relationship, a student-friendly atmosphere, availability of learning opportunities, and the unit leadership style (Chuan & Barnett, 2012; Dale, Leland, & Dale, 2013; Hägg-Martinell, Hult, Henriksson, & Kiessling, 2014; Jokelainen, Jamookeeah, Tossavainen, & Turunen, 2013). However, the broader organizational contexts within which these attributes are constructed and come to impact the PD of nursing students have not yet been fully explored.

Many of these existing studies used quantitative surveys and measurement scales to measure organizational cultural values within PLEs (Henderson, Creedy, Boorman, Cooke, & Walker, 2010; Warne et al., 2010). Only a few studies took an interpretive-constructivist viewpoint, conceptualizing these values as socially constructed realities of the organization and using naturalistic approaches to explore them (Hägg-Martinell et al., 2014; Hegenbarth, Rawe, Murray, Arnaert, & Chambers-Evans, 2015; Jokelainen et al., 2013). Yet, as Scott-Findlay and Estabrooks (2006) indicate, over-reliance on quantitative measurements does not allow for a deeper understanding of the meaning and influence of values held within the organization and how these shape the development of the professional practice of nursing students. Hence, there is still an epistemological and a methodological gap (Scott-Findlay & Estabrooks, 2006) in the knowledge of the values and assumptions embedded in organizations and how they influence the PD of nursing students.

Additionally, a gap related to the unit of analysis (Scott-Findlay & Estabrooks, 2006) was identified in the literature, as many of the available studies have been undertaken from an individual perspective, mainly from the perspective of the student (Dale et al., 2013; Shen & Spouse, 2007) or the professional nurse (Hegenbarth et al., 2015; Jokelainen et al., 2013). Only a few studies have explored both the practice setting and academic nursing program perspectives and have been undertaken at group or unit levels (Chuan & Barnett, 2012; Hegenbarth et al., 2015). Given that values and assumptions are also collective phenomena, it has been proposed that they should also be studied at the group level, unit level, or organizational level (Scott-Findlay & Estabrooks, 2006).

Finally, there is still a contextual gap related to the predominance of Western studies in the literature. Almost all the studies identified in the literature that used an organizational perspective to study PLEs were conducted in Western cultural contexts such as Australia, Canada, Finland, Norway, Sweden, the United Kingdom, and the United States (Hegenbarth et al., 2015; Henderson, et al., 2010; Young et al., 2014) and in some Asian contexts like China, Korea, and Malaysia (Chuan & Barnett, 2012; Shen & Spouse, 2007). No study exploring the ways in which values and assumptions within PLEs influence the PD of nursing students could be located in the African context.

Studies conducted within Sub-Saharan African PLEs highlighted a number of structural barriers hindering the creation of supportive PLEs. These included inadequate infrastructure and resources limiting the capacity of clinical settings to provide a conducive PLE, ineffective instructional support, and limited partnership and collaboration between clinical settings and academia (Anarado, Agu, & Nwonu, 2016; Bvumbwe, Malema, & Chipeta, 2015; Msiska, Smith, & Fawcett, 2014; Mwale &

Kalawa, 2016). However, none of these studies explored PLEs from an organizational perspective, exploring the values, assumptions, practices, and behaviours of the key people involved in developing the PD of nursing students within PLEs. Thus, available evidence from African and western clinical learning contexts may not accurately or comprehensively reflect the cultural reality of PLEs within a resource-limited context such as Rwanda.

Overview of Nursing Education in Rwanda

Rwanda is a landlocked country situated in east-central Africa, with a population of approximately 11,274,221 within an area of 26,338 square kilometers (National Institute of Statistics Rwanda, 2015). Nurses comprise the majority of the health professionals in the healthcare system in Rwanda. As of 2014, Rwanda had 9448 nurses/midwives and 678 physicians (Ministry of Health Rwanda, 2014). Yet, Rwanda still falls below the minimum level of health professional density of 2.5 per 1000 population recommended by the World Health Organization, with a density of 0.83 nurses/midwives per 1000 population (World Health Organization, 2018). In addition, the majority of the practicing nurses in Rwanda have the lowest level of professional preparation, which is equivalent to an enrolled nurse certificate obtained at the high school level (Binagwaho et al., 2013).

Notwithstanding the above-mentioned challenges, nursing education in Rwanda has experienced sustained improvements over the last two decades. Nursing education in Rwanda underwent the same paradigm shift as other parts of the world where nursing education evolved from the traditional hospital-based training model to a higher education academic model of teaching and learning (Gaberson & Oermann, 2010). In 1996 Rwanda moved away from purely hospital or clinic-based training and began to

offer nursing education at a level of higher education (Mukamana, Uwiyeze, & Sliney, 2015). This represented a transition for nursing students from a high-school level of education to a post-secondary and university level of education. Currently, there are two nursing programs that lead to nursing professional registration in Rwanda: the advanced diploma in nursing (A1), which is a three-year post-secondary program, and the bachelor's degree in nursing (A0), a four-year post-secondary program.

Since 2007, higher education in Rwanda, including nursing education, has shifted from a behaviourist paradigm of teaching or teacher-centered learning pedagogy to a student self-directed teaching and learning philosophy (Higher Education Council, 2007). This move involved modifying the classroom teaching environment to accommodate such a paradigm shift, reviewing the curricula to reduce the time spent lecturing, and shifting teaching strategies from teacher-led to more participatory teaching methods that invite students to actively participate in their learning. While these changes might have happened within classroom environments, little is known about how these changes have been integrated within the PLEs used by nursing students and their instructors or how the changes impact student PD.

Practice-based learning in Rwanda takes place in different practice contexts, including acute care hospitals such as the national referral and teaching hospitals, provincial referral and district hospitals, as well as in some community health settings. Generally, practice-based learning in the nursing programs starts from the second semester of the first year of the nursing program and runs concurrently between blocks of theory courses followed by blocks of clinical rotation in practice settings. Thus, students may attend classroom blocks for a period of approximately two months, followed by

eight to 10 weeks of practice-based blocks of placement in the PLEs (University of Rwanda, 2016).

The national referral and teaching hospitals provide the highest level of care in Rwanda, act as referral hospitals for more specialized care, and are mandated to conduct research and provide education to health professionals (Ministry of Health Rwanda, 2017). Acute care practice (ACP) environments, particularly the medical and surgical units within these practice settings, are the most commonly used units by nursing students during their clinical rotations.

Currently, nursing education in Rwanda uses a collaborative model of student mentoring in which school instructors are supposed to collaborate with staff nurses in the clinical settings to facilitate student learning (Maguire, Zambroski, & Cadena, 2012). In the educational setting, clinical teaching is done by nurses specifically known as "clinical instructors" (CIs) and by all nursing faculty who have a clinical teaching workload in addition to their theory course workload. Clinical instructors are employed full-time by a school of nursing to support student learning in the practice setting. Clinical instructors are based in the academic setting and rotate through different practice settings where students are placed for practice-based learning. Generally, one CI is assigned to approximately 19 students during a clinical placement block of approximately eight to 10 weeks (University of Rwanda, 2016).

In the practice settings, staff nurses who are registered nurses with at least a diploma level of education are required to facilitate student learning, as well as supervise and evaluate students, as part of their responsibilities (Republic of Rwanda, 2012). There is no known formal mentorship or preceptorship educational program for nurses to prepare for their role. Recently, a US-Rwanda Human Resource for Health program,

geared to improve the quality of clinical nursing education in Rwanda, provided mentorship to clinical educators who were associated with Rwandan nurses through a "twinning model" to facilitate building the capacity of hospital staff nurses regarding practice-based teaching and learning strategies (Uwizeye et al., 2018).

There have been no known studies in Rwanda that examined PLEs, especially the ACP environment and their influence on the PD of nursing students. Current available evidence from one educational institution in Rwanda identified a range of challenges that diminished the CIs' sense of empowerment and hindered their ability to support student PD. These challenges included a significant shortage of CIs, limited formal educational preparation of CIs to meet their responsibilities, and limited collaboration and communication between academic and practice settings (Thuss, Babenko-Mould, Andrusyszyn, & Laschinger, 2016). This findings of this study identified a need to assess the current PLE for nursing students in Rwanda to gain the perspectives of key stakeholders involved in the PD of nursing students, such as CIs, professional nurses, nurse leaders, and students themselves. Therefore, the present study was conducted to address that gap in knowledge and to seek the perspectives of various stakeholders from both the practice and academic settings on organizational cultural factors in ACP environments that support or hinder the PD of nursing students.

Study Purpose

Nursing students are embedded in classroom and real-world practice setting cultures. The similarities and diversity in values, assumptions, practices, and behaviours among stakeholders in these settings often influence the way nursing students develop as professionals across their educational programs (Young et al., 2014). A more comprehensive understanding of how these different values, assumptions, practices, and

behaviours shape an ACP environment and student PD can be facilitated by bringing together perspectives from the various stakeholders involved. Therefore, the purpose of this study was to explore the values, assumptions, practices, and behaviours within ACP environments in Rwanda, and how they support or hinder the PD of nursing students.

Research Questions

This study was designed to respond to two main research questions: 1) what are the shared and non-shared values, assumptions, practices, and behaviours that support the professional development of nursing students in acute care practice environments in Rwanda? and 2) what are the values, assumptions, behaviours, and practices in acute care practice environments in Rwanda that constrain the professional development of nursing students?

Study Significance

The future of the nursing profession in Rwanda in large part depends on the nursing students who join the workforce and the training they have received. Moreover, preparing nurses to enter the profession with the necessary clinical competencies, values, and attitudes requires PLEs that foster the competencies, values, and attitudes needed to facilitate the PD of nursing students. Unfortunately, studies conducted within African PLEs continue to highlight a significant gap between what is preferred as a supportive learning environment for preparing students for their professional role and what is often experienced by students in practice (Msiska et al., 2014; Mwale & Kalawa, 2016).

Narrowing this gap requires an understanding of the broader organizational contexts within which nursing students develop the knowledge, skills, and values to achieve professional practice. Yet, available evidence suggests that this has mainly been explored from an individual perspective. Thus, this study adopts an organizational

approach in an attempt to understand the complex nature of PLEs to reveal more comprehensive information.

By adopting a naturalistic, focused ethnographic approach (Roper & Shapira, 2000), this study contributes to bridging the epistemological-methodological gap in the literature regarding PLEs (Scott-Findlay & Estabrooks, 2006). The focused ethnographic approach facilitated the exploration of the values and assumptions co-constructed by multiple stakeholders involved in the professional growth of students, particularly from the perspective of students, staff nurses, CIs, and nurse leaders.

One of the strengths of this study is that it explores this topic from various perspectives, including both the practice and educational setting, and involves key individuals who have insightful experiences about the PD of nursing students during their practice-based learning. Findings from these multiple perspectives have the potential to provide a more comprehensive representation of shared and non-shared values, assumptions, as well as practices and behaviours within PLEs and educational setting, and how these influence the creation of an ACP environment conducive to preparing nursing students for professional practice.

Findings from this current study illuminate commonalities and diversities in values, assumptions, and practices between the ACP environments and the educational setting. Recognizing what is shared or not shared in terms of values and assumptions among these settings would allow for a greater understanding and clarification of expectations, which ultimately may assist practice settings in creating an environment that responds to student learning needs and PD, all the while fulfilling the primary mission of patient care provision. Furthermore, these findings have the potential to serve academic settings, such as nursing educational programs, as a basis for curriculum

review, as well as the adoption of appropriate learning approaches that are both supportive of student PD and respectful of the values held within practice-based settings.

Findings from the current study provide a better understanding for administrators of practice settings and of educational programs about the assumptions that underpin the behaviours of unit members, as well as the structural factors within PLEs that impact member engagement or lack of concern regarding the PD of nursing students. These may subsequently assist nurse leaders in designing new strategies to foster learning within their clinical contexts. If the PLE is enhanced, this will likely improve the quality of practice-based education offered to students, and students will graduate equipped with the required clinical competencies, attitudes, and values for their professional role, which ultimately can contribute to improving the quality of patient care in Rwanda.

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Key Concepts

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Values and Assumptions

Values within an organization represent the ideal principles that the organization and its members claim to be important to them, which they claim to try to achieve, what they hold to be true, (Schein, 2010; Taplay et al., 2014). When values have evolved over time, they become underlying assumptions, which determine the behaviours, perceptions, thoughts, and feelings within the organization, as well as how members perceive, think, and feel about things around them (Schein, 2010). Basic assumptions guide actions, impact thoughts and feelings, and contribute to the adoption of given behaviours of members in an organization (Schein, 2010). In this study, values and assumptions were explored through interviews with relevant key stakeholders, including students, CIs, staff nurses, and academic and practice setting leaders, and by analyzing organizational documents such as mission and vision statements and guidelines.

Professional Development

In nursing, PD has been defined as a lifelong process based upon formal education and clinical learning that leads to acquiring and improving the knowledge, clinical competencies, skills, and attitudes related to the nursing profession (Dall'Alba & Sandberg, 2006). PD as a process comprises both the skills progression dimension, in which the individual acquires psychomotor and cognitive skills needed to practice the profession, as well as the embodied understanding of practice dimension, which includes the process of affective skills acquisition, learning and adopting the expectations, and discovering and incorporating the values and beliefs of the profession (Dall'Alba & Sandberg, 2006; Weis & Schank, 2002).

Two forms of PD are identified in the literature: the PD that occurs through formal courses and programs in professional education and the continuous PD that occurs in the workplace (Dall'Alba & Sandberg, 2006). The latter entails a lifelong process that generally occurs after the completion of a nursing educational program, and includes learning experiences designed for enhancing professional skills, knowledge, and attitudes, keeping professionals informed of up-to-date information and practice changes (Marzin, 2011). Since the purpose of this study was to explore influences on the developmental process of nursing students during their nursing educational program, the concept of PD was used and considered as the ongoing learning process through which nursing students acquire the knowledge and skills, values, attitudes, and clinical competencies required to develop as a professional.

Practice-Based Learning Environment/Acute Care Practice Environment

The PLE is defined as an interactive network of elements and forces that surround the nursing student within the clinical setting, including the physical characteristics of the

setting, the psychosocial and interactional factors of the care providers, the patients and their families, the teaching effectiveness of the instructor and engagement of the student, and the organizational culture, all of which interact to influence nursing student PD (Flott & Linden, 2016; Papp et al., 2003). The PLE may be any setting that allows students to interact with patients for the purpose of acquiring clinical skills, such as acute care settings, community-based environments, and transitional homes (Flott & Linden, 2016; Gaberson & Oermann, 2010).

The ACP environment combines various units that provide acute care services, such as critical care, medical, surgical, perioperative, pediatric, accident and emergency, obstetric, and step-down units (Choi & Boyle, 2014). In the context of this focused ethnographic study, the ACP environment included the medical and surgical units within in-patient hospital settings in which nursing students engage in practice-based learning to acquire the knowledge, skills, values, attitudes, and competencies required to practice nursing.

Clinical Instructor

In the Rwandan nursing education context, a CI is a nurse faculty member, generally with a baccalaureate degree, employed by a nursing educational program to support students during practice-based learning in the simulation laboratories and in the PLEs. Some of these faculty members are also involved in teaching theory-based courses.

Declaration of Self

The researcher in ethnography is considered a human instrument that enters the setting with personal assumptions and preconceptions (Fetterman, 2010). Particularly, it is often the case in focused ethnographic research that the researcher may have deeply

held and internalized assumptions similar to what the research is trying to identify (Higginbottom, Pillay, & Boadu, 2013). On one hand, this closeness can be an opportunity, but on the other hand it can affect the quality of the findings (Lykkeslet & Gjengedal, 2007). To minimize such interference, ethnographic researchers are encouraged to adopt a self-conscious and reflective approach (Roper & Shapira, 2000). To that end, it is important that the PI situates themselves as a nurse educator in the context in which this study took place.

I am a registered nurse whose career has been mainly in nursing education. I have worked as a CI and a nurse teacher, and I have held leadership roles in a nursing school in Rwanda. My main responsibilities as a CI consisted of supporting nursing students during their practice-based learning in different PLEs, including two of the ACP settings involved in this study. During my leadership term in the nursing program, I coordinated teaching and learning activities, including planning and overseeing practice-based education. This enabled me to collaborate within the different practice environments used by instructors and students in their learning, and to consistently interact with students, staff nurses, faculty, and nursing leaders of various practice-based environments involved in the teaching and learning process.

During this experience, I came to witness the challenges faced by different stakeholders, such as the school, the practice settings, the students, and their teachers during practice-based learning. I also witnessed the commitment of these stakeholders who were trying to offer the best possible clinical education experience to students. These interactions and experiences sparked my interest and left me wanting to better understand their perspectives in relation to what was facilitating or hindering their goals. On the one hand, my awareness of some of their values and beliefs, and my familiarity

with the settings and potential participants in this study, offered me important insights needed to explore this topic. Additionally, these previous relationships helped me build the positive connections I needed to conduct this study.

On the other hand, however, I acknowledge that I came into the research with presumptions related to the topic given my experience, and I was aware that this experience might influence the research process, including the recruitment process, the questions asked, and the conduct and analysis of interviews. Going into this research, I identified myself as having both an insider and an outsider status (Roper & Shapira, 2000). As an insider, I belonged to the academic culture and held some knowledge of the culture of the practice settings that I intended to study. As an outsider, even though I interacted within the culture of the practice settings, I was not a permanent member of the settings and only knew part of their values.

I have not been in a formal leadership position for the last five years while in the PhD program, and I was not involved in any clinical or classroom teaching during the time this study was conducted. Also, for the majority of my PhD program I have resided outside of Rwanda. This temporal and geographic distance away from the study contexts helped me to understand stakeholder perspectives without unduly imposing my previously held assumptions. Nevertheless, to anticipate and address the possible influence related to my familiarity with the setting and participants, I consistently reflected on how this relationship might be affecting the study. I kept memos and regularly reviewed them to note incidents where my familiarity with the setting and the participants may have influenced the research process and how I addressed these influences.

Dissertation Overview

This is an integrated article format dissertation. It is divided into six interdependent chapters. Chapter 1 serves as a general introduction of the dissertation and offers relevant background on the topic area and the context of the study. It also provides the background for the remaining chapters. Chapter 2 is a manuscript for publication. It is titled *"Practice-based learning environments for the professional development of nursing students in Sub-Saharan Africa: An integrative review.* The chapter is guided by the question, "*What are factors that facilitate or constrain the PD of nursing students within Sub-Saharan Africa's PLEs?"* and the review synthesizes the current literature on factors influencing the creation of supportive PLEs for nursing students in the Sub-Saharan Africa context. Chapter 3 provides an overview of constructivism as a paradigm and how it guided the conduct of this study and presents the focused ethnography methodology used, the rationale for using it, and how it has been applied in the conduct of this study.

Chapters 4 and 5 are formatted as integrated manuscripts for publication. Chapter 4 is a manuscript titled "*Values, assumptions, practices, and behaviours supporting the professional development of nursing students within acute care practice environments in Rwanda."* The manuscript explores the shared and non-shared values and assumptions prevalent within ACP settings and an educational program, and how they inform the practices of units and the behavioural patterns of unit members regarding the PD of nursing students.

Chapter 5 is a manuscript titled *"Assumptions, behaviours, and practices hindering the professional development of nursing students within acute care practice environments in Rwanda."* This manuscript identifies the assumptions, practices, and

behavioural patterns within ACP environments that constrain the enactment of supportive values and assumptions into unit practices and unit members' behaviours in support of student PD.

Chapter 6 concludes the dissertation. It summarizes the findings and major insights stemming from the study and highlights important implications the study findings have for nursing education, practice, and policy. It suggests a framework for building and sustaining a nurturing and positive learning environment that fosters the PD of nursing students.

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Chapter 2: Integrative Review

A vital component of nursing education that contributes to the professional development (PD) of future generations of competent nurses is practice-based education. This approach to learning allows students to consolidate the theoretical knowledge acquired in the classroom setting into practice, such that students expand their knowledge base, refine clinical skills, and socialize into the nursing profession (Broadbent, Moxham, Sander, Walker, & Dwyer, 2014). The practice-based learning environment (PLE) encompasses all that surrounds the nursing student in the clinical setting, including the patients, family members, nursing staff, clinical teachers, work ethic of health professionals, and physical characteristics of the environment (Koontz, Mallory, Burns, & Chapman, 2010; Papp, Markkanen, & von Bonsdorff, 2003). The interactions of all these elements can contribute to shaping a supportive learning environment that empowers students in their process of becoming professional nurses (Flott & Linden, 2016). The purpose of this paper is to analyse the factors that facilitate or constrain nursing students' PD within PLEs in Sub-Sahara Africa (SSA).

Evidence demonstrates that a supportive PLE offers learning opportunities for students and creates a safe place for patients (Henderson, Briggs, Schoonbeek, & Paterson, 2011; Henderson, Creedy, Boorman, Cooke, & Walker, 2010). This leads to positive outcomes for student learning, growth, and PD (Babenko-Mould, Iwasiw, Andrusyszyn, Laschinger, & Weston, 2012), affords students opportunities to make valuable connections and gain experiential learning opportunities for integrating theoretical knowledge into practice (Kern, Montgomery, Mossey, & Bailey, 2014), and increases students' sense of belonging, making them feel affirmed, supported, and accepted as learners and as persons in their learning (O'Mara, McDonald, Gillespie,

Brown, & Miles, 2014). Supportive PLEs have the potential to significantly contribute to the PD of nursing students.

Conversely, students who learn in unsupportive environments feel vulnerable, become less proactive in their learning, and are afraid to ask questions or to take on additional learning experiences, which results in lost learning opportunities (Dale, Leland, & Dale, 2013; O'Mara et al., 2014). Similarly, studies have shown that the level of anxiety students experience while engaging in practice within unsupportive PLEs decreases their performance and ability to face challenging clinical situations and hinders their capacity to form healthy relationships with their teachers and patients (Anthony & Yastik, 2011; Melincavage, 2011). In addition, verbal abuse and uncivil behaviour increases student vulnerability, leads to burnout, and causes them to doubt their nursing career choices (Babenko-Mould & Laschinger, 2014).

Significance

Nursing students are integral to the future of the nursing profession. Therefore, educating them within unsupportive PLEs may pose a significant threat to the nursing profession and to professional practice. Students will likely graduate with insufficient knowledge and skills required for practice, or their low professional satisfaction may cause them to leave the profession, which in turn may increase the current nursing shortage and affect patient care and professional practice (Babenko-Mould & Laschinger, 2014; Flott & Linden, 2016).

While the shortage of nursing health human resources and nursing positions is a global concern, developing countries, particularly SSA countries, continue to be the most severely impacted. Of the 57 countries classified as facing a critical human resource shortage, 36 of them are within SSA (World Health Organization [WHO], 2006).

Limited capacity of current pre-service training programs in SSA to supply the appropriate number of nurses, the migration of nurses to western countries, and poor retention of nurses in practice are among the factors that account for this critical shortage in SSA (Munjanja, Kibuka, & Dovlo, 2005). In a recent review of the literature to identify nursing education challenges and solutions in SSA, the need for SSA to build a strong and efficient nursing education structure that will enable the development of the required nursing workforce to meet the health needs of the continent was recognised (Bvumbwe & Mtshali, 2018).

Given that nursing is a practice-based discipline, students are required to spend a significant amount of their education in PLEs to develop the necessary competencies required to provide safe patient care. This warrants an understanding of factors within these PLEs that influence nursing students' PD during their preservice education, particularly within resource restrained PLEs such as those in SSA. It is for that purpose that an integrative review of the available literature on SSA PLEs was conducted. The review process allowed for reviewing, critiquing and synthesizing (Torraco, 2005) factors that sustain or constrain students' PD within these PLEs in the SSA context. The findings from this review ultimately add to the body of knowledge for enhancing practice-based nursing education for pre-service programs in SSA to develop an adequately prepared professional future nursing workforce equipped to face the demanding and ever-changing health needs of the SSA population.

Aim

The aim of this integrative review was to critically analyse the factors that facilitate or constrain nursing students' professional development within practice-based learning environments in Sub-Sahara Africa.

Design

To conduct this integrative review, Whittemore and Knafl's (2005) framework was applied. The framework is a rigorous and systematic approach used to summarize and analyse existing literature. It allows for simultaneous inclusion of evidence from various sources, such as experimental and non-experimental research, theoretical, and empirical evidence to support a more comprehensive understanding of the phenomenon under study (Whittemore & Knafl, 2005). Whittemore and Knafl's (2005) integrative review framework was deemed appropriate for this review given the potential data sources available to critically analyse factors that facilitate or constrain nursing students' PD within PLEs in SSA. The framework outlines five stages to include in the review to enhance the rigor of the review process: problem identification, literature search, data evaluation, data analysis, and presentation (Whittemore & Knafl, 2005).

Problem Identification

The purpose of this integrative review was to critically analyse empirical evidence regarding factors that facilitate or constrain nursing students' PD in PLEs in SSA. Therefore, the review intended to answer the following question: What are factors that facilitate or constrain nursing students' professional development within practice-based learning environments in Sub-Saharan Africa?

In this review, the PLE includes all elements that surround the nursing student in the clinical setting, such as the physical space, staff, clinical teachers, work ethics, attitudes, equipment and supplies, psychosocial and interactional factors, and teaching and learning components (Flott & Linden, 2016; Koontz et al., 2010; Papp et al., 2003). Due to the broad contextual difference between acute care practice environments such as hospitals and non-acute PLEs such as community, outpatient and simulated laboratories,

this review was limited to studies that explored acute care hospital learning environments.

Professional development is conceptualized as a lifelong process based upon formal education and clinical learning that leads to acquiring and improving the knowledge, clinical competencies, skills, and attitudes related to the nursing profession (Dall'Alba & Sandberg, 2006). The time at school is a foundational and critical stage in the PD of nursing students because it is during this time that students are socialized into the profession and learn the norms, beliefs, and values of the nursing profession (Papathanasiou, Tsaras, & Sarafis, 2014). Understanding factors that interact to create a learning environment conducive to students for such a critical developmental stage is of particular importance. Thus, factors within the PLE that impact the process of students acquiring nursing competencies for professional practice were critically analyzed, using available evidence in the SSA region.

Literature Search

This review used a combination of three search strategies: computerized and electronic searching, ancestry searching and journal hand searching. The electronic search was done using the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAH), Scopus, and PubMed. These databases were chosen because they are the most common databased to publish nursing articles relevant to the review question. The subject headings and key words were used in various combinations and included "clinical learning", "practice-based learning", "clinical learning environment", "professional development", "nursing student", "preceptors", and "clinical instructors".

Publications were included in the review if: (a) the study was peer-reviewed; (b) the study focused on practice-based learning and PD within acute PLEs; (c) the study was

written in English; (d) the study was published between January 2000 and June 2019; and

(e) the study was conducted in one of the countries in SSA (Appendix A). To obtain a

contemporary analysis of the issues affecting the clinical education of nursing students in

SSA PLEs, publications were limited to articles published after 2000. Publications

focusing on the PD of health professionals in the workplace were excluded as this review

focused on PD that occurs during a nursing education program. In addition, publications

written in a language other than English and publications not conducted within acute care

PLEs were excluded.

Data Evaluation

The data evaluation stage consists of evaluating the methodological quality, the

informational value, and the authenticity of the publications (Whittemore & Knafl, 2005).

In this review, a total of 561 publications were identified in the initial search using the

search terms and applying filters such as the year of publication, English language and

the SSA geographical location. Publication titles and abstracts were reviewed to

determine their relevance to the review aim. After eliminating 499 publications that did

not meet the inclusion criteria, 62 articles were retained for further analysis. An

additional 27 publications were excluded for not meeting one of the inclusion criteria.

An extensive analysis of the remaining 35 publications was conducted to ensure

that the content focused on the review aim, and 13 further publications were discarded.

Twenty-two publications that met all the inclusion criteria were retained. During the in-

depth analysis of the full publications, ancestry review of the bibliographies was

performed, and additional journals were searched by hand to identify other relevant

publications meeting the inclusion criteria that may not have been located through the

electronic search. After the elimination of duplicates, an additional five publications

were added to the list. Ultimately, 27 articles were included in the review. Figure 1

details the data search process.
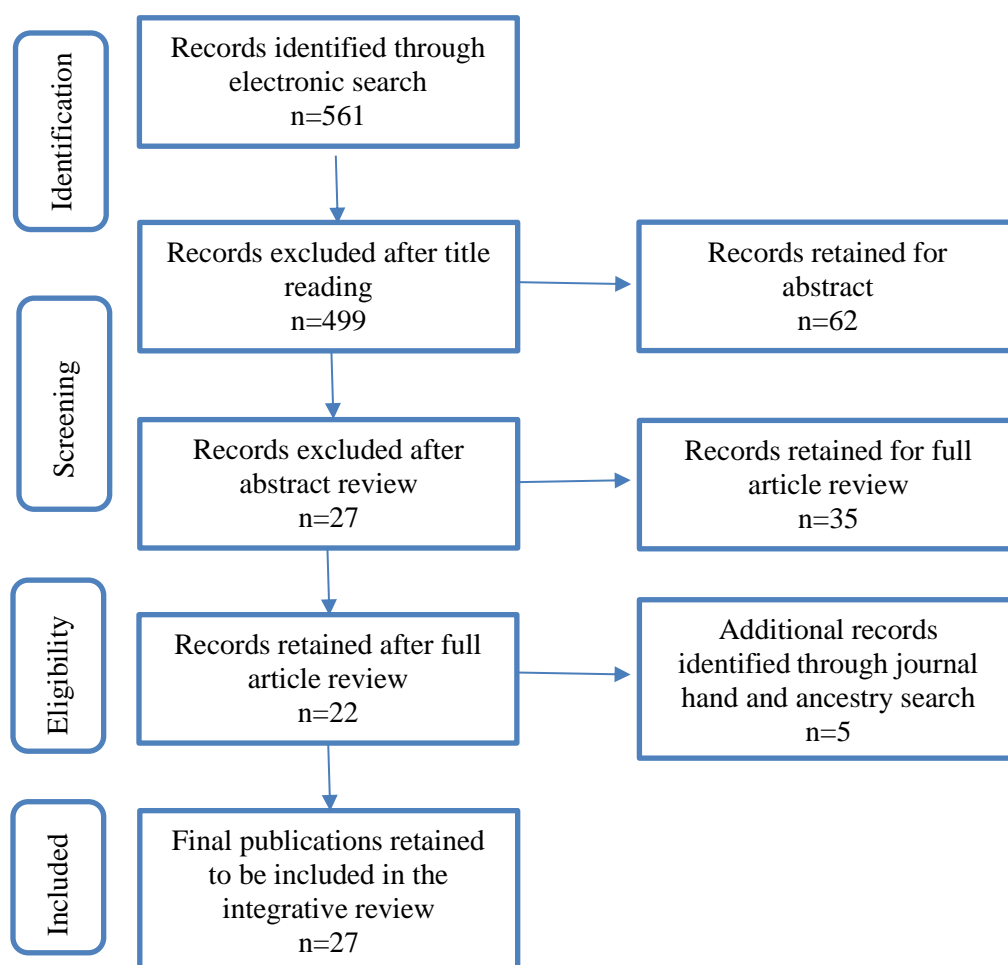
Figure 1. Diagram of Data Search and Inclusion Process

The search was stopped when the same authors and same articles were being

retrieved from different databases, and the references found were often cited in similar

articles. It was then judged that all relevant literature pertaining to the aim of this review

had been found, and that saturation (Francis, Johnston, Robertson, & Glidewell, 2010)

had been reached. Each of the 27 retained publications were evaluated for

methodological quality using Hong et al.'s (2019) Mixed Methods Appraisal Tool

(MMAT) and an appraisal form was kept for each reviewed article (Table 1). The

MMAT assesses the quality of different study designs with five sets of criteria to evaluate qualitative, randomized controlled trial, nonrandomized, quantitative descriptive and mixed methods studies (Hong et al., 2019).

The MMAT was suitable to use in this integrative review as it combines evidence from both qualitative and quantitative studies. Based on Whittemore and Knafl's (2005) recommendation for quality evaluation of primary sources, a descriptive summary on methodological quality was retained instead of a quality score, and no article was excluded from the review based on its quality appraisal.

Data Analysis

The data analysis stage consists of organizing, categorizing, and summarizing data from the primary sources to produce an integrated conclusion about the research question under study (Whittemore & Knafl, 2005). In this review, the unit of analysis consisted of each article. Articles were uploaded into *NVivo 11* computer-assisted data management software (Welsh, 2002) for coding. Each article was read line-by-line to carefully examine the main ideas identified in the article with a focus on the review aim. A data matrix was developed to facilitate the process (Table 2). Using thematic analysis and a constant iterative approach (Richards & Morse, 2013), patterns related to factors facilitating or constraining students' PD within PLEs were extracted and compared for similarities and differences. Emerging patterns were then clustered into five interdependent themes.

Table 1

Quality appraisal of Reviewed Articles using Mixed Methods Appraisal Tool (MMAT), Version 2018

Qualitative Articles						
Articles	Is the qualitative approach appropriate to answer the RQ?	Are the qualitative data collection methods adequate to address the RQ?	Are the findings adequately derived from the data?	Is the interpretation of results sufficiently substantiated by data?	Is there coherence between qualitative data sources, collection, analysis and interpretation?	Overall qualitative score
1. Asifiri et al. (2013)	Y	Y	Y	Y	Y	High
2. Bvumbwe et al. (2015)	Y	Y	Y	Y	CT	High
3. Carlson et al. (2003)	Y	Y	Y	Y	Y	High
4. Carlson et al. (2005)	CT	Y	Y	Y	Y	High
5. de Swardt et al. (2014)	Y	Y	Y	Y	Y	High
6. Iita et al. (2002)	Y	Y	Y	Y	Y	High
7. Kgafele et al. (2015)	Y	N	Y	N	N	Low
8. Mabuda et al. (2008)	Y	Y	Y	Y	Y	High
9. Matshotyana et al. (2015)	Y	Y	Y	Y	Y	High
10. Msiska et al. (2014)	Y	Y	Y	Y	Y	High
11. Msiska et al. (2014a)	Y	Y	Y	Y	Y	High
12. Msiska et al. (2014b)	Y	Y	Y	Y	Y	High
13. Murathi et al. (2005)	Y	Y	Y	Y	Y	High
14. Muthathi et al. (2017)	Y	Y	Y	Y	Y	High
15. Mwale & Kalawa (2016)	Y	Y	Y	Y	Y	High
16. Neshuku & Justus (2015)	Y	Y	Y	Y	Y	High
17. Phuma-Ngaiyaye et al. (2017)	Y	Y	Y	Y	Y	High
18. Rajeswaran (2016)	Y	Y	Y	Y	Y	High
19. Rikhosto et al. (2014)	Y	Y	CT	Y	Y	High
20. Setati & Nkosi (2017)	Y	Y	Y	Y	Y	High

21. Solum et al. (2016)	Y	Y	Y	Y	Y	High
22. Thuss et al. (2016)	Y	Y	Y	Y	Y	High
Descriptive quantitative articles						
Articles	Is the sampling strategy relevant to address the RQ?	Is the sample representative of the target population?	Are measurements appropriate?	Is the risk of nonresponse bias low?	Is the statistical analysis appropriate to answer the research question?	Overall qualitative score
23.Anarado et al. (2016)	Y	Y	Y	Y	Y	High
24.Cassimjee & Bhengu (2006)	Y	N	Y	Y	Y	High
25.Engelbrecht et al. (2017)	Y	Y	Y	N	Y	High
26.Monareng et al. (2009)	Y	Y	Y	Y	Y	High
Mixed Methods articles						
Article	Is there an adequate rationale for using a mixed methods design to address the research question?	Are the different components of the study effectively integrated to answer the research question?	Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Overall qualitative score
27. Eta et al. (2011)	N	N	N	CT	CT	Low

Y: Yes; N: No; CT: Cannot tell

Table 2

Summary of Findings from Reviewed Publications

Authors/ Country	Country	Aim	Design, Methods and Measures	Sample and Sampling	Relevant Findings
Anarado et al. (2016)	Nigeria	To investigate factors hindering clinical training of students in selected nursing institutions in Nigeria	Cross-sectional descriptive study Self-administered questionnaire developed by the researchers	Nursing students (N=283) from diploma and degree nursing programs Purposive sampling	Clinical education was hindered by inadequate equipment in the hospital, inaccessibility of the school library, lack of supervision by clinical teachers and lack of preceptors, limited preparation of students before clinical placements, limited learning opportunities, and not following the correct procedures in practice.
Asirifi et al. (2013)	Ghana	To explore perceptions of nursing students, preceptors and nurse educators regarding their experience	Focused ethnographic study Individual semi-structured interview	Final year students in a diploma program (n=9), preceptors (n=9), and nurse educators (n=8) Purposive sampling	The study identified that preceptorship was not formally established in the practice settings; not all hospitals had preceptors, the preceptor-student ratio was too high, and there was limited preceptorship training. Preceptorship was not valued; there is no link between preceptors and the school and preceptorship was not appreciated and supported by the management of health facilities.
Bvumbwe et al. (2015)	Malawi	Exploring nurses' experiences of CLE for students	Qualitative research study utilizing a descriptive phenomenological approach Focus group	Nurses (N=21) from teaching hospitals who were attending clinical preceptorship training	Learning was hindered by PLEs with limited resources and protective materials, shortage of staff, heavy workloads; poor communication; viewing students as just another pair of hands instead of focusing on their learning needs; and unclear role expectations. Clinical learning was facilitated by appropriate guidance from colleges, supporting nurses and holding joint briefing sessions before the arrival of students.
Carlson et al. (2003)	South Africa	Explore and describe the experiences of first-year nursing students related to their exposure to the CLE	Qualitative, exploratory, descriptive, contextual study	First-year nursing students Random-purposive sampling	Experiences of first year nursing students were characterized by fear, anxiety, frustration, and confusion. Students felt unwanted, isolated, and rejected by hospital personnel. These negative experiences were related to shortage of equipment for learning; unclear expectations of nursing school and hospital regarding the performance of first year students; lack of time for nurses to offer guidance to students; and inconsistency between how procedures

					were practiced and how they were taught in classroom.
Carlson et al. (2005)	South Africa	To explore the experiences of final-year nursing students relating to how they experience their preparedness to fulfil the role of professional nurse	Theory-generative, qualitative, exploratory, descriptive research design Individual interview Direct observation	Final-year nursing students (n=10) and novice professional nurses (n=unindicated) Purposive sampling	Final year nursing students experienced a lack of confidence to take on a professional nursing role because they were not given opportunities to practice decision making, take initiative, and take on responsibilities; they were discouraged by unprofessional attitudes and behaviours of ward personnel who served as negative role models; and students experienced a lack of commitment of nurses to support their learning.
Cassimjee & Bhengu (2006)	South Africa	To investigate student nurses' perceptions of their contact time with clinical staff regarding their clinical instruction	Quantitative descriptive design Self-administered questionnaires designed by the researchers	Third- and fourth-year students (N=59) Purposive convenient sample	The study investigated the frequency, adequacy, arrangement, and content of clinical supervision. Generally, students were dissatisfied with the clinical visits they received. The majority of students believed that the visits were inadequate, as most of them did not have a single visit from their clinical instructor in three months. Reasons for inadequate clinical visits included too many students per wards and busy wards.
de Swardt et.al. (2014)	South Africa	To explore the perception of nurses regarding their role in professional socialization of students and the experiences of students as members of nursing profession	Qualitative, exploratory, descriptive design Focus groups	Professional nurses (n=14) and nursing students (n=48) Purposive sampling	Students experienced a lack of professional socialization in an unsupportive PLE, reporting lack of adequate learning opportunities, lack of orientation to the clinical setting, minimal supervision because of the busy workload, intimidating attitudes of nurses, limited learning resources, exposure to unethical and unprofessional nurse conduct, and limited communication between the clinical setting and schools.
Engelbrech t et al. (2017)	South Africa	To determine the presence and the prevalence of intra-professional violence as experienced by undergraduate nursing students in the CLE	Quantitative design Adapted questionnaires from Nurse Workplace Survey and the Bullying in Nursing Education Questionnaire	Undergraduate nursing students (N=680) Convenience sampling	Majority of nursing students have experienced intra-professional violent behaviours in their clinical experience. The violent behaviors most commonly experienced were being treated differently as students; inappropriate rude, nasty, and hostile behavior; being ignored; and being physically isolated. The findings highlight a significant concern, as the main perpetrators of intra-professional violence were the qualified personnel in charge, such as

					registered nurses and sisters to whom students turned to for guidance and support.
Eta et al. (2011)	Cameroon	To describe the major challenges faced by clinical nurse educators in Cameroon	Qualitative method supplemented by quantitative method Self-administered questionnaire	Clinical nurse educators (N=56) Consecutive sampling	Students experienced challenges related to poor preparedness before clinical rotation; the short duration of rotation to achieve their learning objectives; overcrowding of students in units; lack of equipment, supplies, and other resources resulting in improvising and teaching students procedures not as they were ideally taught; lack of financial resources; and limited clinical skills and teaching skills.
Iita et al. (2002)	Namibia	To identify the factors that influence the selection of learning opportunities for primary health care in hospital units in Namibia	Qualitative, exploratory, descriptive research design Focus group discussions	Participants (N=41) Student nurses (n=18) Registered nurses (n=16) Lecturers (n= 7) Convenience sampling	The selection of learning opportunities and the support offered to students was hindered by the lack of knowledge to select appropriate clinical learning opportunities and a shortage of personnel; poor communication between nurses, lecturers, and students; unsupportive attitude of registered nurses created student frustration and avoidance; nurses' unwillingness to include students in their routine procedures; theory/practice gap; and a lack of appropriate material and equipment in the units.
Kgafele et al. (2015)	South Africa	Explore and describe pre-graduate students' views regarding the clinical accompaniment they received	Qualitative, contextual, exploratory, descriptive and interpretive research Self-report interview guide	Nursing students (N=217)	The supervision sessions by nurse educators were found to be infrequent and short, especially during the first day orientation and during the period of clinical learning. Nurses educators were not available to offer support and guidance to students during procedures. Students experienced a significant gap between theory and practice.

Mabuda et al. (2008)	South Africa	To explore student nurses' experiences during clinical practice at a nursing college in Limpopo province	Qualitative exploratory design using a phenomenological approach Individual interviews	Student nurses (N=11) in the final year of the four-basic nursing program Purposive sampling	Students found that nurses were unwilling and unqualified to teach them. They also experienced short rotation periods, had limited access to learning opportunities, saw discrepancies between theory and practice, were considered just a pair of extra hands, and noted a lack of communication between the school and clinical facilities. Clinical learning was facilitated by unit managers who made teaching a priory and involved students in tasks to stimulate their learning.
Matshotyana et al. (2015)	South Africa	To explore and describe the experiences of first-year nursing students in the comprehensive four-year diploma programme	Qualitative, explorative, descriptive and contextual approach Semi-structured interviews	Second-year students (N=14) from two nursing colleges Convenience Sampling	The study explored students' experiences both with the acquisition of knowledge in the classroom and in the PLE. In the PLE, clinical learning was hindered by unavailability of nurse educators; negative attitude of professional nurses toward students; inconsistencies between theory and practice; not considering the learning objectives of students; and delegating tasks beyond students' scope of practice.
Monareng et al. (2009)	Botswana	To describe the views of preceptors and preceptees regarding the role of the preceptor on planning learning activities during accompaniment of student in Botswana	Non-experimental, exploratory, quantitative design	Preceptors (n=72) and students in the final year (third) (n=200) Convenience sample	Clinical accompaniment of students was hindered by inadequate preceptor-preceptee ratio. Preceptorship was mainly based on unit needs rather than the students learning needs; preceptor's lack of time to plan and to be involved in precepting, lack of motivation to precept, inadequate educational preparation. One the other hand, their experience was facilitated by clarity of expectations from both preceptors and preceptees, being actively involved in planning their own learning activities, and their motivation to learn.
Msiska et al. (2014)	Malawi	To explore the clinical learning experience of undergraduate students in Malawi	Qualitative, hermeneutic phenomenology Individual interviews	Third- and fourth-year nursing students (N=30) Purposive sampling	An inadequate student-teacher relationship created fear and anxiety in students. Students received minimal support from the clinical educators. Students found their experience with the clinical supervision approaches used to be negative: educators were "policing" students instead of supporting them, shouting at them during bedside care, focusing on their weaknesses, and ignoring their strengths.

Msiska et al. (2014a)	Malawi	To explore Malawian students' perceptions of their clinical learning experiences	Hermeneutic phenomenology Conversational interviews	Third- and fourth-year undergraduate students (N=30) Purposive sampling	Challenging situations encountered in the PLEs such as facing death and dying increased the emotional load on students. Students were forced to work as nurses, leaving them physically exhausted. Nurses exhibited a dismissive attitude, hostility, shouting at students, and criticizing their mistakes resulting in student absenteeism and non-learning. Educators were not regularly available to support students.
Msiska et al. (2014b)	Malawi	To explore students' perceptions of their clinical learning experience	Qualitative, hermeneutic phenomenology Conversational interviews	Third- and fourth-year undergraduate students (N=30) Purposive sampling	The PLE suffered a significant shortage of nurses, and students were often considered extra workers to cover the shortage, which impacted their learning. Students could not get appropriate materials and supplies to perform procedures as they had learned in the classroom and instead had to "improvise" procedures. Nurses in the ward also demonstrated a hostile attitude toward students and an unwillingness to teach them. Students felt alone, unsupervised, and abandoned.
Murathi et al. (2005)	South Africa	To explore and describe the experience of unit managers teaching student nurses in the clinical area	Qualitative explorative using phenomenological approach In-depth interviews	Unit managers (N=6) Purposive sampling	Unit managers shared more negative experiences than positive ones in their role teaching student nurses in the clinical area: inadequate collaboration between unit managers and the schools/colleges of nursing; lack of support and poor communication between tutors and unit managers; and lack of updated teaching knowledge.

Muthathi et al. (2017)	South Africa	To explore the best practices in clinical facilitation from the student nurses' perspective	Exploratory qualitative descriptive design Focus group	Nursing students (n=24): second year (n=8), third year (n=7) and fourth year (n=9) Purposive sampling	This study explored best practices in clinical facilitation in the skills laboratory and in the PLE. The latter is highlighted in this review. Students appreciated consistency in performing procedures and preferred a full day allocation placement as opposed to half day as it allowed for continuity of learning. Students found it easy to learn when their clinical practicum was organized immediately after the skills laboratory to reinforce the demonstrated skills. Clinical facilitation was hindered by inadequate support from nurse educators and a lack of standardization of procedures which resulted in confusion and a lack of confidence.
Mwale & Kalawa (2016)	Malawi	To explore the experiences of students, nurses and tutors when acquiring the acquisition of psychomotor clinical skills	Qualitative, exploratory, descriptive design In-depth interview	Students in second year (n=7) and third year (n=4), clinical nurses (n=2) and tutors (n=2) Purposive sampling	The acquisition of psychomotor skills was hindered by: inadequate knowledge of students before placement; short rotation with too many students; shortage of materials and unqualified nurses; poor role models, knowledge gap and discrepancies between theory and practice; and poor relationship between the students, their tutors, and the nurses. Students' acquisition of psychomotor skills was facilitated in PLEs when many patients and staff were willing and open to guiding students and offering them diverse learning opportunities.
Neshuku & Justus (2015)	Namibia	To describe and explore the experiences of registered nurses and students regarding the clinical supervision of student nurses	Qualitative, explorative, descriptive and contextual In-depth individual interviews	Student nurses (n=27) and registered nurses (n=8) Purposive sampling	Clinical learning was hindered by staff shortages, a heavy workload, and wards overcrowded with students with an inappropriate student-supervisor ratio; most nurses and clinical instructors lacked updated knowledge and had no opportunities for PD; unclear expectations about students' learning needs; shortage of equipment and materials needed for care provision; poor guidance of students by their clinical instructors.
Phuma-Ngaiyaye et al. (2017)	Malawi	To explore the students' perception of using clinical preceptors to improve	Cross-sectional explorative design using both qualitative and quantitative methods	Second-, third- and fourth-year nursing students from 13 colleges (N=48)	The preceptorship model of clinical teaching was perceived by students as facilitating their clinical learning. The friendly, receptive and welcoming attitude of the preceptors helped in creating a positive

			Semi-structured interview	Purposive and convenient sampling	PLE. Students felt valued and respected as members of the clinical team and were eager to learn and free to ask question. The preceptors' positive attitude toward students helped to develop a positive attitude toward the patients and nursing as a profession.
their clinical learning outcomes					
Rajeswaran (2016)	Botswana	To obtain nursing students' opinions and explore their experiences of their clinical learning	Qualitative exploratory, descriptive and contextual research Focus group discussion	Students in level 2 and 3 (N=40) from one of the Institute of Health Sciences in Botswana Convenience sampling	Clinical learning in the PLE was found by students as anxiety-inducing, particularly the junior students. This was related to lack of support and guidance from both the school lecturers and the ward staff; lack of organizational support and collaboration from both the hospital and the academic setting; and inadequate hospital equipment resulting in discrepancies between practiced procedures and how they were taught in classrooms.
Rikhosto et al. (2014)	South Africa	To explore and describe the perceptions of nursing students with regard to clinical guidance	Qualitative, explorative, descriptive and contextual design Focus group	Nursing students in level 2 (N=23) Purposive sampling	Nursing students perceived that clinical guidance and support received was inadequate, mainly due to the shortage of professional nurses that hindered their involvement in clinical guidance; insufficient clinical equipment; and poor interpersonal relationships between students and professional nurses.
Setati & Nkosi (2017)	South Africa	To explore the perceptions of professional nurses on student mentorship in clinical area	Qualitative, hermeneutic, phenomenological study In-depth individual interview	Operational nurse managers (N=16) Non-probability purposive and convenient sampling	Professional nurses were willing to get involved in the mentoring of students and assignment of activities took into consideration students' level of training and their clinical learning outcomes. Mentoring was a team effort. Students' contribution in the wards was appreciated. Students' mentorship was hindered by lack of mentees' commitment towards their learning, poor communication between clinical settings and colleges, and heavy workload for nurses.
Solum et al. (2016)	Malawi	To explore the challenges experienced by nurse teachers in Malawi in their efforts to enhance students' moral competence in clinical practice	Qualitative hermeneutic approach Individual interviews Focus group discussion	Nurse teachers from colleges of nursing in Malawi (n=17) Purposive sampling	An authoritarian learning climate characterized by fear of disclosing mistakes hindered students' development of moral competence. Students preferred covering up the unethical practices of nurses out of fear of being punished, being negatively evaluated, or even expelled from the clinical setting. The absence of role models caused students to model the immoral nursing practices they observed. The

					lack of resources and equipment increased the gap between what is taught in classroom and how it is practiced.
Thuss et al. (2016)	Rwanda	To explore Rwandan clinical instructors' experience of structural and psychological empowerment	Descriptive qualitative method using Kanter's structural and Spreitzer' psychological empowerment theories Interview Secondary analysis	Clinical Instructors (N=21)	Clinical instructors felt that informal power in terms of their relationships with students, colleagues and staff within PLE and support from the academic institution increased their structural empowerment. In addition, a sense of competence and self-determination towards their role increased their psychological empowerment. However, lack of collaboration between academic institutions and clinical settings, limited information, lack of materials, and high instructor-student ratio diminished their sense of structural empowerment and their ability to carry out their responsibilities.

Findings and Discussion

Study Characteristics

Twenty-seven articles were included in this review. The characteristics of each

study are displayed in Table 3.

Table 3

Study Characteristics

Characteristics of articles *(N=27)*		N	%
Geographical Location	South Africa	12	44.4
	Malawi	7	26
	Namibia	2	7.4
	Botswana	2	7.4
	Cameroon	1	3.7
	Ghana	1	3.7
	Nigeria	1	3.7
	Rwanda	1	3.7
	Total	**27**	**100**
Study Design	Qualitative	22	81.5
	Quantitative	4	14.8
	Mixed methods	1	3.7
	Total	**27**	**100**
Study Population	Students	14	51.8
	Nurses, preceptors, nurse managers	3	11.1
	Nurse teachers-educators-clinical instructors	3	11.1
	Combined group (students-nurses-nurse educators)	7	26
	Total	**27**	**100**

Factors Influencing Students' Professional Development

A synthesis of factors that influence students' PD within SSA PLEs was

conducted from the 27 articles reviewed. Identified factors were clustered into five

interdependent themes: *infrastructure and resources, organization of learning, unit*

culture, interpersonal factors, and academic-practice collaboration. Table 4 describes

these themes and highlights the articles associated with each theme. Overall, there were

many more barriers to PD in the practice setting that were identified in the reviewed studies than there were facilitators, calling for recreating PLEs that minimize barriers and promote enabling practices that foster learning environments conducive to students' PD.

Infrastructure and resources. Twenty (74%) of the reviewed articles reported a significant infrastructure and resource gap within SSA PLEs. In most of the SSA PLEs, significant challenges in establishing supportive PLEs for students were caused by the infrastructure gap, including the inadequate provision of basic medical materials and supplies and unavailable, malfunctioning, and low quality medical equipment (Anarado, Agu, & Nwonu, 2016; Carlson, Kotze, & van Rooyen, 2003; de Swardt, van Rensburg, & Oosthuizen, 2014; Eta, Atanga, Atashili, & D'Cruz, 2011; Iita, Alberts, Van Dyk, & Small, 2002; Msiska, Smith, & Fawcett, 2014a; Neshuku & Justus, 2015; Rajeswaran, 2016; Rikhotso, Williams, & de Wet, 2009; Solum, Maluwa, Tveit, & Severinsson, 2016; Thuss, Babenko-Mould, Andrusyszyn, & Laschinger, 2016).

While lack of inadequate pedagogical materials such as computers, library books, and other learning resources have been identified within international nursing literature as constraining students' learning experiences (Chuan & Barnett, 2012; Jokelainen, Jamookeeah, Tossavainen, & Turunen, 2013), PLEs in limited resource contexts such as SSA are uniquely burdened by insufficient basic medical equipment; a lack of supplies and protective materials such as masks, gloves, sterile dressing packs, syringes, aprons; and inadequate, old or malfunctioning equipment. In some contexts, hospitals require nursing colleges to contribute to basic materials to allow students to learn (Bvumbwe, Malema, & Chipeta, 2015), a practice that was not identified elsewhere in the international nursing literature.

Table 4

Identified Themes and Associated Articles

Articles	Themes				
	Infrastructure and Resource	Organization of Learning	Unit Culture	Interpersonal Factors	Academic-practice Collaboration
1. Anarado et al. (2016)	V	V	V		
2. Asirifi et al. (2013)		V			
3. Bvumbwe et al. (2015)	V	V			V
4. Carlson et al. (2003)	V	V	V		
5. Carlson et al. (2005)			V		
6. Cassimjee & Bhengu (2006)		V			
7. de Swardt et. (2014)	V		V	V	V
8. Engelbrecht et al. (2017)				V	
9. Eta et al. (2011)	V	V			
10. Iita et al. (2002)	V	V	V	V	V
11. Kgafele et al. (2015)		V			
12. Mabuda et al. (2008)	V	V	V	V	V
13. Matshotyana et al. (2015)	V	V			
14. Monareng et al. (2009)	V	V			
15. Msiska et al. (2014)	V		V		
16. Msiska et al. (2014a)	V	V			
17. Msiska et al. (2014b)	V			V	
18. Murathi et al. (2005)		V			V
19. Muthathi et al. (2017)	V		V		
20. Mwale & Kalawa (2016	V	V	V	V	
21. Neshuku & Justus (2015)	V	V		V	V
22. Phuma-Ngaiyaye et al. (2017)		V	V		
23. Rajeswaran (2016)	V		V	V	V
24. Rikhosto et al. (2014)	V			V	
25. Setati & Nkosi (2017)	V	V	V		V
26. Solum et al. (2016)	V	V	V	V	
27. Thuss et al. (2016)	V		V		V
Total articles	20	18	14	10	9

Nursing students' PD in such resource-constrained PLEs may be hindered by learning inappropriate procedures and observing poor nursing practice as nurses resort to shortcuts and improvise procedures, which was found to widen the gap between what is taught to students in the classroom and what is practiced in the clinical settings (Iita et al., 2002; Msiska, Smith, & Fawcett, 2014b; Muthathi, Thurling, & Armstrong, 2017; Mwale & Kalawa, 2016; Solum et al., 2016). Some students missed learning opportunities because they were afraid of contracting contagious diseases by performing procedures on patients without adequate protection, thus hindering their PD (de Swardt et al., 2014).

The shortage of professional nurses in SSA PLEs hindered students' clinical competency acquisition in order to support PD. Nurses in SSA are often overwhelmed with heavy patient workloads and have limited time left to commit to guiding students in their development. Mentoring students was hence seen by those overworked nurses as time consuming and students were considered a nuisance (de Swardt et al., 2014; Monareng, Jooste, & Dube, 2009; Msiska, Smith, & Fawcett., 2014a, 2014b; Neshuku & Justus, 2015; Rajeswaran, 2016; Setati & Nkosi, 2017). Alternatively, the nursing shortage resulted in students being used as cheap labour to help with non-nursing duties such as documentation and transport, which often do not address students' intended learning outcomes (Bvumbwe et al., 2015; Mabuda, Potgieter, & Albert, 2008; Matshotyana, van Rooyen, & du Randt, 2015; Monareng et al., 2009; Msiska, Munkhondya, & Chilemba, 2014; Msiska, Smith, & Fawcett., 2014b; Rajeswaran, 2016). Students were occasionally assigned to tasks beyond their competency level and, in most instances, these procedures were performed by students independently and unsupervised (Mabuda et al., 2008; Matshotyana et al., 2015; Neshuku & Justus, 2015). Leaving students to do procedures unsupervised increased their anxiety as they felt insecure in

their learning and caregiving due to fear of putting patients' well-being at risk while learning through trial and error (Carlson et al., 2003; Msiska, Smith, & Fawcett, 2014a). Malawian students in Msiska, Smith, & Fawcett's (2014a) study shared that their clinical learning experiences produced emotions and traumatic experiences associated with caring for patients with complicated conditions and dying patients while they had minimal support from their clinical instructors.

The tendency of treating nursing students as workers as opposed to learners has been found in other studies in developing countries such as China and Malaysia (Chuan & Barnett, 2012; Shen & Spouse, 2007). A common trend behind this might be the critical shortage of nurses within practice contexts in developing countries. In those settings, service needs take precedence over students' learning needs, thus leaving students learning with minimal support and guidance, often performing procedures unsupervised or getting involved in menial tasks that are less challenging, inhibiting students from being challenged to develop high-level thinking skills (Chuan & Barnett, 2012).

Organization of learning. A significant barrier concerning inadequate support and guidance offered to students by both professional nurses and CIs from schools was mentioned in 18 (66.6%) of the reviewed articles. Some students started their practice rotation without being oriented, with no learning objectives, and without a presence of a CI to introduce them to the practice sites (Bvumbwe et al., 2015; Carlson et al., 2003; Kgafele, Coetzee, & Heyns, 2015; Murathi et al., 2005). Poor orientation increased confusion and lack of clarity of roles and responsibilities of students in the practice areas and constituted a barrier to professional nurses in providing students with appropriate guidance in their PD as they were not aware of the different student needs (Ali & Ali,

2017; Carlson et al., 2003; Iita et al., 2002; Mabuda et al., 2008; Murathi et al., 2005; Neshuku & Justus, 2015). This lack of information about curriculum content and missing support from CIs may be associated with the practice of involving students in activities beyond their scope of practice, which may then negatively impact patient care and hinder students' PD.

The length of practice-based placement rotations in some of the reviewed articles was considered too short to allow students to have sustained learning experiences and appeared more disruptive to students' PD. Additionally, the sequencing of theoretical courses and practice was found to be inadequate and often affected the level of preparedness of students before the practice placement (Ali & Ali, 2017; Eta et al., 2011; Mabuda et al., 2008; Mwale & Kalawa, 2016; Setati & Nkosi, 2017). This finding corroborates previous studies (Corlett, 2000; Lee, Clarke, & Carson, 2018; O'Mara et al., 2014) that have consistently uncovered that curriculum design and delivery, theory-practice sequencing, the length of time spent in the PLE, and the approach of clinical guidance significantly affect students' achievement of clinical learning outcomes and their PD. Shorter placement duration has consistently been reported to negatively affect students' practice-based learning experiences and prevent them from achieving a sense of belonging and competency, a requirement for PD to occur (Levett-Jones, Lathean, Higgins, & Mcmillan, 2008).

From the reviewed publications, preceptorship was the approach that proved to be appreciated by students in SSA as supporting their PD. Preceptors were perceived as more supportive and helpful in supporting students' achievement of learning outcomes and their overall practice learning experiences than were regular nurses, and preceptors increased students' confidence, competence and commitment to their learning and PD

(Monareng et al., 2009; Phuma-Ngaiyaye, Bvumbwe, & Chipeta, 2017). This might be related to the fact that in the preceptorship model a designated staff nurse is assigned to precept several students for an extended period of time (Gaberson & Oermann, 2010), which likely enables the establishment of a consistent student-preceptor relationship. Other studies (Carlson, 2013; Jessee, 2016) reached similar findings, discovering that the more individualized and student-focused the partnering approach, the better the outcomes experienced by students.

In settings that did not use a preceptorship approach, clinical instruction and support offered to students was judged unsatisfactory both in frequency and length. Clinical instructor visits were often too short or limited to student evaluations, and they did not provide sufficient guidance to students and to professionals in some clinical settings to support students' PD (Anarado et al., 2016; Asirifi, Mill, Myrick, & Richardson, 2013; Bvumbwe et al., 2015; Carlson et al., 2003; Cassimjee & Bhengu, 2006; Kgafele et al., 2015; Matshotyana et al., 2015; Mwale & Kalawa, 2016; Neshuku & Justus, 2015; Solum et al., 2016).

This minimal guidance and support not only deprived students from learning under the guidance of experienced professionals, but also it affected the formation of the supportive student-clinical instructor type of relationship necessary for developing as a professional. Student participants in Msiska, Smith, & Fawcett's (2014b) study used the term "policing" as an approach they perceived was used by their CIs who only visited practice settings occasionally to monitor what was being done by students and to question them about their procedures, resulting in their presence being more stressful to students than supportive.

Unit culture. Fourteen (51.8%) of the reviewed articles noted that the prevailing atmosphere within hospital units was a determining supporting factor in the creation of a supportive PLE. Unit managers in some settings created an environment where students were perceived as a benefit to their organization as their presence improved patient care (de Swardt et al., 2014; Mabuda et al., 2008; Muthathi et al., 2017; Setati & Nkosi, 2017). In these units, members viewed teaching students as a unit responsibility, and everyone in the unit got involved. Nurses embraced mentoring students as an in-service learning opportunity and improved their practice through their involvement in teaching students. Consequently, students felt accepted and included because the healthcare team made them feel involved and accommodated, which increased their satisfaction with the learning environment and their motivation for PD (de Swardt et al., 2014; Phuma-Ngaiyaye et al., 2017).

Studies revealed that a positive atmosphere characterized by teamwork, open communication, cohesion, and the validation of team member contributions offered students a welcoming and supportive environment, allowed students to gain a sense of safety, and increased their curiosity and commitment, which helped students to achieve effective PD (Chuan & Barnett, 2012; Dale et al., 2013; Hägg-Martinell, Hult, Henriksson, & Kiessling, 2014). Conversely, student participants in the articles reviewed shared how their learning and PD were ineffective when they learned in units with a hostile and oppressive atmosphere, lack of harmony, minimal team work, and poor communication (Msiska, Munkhondya, & Chilemba, 2014; Rajeswaran, 2016).

The quality of nursing practice in units was identified as an important determinant of the quality of student learning, yet many of the reviewed studies reported an important gap between nursing practice as practiced in units and as taught to students in classroom

settings (Ali & Ali, 2017; Anarado et al., 2016; Carlson et al., 2003; Mabuda et al., 2008; Thuss et al., 2016). This theory-practice gap has been consistently identified in previous studies as a concern in practice-based nursing education contexts, suggesting a perceived disconnect between recommended ethical practice and the realities of the practice setting (Corlett, 2000; Sharif & Masoumi, 2005). While familiarity and routine may play a role in this theory-practice discrepancy (Corlett, 2000), in SSA PLEs, this gap may also be related to the identified shortage of materials and the heavy workload of nurses, who, within the confined realities of their PLEs, opted for the "getting the job done" approach to practice.

Similarly, most of the reviewed studies reported a prevalent lack of work ethic, unprofessional practices and behaviours within units, uncaring and unempathetic attitudes towards patients, lack of professional accountability and lack of professional pride among unit members (Carlson, Kotze, & van Rooyen, 2005; de Swardt et al., 2014; Iita et al., 2002; Mwale & Kalawa, 2016; Rajeswaran, 2016). In their study, Solum et al. (2016) revealed a lack of openness to criticism and a culture of covering up mistakes among nurses, which dissuaded students from reporting unprofessional practices observed in units due to the threat of failure or disqualification from the practice settings. Other researchers (Levett-Jones et al., 2008; Levett-Jones & Lathlean, 2009) have identified that conformity and compliance with poor practices in a unit often become adopted by students since this increased their likelihood of being accepted and thus achieving belongingness within the PLEs.

Research has indicated that an empowering workplace environment in which nurses can accomplish their work goals with autonomy, perform ethical practice, control their own work, and make a positive impact strongly influences effective professional

practice, increases work effectiveness, and ultimately improves nurses' satisfaction with their job (Manojlivich & Ketefian, 2002; Spence Laschinger, Nosko, Wilk, & Finegan, 2014). In contrast, a workplace ethos characterized by power imbalance where nurses are put in a powerless position, their inputs are not valued, and their initiative is punished prevents nurses from trying new approaches, challenging the status quo, and asking questions or reporting errors (Scott & Pollock, 2008).

Based on the findings in the reviewed studies, it is reasonable to believe that the culture of covering up mistakes and fear of reporting errors may be evidence that the working conditions within many SSA nursing practice contexts often fail to empower nurses. By extension, nursing students observe poor-quality care standards in units and likely copy the uncaring and unethical behaviours without challenging them. Practice learning environments with this type of culture can negatively impact students' PD. These practice conditions also increase the risk of perpetuating the same poor practices once students are qualified as professional nurses.

Interpersonal factors. Interpersonal factors were identified in 10 (37%) of the reviewed articles. The relational factors identified suggest that students appreciated educators who were approachable and supported them in their learning needs and goals, all while recognizing students' strengths and considering them as human beings (Msiska, Munkhondya, & Chilemba, 2014). These qualities helped build confidence in students and afforded them with opportunities to ask for and receive constructive feedback that supported them in their PD and in the acquisition of necessary psychomotor, cognitive and affective skills (Mwale & Kalawa, 2016). This finding supports the notion that the quality of the relationship between students and their clinical teachers and mentors/preceptors remains an important aspect of effective practice-based learning as it

enables students to achieve a sense of belonging, and feel affirmed, supported and accepted as learners and as persons in their learning and professional growth (Gillespie, 2002; Saarikoski, Warne, Kaila, & Leino-kilpi, 2009; Walker et al., 2014).

Nonetheless, students in the reviewed studies generally experienced a lack of positive interpersonal relationships with their CIs and nurses. Holding negative attitudes towards students, considering them burdensome (Engelbrecht, Heyns, & Coetzee, 2017; Iita et al., 2002; Mwale & Kalawa, 2016; Neshuku & Justus, 2015; Rikhotso et al., 2009; Solum et al., 2016), and using abusive language such as calling them "septic dangerous junior nurses" (Mabuda et al., 2008, p.24) and "hazards" (de Swardt et al., 2014, p. 12) have all been experienced by students in various PLEs in the reviewed studies. In the majority of cases, the perpetrators of these acts of incivility towards students were professional nurses with authority who were expected to protect the students (Engelbrecht et al., 2017). In three of the reviewed studies, racial discrimination, tribalism, and treating students differently depending on the colour of their skin or the language they spoke (de Swardt et al., 2014; Rajeswaran, 2016; Rikhosto et al., 2014) were apparent in the nurse-student-tutor relationships. This finding raises significant concern about the likelihood these discriminatory attitudes impact the nurse-patient relationship, and thus requires further investigation.

Incivility towards nursing students is not a new phenomenon in nursing education. Studies outside of SSA PLEs (Anthony & Yastik, 2011; Babenko-Mould & Laschinger, 2014) have consistently uncovered the devastating effects of incivility experienced by students in their practice-based learning experiences, exposing them to burnout, creating self-doubt, and causing them to question if they belong in the nursing profession.

Academic-practice collaboration. A strong partnership between practice agencies and educational providers is undeniably a critical factor that influences the quality of PLEs for students (Henderson et al., 2011). Nine (33.3%) of the articles from this review identified academic-practice collaboration as negatively or positively affecting nursing students' PD. In some settings where collaboration existed between practice settings and colleges of nursing, integrated planning of students' learning was shared, a practice that allowed for role clarification (Bvumbwe et al., 2015). Also, informal power in the form of positive connections and relationships between clinical staff and academic clinical instructors led to support for decision making, thus empowering clinical instructors to provide adequate guidance to students in their PD (Thuss et al., 2016).

Unfortunately, the majority of the studies from this review, as seen supported in other international studies (Corlett, 2000; Hägg-Martinell et al., 2014), indicate a significant collaboration and partnership gap between practice settings and schools of nursing. In PLEs within SSA, this gap ranged from the absence of a working partnership and regular contact between academic settings and practice settings (Murathi et al., 2005; Rajeswaran, 2016; Thuss et al., 2016); limited support of the academic programs extended to practice settings in the guidance of students (Bvumbwe et al., 2015; Iita et al., 2002; Neshuku & Justus, 2015; Setati & Nkosi, 2017); and ineffective communication concerning students' schedules (Murathi et al., 2005). As a consequence of this collaboration gap, expectations of each other were not shared and clarified (de Swardt et al., 2014; Mabuda et al., 2008), which affected the support offered to students and diminished the structural empowerment of clinical instructors who supported students in their PD (Thuss et al., 2016).

Paradoxically, inadequately resourced PLEs, such as those in the reviewed publications, would significantly benefit from collaborating with the academic settings. Collaboration would improve working relationships and maximize optimal sharing of material, human resources, and expertise, which would lead to improved learning and patient outcomes. For example, in Malawi, formal practice-academic partnerships that embraced resource sharing proved to be a cost-sharing strategy that improved resource challenges faced by both nurses in practice and students in their PD (Bvumbwe & Mtshali, 2018).

Implications and Recommendations

New graduate nurses' knowledge and skills depend heavily on the quality of education they experienced as students in the classroom, during simulations, and in the practice context. Therefore, if nursing students experience barriers that impede their PD while obtaining their nursing education, it is easy to envision how those barriers can translate into deficits in the competence and professional attitudes required for patient care during and upon completion of their programs (Benner, Sutphen, Leonard, & Day, 2010; Papathanasiou et al., 2014).

A synthesis of the reviewed studies revealed interdependent factors that interact to influence nursing students' PD within resource-restrained PLEs in SSA. Identified factors co-exist at the academic-practice partnership level, the PLE level, and the interpersonal level. While most of the identified factors are largely consistent with existing factors identified by previous studies as influencing students' PD within international PLEs (Chuan & Barnett, 2012; Jokelainen et al., 2013), inadequate facilities and resources emerged as a barrier to students' practice-based learning specific to PLEs in limited resource contexts such as SSA. Findings from this review offer an important

contribution to policy, nursing education and practice, and research towards improving

the PLEs experienced by students during their PD.

Implications for Policy

The resource and infrastructure barriers identified by this review may likely be

influenced by external structural factors that are outside of the direct control of the PLEs,

such as the funding systems specific to each country and their respective budget

limitations. However, health ministries in SSA countries could revisit policies that

address teaching hospital funding so that the hospitals can provide adequate and

appropriate resources that take into consideration both the day-to-day needs of the

teaching hospital as an organization delivering patient care and the teaching-learning

needs of students to support their PD as soon-to-be nurses. Governments in the SSA

should consider the PLE a crucial factor in developing the next generation of competent

healthcare professionals. Thus, necessary resources should be devoted to achieving this

goal. Not only would an increase in monetary and human resource investments to

teaching hospitals support nursing student PD, but also it would support the PD of other

healthcare professionals involved in PLEs, such as medical students, midwives, physio

and respiratory therapists, as well as lab technicians. Investment may include aligning

national health policies, creating strategic plans, and allocating resources to meet the

training needs of health professionals as outlined by respective regulatory bodies

(Bvumbwe & Mtshali, 2018).

It stands to reason that when teaching hospitals receive sufficient funding to

support students' PD, the successful graduation and subsequent practice of competent

nurses will improve health care for the country as a whole. The investment at the

educational level to produce a strong nursing workforce reaps many benefits and fosters a

healthy SSA society. Additionally, it is proposed that by embedding students' PD as a priority within organizational policies that are enacted via values and norms, adequately resourced teaching hospitals in partnership with academic settings can develop students who will graduate with the knowledge, skills, and judgement necessary to practice in ever-changing, complex healthcare environments.

Implications for Nursing Education and Practice

Nurses are a key human resource workforce contributing to patient care now and in the future of SSA countries. Yet, a number of barriers have been identified by this review as hindering nursing students' PD. Practice settings and academia should provide the necessary organizational support to staff nurses and nurse educators involved in practice-based nursing education. Teaching hospitals should collaborate with nursing schools to adjust the nurse-patient, student-instructor ratio to alleviate the workload, recruit well-qualified nurse educators and build the capacity of existing nurses and nurse educators. This may minimize the theory-practice gap and ultimately improve the support and guidance offered to students. It has been previously proven that supportive workplace conditions and empowering structures such as access to resources, information, support and opportunities positively increase nurses' work satisfaction and commitment, prevent them from burn out, and enable them to practice nursing according to professional standards (Laschinger, Finegan, Shamian, & Wilk, 2001; Laschinger, Finegan, & Wilk, 2009). By extension, an empowered and satisfied nursing workforce has been found to be willing and committed to empower and mentor future nurses (Wiens, Babenko-Mould, & Iwasiw, 2014). If PLEs within SSA strive to enhance job effectiveness, nurses' performance and satisfaction, through offering institutional support to develop a culture of openness to learning and inquiry, these are likely to be translated

into empowering nurses' interactions with students during clinical placements. As a result, students' experiences will be improved, and their learning and their professional growth will be enhanced.

Implications for Nursing Research

While there is a consensus in the nursing literature across the globe that the organizational commitment of the PLE is an important factor in the creation of a positive learning environment for students (Jokelainen et al., 2013), none of the reviewed studies from SSA learning contexts explored this topic from an organizational perspective. Many studies took an individual perspective, and only a few considered the perspective from clinical settings and academic programs; yet, factors influencing learning intersect beyond individual levels. Future research needs to take a broader organizational perspective and explore how different beliefs and assumptions within PLEs are constructed and inform the behaviours and practices of its members in regard to students' clinical learning experiences and PD. In addition, future studies should aim at bringing together perspectives from major stakeholders in the preparation of students for professional practice, such as students, clinical settings staff, nursing faculty and managers of both settings. This can help address implications of the identified factors regarding different aspects of students' PD.

<div align="center">

Limitations

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Although the aim of this integrative review was to uncover facilitators and barriers of PLEs within SSA, the majority of the reviewed articles originate from a South African context. Given the advanced state of nursing practice and nursing education in South Africa compared to other SSA countries (Klopper & Uys, 2013), and that nursing education programs involved in this review have different structural and contextual

variations, attention might be paid towards the transferability of these findings and its

generalizability to other contexts. While careful consideration was used to ensure the

inclusion of most relevant literature, the author is unable to confirm that all of the

relevant articles were included. Finally, only studies published in English were included,

which may have resulted in the exclusion of relevant studies published in other languages

used in SSA.

Conclusion

This review brought to the forefront current factors impacting the PD of nursing

students within SSA PLEs. Similarities were identified between the findings of this

review and those from North American, Australian and European literature, suggesting

the universality of some of the factors affecting practice-based nursing education.

Studies in this review revealed that PLEs within SSA are experiencing common barriers

ranging from inadequate infrastructure and resources that limit the capacity of clinical

settings to provide a conducive PLE, limited academic-practice partnerships and

collaboration, ineffective instructional support, compromised learning cultures in hospital

units, and poor interpersonal relationships between students and clinical instructors and

nurses.

Effective education of nursing students is a critical step towards dealing with the

current pervasive shortage of an effective nursing workforce. Hence, evidence from this

review suggests there is an urgent need to reshape the clinical nursing education funding

system to provide the necessary funds to achieve the teaching mission of PLEs.

Appropriate partnership approaches between clinical settings and academia are of

paramount importance and warrant that organizations commit to creating effective PLEs

that are conducive to PD and to delivering optimal patient care.

Developing strategies that address the identified barriers and optimize the identified facilitators has the potential to positively improve the skills and competencies of nursing students and to improve the performance of future nurses who will deliver safer patient care. Failure to address these barriers will likely continue to result in inadequately prepared nurses and to contribute to the long-lasting shortage of skilled nurses in SSA.

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Chapter 3: Research Methodology

The purpose of this study was to explore the values, assumptions, practices, and behaviours within acute care practice (ACP) environments in Rwanda, and how these influence nursing students' professional development (PD). Specifically, this study addressed two questions: (1) what are the shared and non-shared values, assumptions, practices, and behaviours that facilitate nursing students' PD in ACP environments in Rwanda and (2) what assumptions, practices, and behaviours in ACP environments in Rwanda constrain nursing students' PD?

This study was conducted using a constructivist theoretical lens, and focused ethnography was chosen as the methodological approach to address the research questions. This chapter outlines how the study was conducted. It sets out the rationale for using constructivism as the theoretical lens and focused ethnography as the research design. Particularly, the chapter explores the use of focused ethnography as situated within the nursing education literature and how it was applied within this study.

Theoretical Lens

Constructivism was the theoretical lens applied to guide this study. Constructivism considers questions such as "how have the people in this setting constructed reality, what are their reported perceptions, truth, explanations, beliefs, and world-views, [and] what are the consequences of their constructions for their behaviours and for those with whom they interact?" (Patton, 2002, p. 96). Accordingly, the aim of this study was to explore how nursing students, staff nurses, clinical teachers, and nurse leaders give meaning to different values and assumptions in ACP environments, how the interpretation of these beliefs informs nurses, clinical teachers, and administrators'

behaviours and practices towards students, and how all these factors influence nursing

students' PD.

Constructivism assumes a relativist ontology. This means that constructivism

denies the existence of an external single reality and instead emphasizes the existence of

multiple realities all of which are socially constructed by individuals (Denzin & Lincoln,

2011). In a practice-based learning environment (PLE), PD involves the interactions of

many people, including nurses, students, teachers, patients, and other members of

multidisciplinary teams. The social interactions these individuals have with one another

constitute the reality of individuals' experiences of teaching or learning within PLEs

(Carlson, 2013). By using this multiple realities perspective (Denzin & Lincoln, 2011),

this study assumed that the degree to which values, assumptions, practices, and

behaviours within ACP environments are perceived to facilitate or hinder students' PD

will be a result of the co-construction of reality by different stakeholders involved in

students' PD.

Further, the interactions of stakeholders are often grounded in the values,

common beliefs, and assumptions embedded in official documents such as mission and

vision statements, policies, and practices guidelines. The interaction of clinical teachers

and nurses with students can be associated with how these institutional values create

realities for the roles of teaching and learning, and how they are interpreted by

stakeholders. The different stakeholders involved in nursing students' PD come from

various organizational contexts and may hold shared or non-shared values and

assumptions related to education in practice. These shared and non-shared values and

assumptions can be enacted into practices and behaviours that either facilitate or hinder

students' PD. This study sought to understand these meanings as co-constructed by these members and from their combined perspectives.

Constructivism also assumes a transactional and subjectivist epistemology (Denzin & Lincoln, 2011). This means that researchers are part of the world and of the data they are trying to collect; hence, their past and present experiences play a role in the co-construction of knowledge through their subjective interactions with participants (Patton, 2002). From this epistemological stance, the researcher comes to understand the world of the research participants through a naturalistic inquiry that involves a reciprocal and collaborative relationship between the researcher and participants in the process of co-constructing their meanings (Denzin & Lincoln, 2011; Patton, 2002). The researcher emphasizes interacting with study participants throughout the research process to access their views of reality.

These epistemological underpinnings formed the basis of the choice of constructivism as the theoretical lens for this study. It is mainly through interacting with students, staff nurses, clinical teachers, and nurse leaders that one could understand how their values and assumptions shape their practices and behaviours towards nursing students' PD during their PLE experiences.

Study Design: Focused Ethnography

Based on the methodological underpinnings of a constructivist theoretical lens, focused ethnography was chosen as a naturalistic research design to explore the shared and non-shared values and assumptions that shape the practices and behaviours within ACP environments. This research design approach helped to give meaning to the experience of students, clinical instructors (CIs), staff nurses, and academic and practice setting nurse leaders and assisted with exploring how these elements shape a PLE

conducive to students' PD. A discussion about ethnography as a research methodology

follows to lay the foundation for understanding the rationale for using focused

ethnography in this study.

Ethnography

Ethnography as a research methodology is rooted in anthropology and has also

been attributed to other disciplines such as sociology (Wolf, 2010). It has been applied in

different research settings, including health and education research (Patton, 2002;

Savage, 2006; Wolf, 2010).   Literally, ethnography translates as a research process of

"learning *about* people by learning *from* them," an approach used to "understand and

describe why a group of people do what they do" (Roper & Shapira, 2000, p. 1).

Culture is central to any ethnographic approach (Patton, 2002; Roper & Shapira,

2000).   Culture encompasses the collection of beliefs, values, norms, attitudes,

assumptions, behaviours, social arrangements, and physical artifacts that are shared by

members of a community or institution (Fetterman, 2010; Richards & Morse, 2013). As

a research methodology, ethnography provides a systematic way of recognizing

behavioural patterns and uncovering the meaning assigned to these behavioural patterns

in a cultural context (Robinson, 2013). Emphasis on the cultural context is another key

feature of ethnography (Roper & Shapira, 2000; Savage, 2006). As Whitehead (2004)

has noted, ethnography facilitates an understanding of the "interrelationship between the

socio-cultural context, the socio-cultural processes and the socio-cultural meaning" (p. 6).

As such, for an ethnographer to understand the realities of certain experiences, they must

first analyse the socio-cultural context within which these experiences emerge, the

processes, including the interactions that individuals have with their environment and

through which experiences are constructed, and the realities assigned to those experiences (Whitehead, 2004).

In order to understand a culture in its totality and to capture a holistic perspective of the activities, knowledge, beliefs, and cultural practices of the studied group, conventional ethnographic researchers use various methods, such as participant observation and intensive face-to-face contact, prolonged and extended cultural immersion in the natural setting, as well as extensive field notes (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2001; Fetterman, 2010; Richards & Morse, 2013; Roper & Shapira, 2000). Through participating in activities, observing practices, and asking the cultural group about their beliefs and social realities, the ethnographer gains the emic perspective, or an insider's view, of the group's cultural world. When the ethnographer makes sense of what they see, they bring the etic perspective, the outsider's view (Roper & Shapira, 2000). Hence, conventional ethnographies suggest that for an ethnographer to grasp the holistic realities of the culture being studied they must be unfamiliar with the cultural setting being studied and not enter the field with formally specified research questions, but rather with a broad, undefined purpose (Richards & Morse, 2013; Roper & Shapira, 2000).

Focused Ethnography

Over the years, researchers from different fields have been engaged in methodological adaptations of some features of conventional ethnography, mainly in response to emerging fields of study, various study populations, and new types of research opportunities and questions that could not be answered using conventional ethnography (Savage, 2006; Wall, 2015). Focused ethnography emerged as one of the forms of applied ethnography. In that sense, focused ethnography shares essential

features with conventional ethnography, but it allows researchers to study fields and

respond to research questions within cultural contexts that conventional ethnography's

features would not be able to study (Wall, 2015), such as the culture of ACP

environments within a large hospital culture. As Knoblauch (2005) has highlighted,

focused ethnography offers a unique strategy for studying selected, specified, and

focused aspects of cultural contexts within the socially and culturally fragmented

contemporary society.

Similar to conventional ethnography, focused ethnography's principal goal is

centred on understanding what is happening within a specific group in the context of their

culture and sub-culture (Richards & Morse, 2013). That way, the study is conducted

within the naturalistic setting in which the experience happens (Higginbottom, Pillay, &

Boadu, 2013; Roper & Shapira, 2000). Focused ethnography also values both insider and

the outsider views and recognizes the existence of multiple realities (Higginbottom et al.,

2013). Focused ethnography, however, differs from conventional ethnography in that it

uses a situation-focused framework and is framed within a discrete, specific context

(Higginbottom et al., 2013). Roper and Shapira (2000) found that focused ethnography

examines a "distinctive problem within a specific context among a small group of

people" (p. 7). The approach allows the researcher to concentrate on a distinct issue or

shared experience within a specific context, in a given culture or sub-culture, and in

specific settings such as the ACP environments that were the focus of this study, as

opposed to the entire community or cultural group (Cruz & Higginbottom, 2013;

Higginbottom et al., 2013; Richards & Morse, 2013).

While the main emphasis of conventional ethnography is on entire social groups,

social institutions, or social events, the focused ethnographic approach considers selected

and explicit actions, interactions, and social situations (Knoblauch, 2005). As a result, the researcher in focused ethnography enters the field with formally specific and predefined research questions to answer and holds prior knowledge of the setting before entering it (Knoblauch, 2005; Roper & Shapira, 2000). Due to its focused framework, focused ethnography does not require extended time and continual field work as does conventional ethnography; instead, focused ethnography can be accomplished in shorter time and can involve a limited number of participants. However, the short time length is compensated for by the extensive amount of data collected (Cruz & Higginbottom, 2013; Knoblauch, 2005).

Since this study focused on how values and assumptions influenced unit members' practices, behaviours, and interactions with nursing students regarding their PD within ACP units as opposed to an entire hospital's culture, the focused ethnographic approach was found to be the appropriate research methodology as it allowed for a deeper examination of these specific questions. Additionally, focused ethnography offered a more pragmatic approach to collecting multiple perspectives from stakeholders who belong to different academic and practice cultural communities yet share similar experiences by being involved in the teaching and learning processes for students' PD. One of the strengths offered by focused ethnography is it allows the exploration of the cultural meanings that people from different contexts assign to their shared realities (Cruz & Higginbottom, 2013; Roper & Shapira, 2000). In this study, shared and non-shared constructions across settings and within different groups of participants constituted the unit of analysis and provided deeper insights on cultural-bound practices and behaviours that facilitate or constrain the creation of a PLE that is likely to foster students' PD.

Focused Ethnography in Nursing Education Research

Since its emergence, focused ethnography has proven to be a useful and relevant research strategy used by nurse researchers to understand the interrelationship between people and their cultural context (Cruz & Higginbottom, 2013). Particularly, focused ethnography has increasingly been utilized in nursing education research to explore various cultural contexts within nursing education. A search in the literature using the key words "focused ethnography" and "nursing education" was performed using three databases that publish nursing education research, including CINAHL, PubMed, and Scopus. The search was limited to peer-reviewed articles published in the English language during the last ten years (2008-2018) in which focused ethnography was adopted as the research approach. The search yielded eleven publications (Table 5) from four groups of researchers and two independent researchers who published different studies applying focused ethnography within nursing education research.

The purpose of these studies included examining the professional socialization of baccalaureate nursing students during their rural hospital clinical experience (Sedgwick & Yonge, 2008a, 2008b; Sedgwick & Yonge, 2009); identifying the influence of an undergraduate problem-based learning program on evolving professional nursing graduate practice (Spiers et al., 2014; Williams et al., 2012); understanding the culture of learning and the factors that affect student learning in specific contexts such as high-fidelity simulation (Harder, Ross, & Paul, 2013a; Harder, Ross, & Paul, 2013b); investigating the culture of nursing and how nursing faculty and preceptors bring students into that culture (Strouse & Nickerson, 2016; Strouse, Nickerson, & McCloskey, 2018); examining the acculturation of students to the research methods and theories used within a current undergraduate nursing program curriculum (Duncan, Babenko-Mould, Iwasiw,

McWilliam, & Hibbert, 2016); and examining how nursing education programs might shape student knowledge of culture over time (Vandenberg & Kalischuk, 2014).

The use of focused ethnography allowed these researchers to explore selected and specific areas of beliefs, values, norms, and practices pertaining to nursing education culture such as professional socialization (Sedgwick & Yonge, 2008a), problem-based learning (Williams et al., 2012), culture of care (Vandenberg & Karischuk, 2014), and research utilization (Duncan et al., 2017), in specific cultural contexts such as rural practice environments (Sedgwick & Yonge, 2009), and a high-fidelity simulation laboratory (Harder et al., 2013b). The use of focused ethnography permitted these researchers to compare perspectives from different groups of people, including nursing faculty (Strouse & Nickerson, 2016), nursing students (Sedgwick & Yonge, 2009), and preceptors (Strouse et al., 2018), often dispersed geographically and in different contexts but linked by their experiences of engaging in nursing education.

Table 5

Selected Recent Studies using Focused Ethnography in Nursing Education

Study	Purpose	Sample	Methods	Results
Duncan, Babenko-Mould, Iwasiw, McWilliam, & Hibbert (2017)	Examine the enactment of acculturation to research utilization within an undergraduate nursing program curriculum in-action	Nursing educators Students Documents from one undergraduate nursing program in Canada	Interviews, Participant observation, Document review	The study revealed that values, norms, and attitudes regarding research methods and theories were unintentionally internalized and enacted within the current nursing curriculum. Such unintentionality resulted in unclear definition, meaning, and enactment of research. The study recommended a more intentional acculturation to the use of research in the nursing curriculum to enhance the professionalization of nursing as a research-based profession.
Harder, Ross, & Paul (2013a)	To explore what is it like to engage in simulated clinical experience as an instructor	CIs (N=20)	Individual interviews Focus group Observation Field notes	Generally, instructors expressed lack of confidence and feeling of inadequacy in understanding their roles in HFS in facilitating students' learning in the sim lab. Their low comfort level affected the support they provided to students. Adequate preparation of instructors for their roles prior to the use of FHS and ongoing support were recommended to improve the comfort level of instructors and to enhance the students' simulated learning experiences.
Harder, Ross, & Paul (2013b)	To explore students' perceptions of learning in high-fidelity simulation	Third-year students (N=84) from a Canadian university	Individual interviews Participants observations	The study identified the culture of learning and the factors that affect student learning in HFS. Students expressed that role assignments in the HFS were often unclear and source of confusion in their learning. Students preferred being assigned to play active nursing roles as opposed to non-nursing

				roles. The acquisition of skills was better facilitated when the role was clear and the students were prepared with a scenario script ahead of the role playing.
Sedgwick & Yonge (2008a)	To examine the professional socialization of undergraduate fourth-year nursing students during a rural hospital preceptored clinical experience	Fourth-year nursing students Preceptors	Interview Students journal Field notes Focus group session	Focused ethnography allowed an understanding of the experiences and meaning of engaging in rural practice. The study identified that for a rural clinical experience to be successful, students' preparation, including cognitive and psychological preparation, was key.
Sedgwick & Yonge (2008b)	To describe the experiences of nursing students and preceptors during a rural hospital preceptorship practicum	Nursing students Registered nurse preceptors	Interview Students journal Field notes Focus group session	The study identified that a sense of belonging is central to the success of a clinical experience in a rural hospital context. Belonging was shaped by different factors, such as individual characteristics, significant interpersonal relationships with staff and preceptors, and the unit climate.
Sedgwick & Yonge (2009)	To examine undergraduate nursing students' experiences and perception of faculty involvement in rural hospital preceptored clinical experience	Fourth-year nursing students (N=12)	Interviews	Students expressed feeling isolated as a result of limited support and communication from their faculty. This affected their rural clinical experience. The authors recommended improving faculty presence and communication.
Spiers, Williams, Gibson, Kabotoff, McIlwraith, Sculley, & Richard (2014)	To explore the experience trajectories and satisfaction of graduates who had completed an undergraduate problem-based learning nursing program	Nursing student graduates	Individual and group semi-structured interviews	The level of satisfaction with problem-based learning was perceived differently by graduates depending on their understanding and valuing of PBL and individual learning preferences and styles. Graduates with a deep learning style experienced PBL more positively, whereas surface learners encountered frustration and demotivation.

Strouse & Nickerson (2016)	Explore nursing faculty perceptions about the culture of nursing and how they bring students into that culture	Nursing faculty (N=16) from two public schools of nursing in a midwestern US state	Interviews Fieldnotes from observation and document review	Participants agreed that nursing is a professional culture that is multifaced and often contradictory. They expressed that the culture is influenced by many factors, both intrinsic and extrinsic to nursing. Faculty believed that they play a significant role in bringing nursing students into that culture by acting as culture brokers, although navigating the different subcultures encountered in their roles appeared often challenging.
Strouse, Nickerson, & Mccloskey (2018)	Explore preceptors' perceptions of nursing culture and their role in bringing students into that culture	Preceptors from three hospitals in two cities in a midwestern US state	Semi-structured interviews	Preceptors believed that the nursing profession has a unique, difficult to describe culture that varies depending on many factors. Nursing students belong to that culture but often hold an idealized view of nursing based on what they learned in school. Preceptors play an important role by bringing students into that culture and helping them transition from academia to practice and teaching them the real culture during their PLE.
Vandenberg & Karischuk (2014)	To explore and critique what nursing students learn about culture and cultural care	First-year (n=40) and fourth-year (n=31) nursing students	Participant observation Focus group Interview	The study uncovered that students hold an essentialist understanding, equating culture to racial and ethnic differences, with limited incorporation of political and institutional factors that seem to shape healthcare inequities, and much of the content covered in the nursing curriculum tended to reproduce that essentialist view rather than expose those critical factors. While this perspective seemed to evolve and improve over the nursing education journey, senior students' understanding of culture care was found to be limited to awareness of differences and improved interpersonal relationship and communication.

| Williams, Spiers, Fisk, Richard, Gibson, Kabotoff, Mcllwraith, Sculley & (2012) | To determine how problem-/context-based learning graduates describe the contribution of the educational experience to their professional practice as nurses | Problem-based learning graduate (N=45) | Individual interviews Focus group discussion | Participants believed that the problem-based program provided them with opportunities to develop many of the skills and abilities required for effective professional nursing practice. Nurses who graduated from problem-/context-based learning programs described themselves as critical thinkers, more self-aware, and self-directed. They felt confident to be able to advocate for their patients holistically and to base their practice on evidence. |

These scholarly articles illustrate the merits of using focused ethnography in the present study. Focused ethnography reveals the realities, values, and assumptions of relevant stakeholders in nursing education within the specific context of the ACP. Moreover, it enables the examination of how those values and assumptions are enacted into behavioural patterns and practices within the ACP environment in Rwanda, and ultimately how they influence nursing students' PD. Focused ethnography offered a suitable approach to address these pre-defined questions by a researcher with some degree of familiarity with the research setting, and within the limited timeframe of a doctoral dissertation. Congruent with the constructivist theoretical assumptions (Patton, 2002) this study ascribed to, this focused ethnographic study privileged participants' perceptions and interpretations to explore the understanding they assign to their cultural realities.

Methods

Research Settings

The primary setting of this study included three ACP settings (referred to as sites A, B, and C), and one associated academic setting where students were enrolled in a nursing program. The academic setting is a public higher learning institution that provides post-secondary education to a variety of health professionals, including nursing. This academic setting provides a variety of nursing programs at diploma level, a baccalaureate nursing program, and graduate nursing programs. The baccalaureate nursing program offered by this academic institution was included in this study because it is the largest and oldest of its kind in Rwanda. The nursing program plans the PLE and allocates clinical instructors (CI) to the three clinical settings to support students during their practice-based education. Including the nursing program in this study permitted the

exploration of values and assumptions shared or not shared within the clinical settings in relation to students' PD.

The three practice settings were purposively chosen because they serve as the primary PLEs used by the majority of nursing students at different levels of their nursing courses. All three practice settings are located in an urban geographic area and share the same mission as they are all designated national referral and university teaching hospitals. They provide the highest level of care within Rwanda, act as referral hospitals for more specialized care, and are mandated to conduct research and provide education to health professionals (Ministry of Health Rwanda, 2017). However, these settings differ in terms of their status. Two of the settings are public referral and teaching hospitals, whereas the remaining setting is a public-private referral hospital, mandated to provide a higher level of technical expertise than provided in other referral hospitals (Ministry of Health Rwanda, 2017). These similarities and differences were included in the study to allow diverse and in-depth understanding of how different values, assumptions, practices, and behaviours within these learning environments are constructed and enacted into practices and how they support or hinder the creation of a supportive ACP environment for nursing students' PD.

Given the limited number of health facilities and academic programs that share similar characteristics with the three ACP settings involved in this study, detailed descriptions of the settings and their cultural contexts have been purposively omitted in the aim of preserving the anonymity of both the institutions and the participants.

Getting-In and Recruitment

After receiving research ethics board approval from Western University, the University of Rwanda, and each of the three participating practice settings, gatekeepers

were identified in each setting to facilitate access to units (Appendices B). The getting-in procedure was different for each site depending on its "ways of doing." In sites B and C, the primary investigator (PI) was requested to give a formal presentation to all nurse unit managers to introduce the study, whereas in site A, the gatekeeper introduced the PI to the unit managers of surgical and medical units. From that point, arrangements were made with the managers of each unit to plan for recruitment.

In site C, the unit managers provided the PI with a room to discuss the research study with staff nurses on duty. Those who were interested in participating left their contact information with the PI and an appointment was made with them for a later date. In site B, after a meeting with the unit managers, one staff nurse in attendance who coordinates nursing education activities volunteered to participate and recommended other nurses to the PI. These individuals were later contacted, and appointments were made with those who agreed to participate.

In site A, the unit manager offered the PI time during a morning staff meeting to introduce the study to staff nurses. At the end of the meeting, a paper was left on the table for those interested to contact the PI or to leave their contact information in the room so that the PI could contact them. This process yielded no results; none of the nurses left their contact information and none tried to contact the PI. The following time, through a snowball sampling strategy (Richards & Morse, 2013), the PI requested the unit manager indicate which staff nurses might be interested in student education and then these nurses were approached individually. Those who spoke to the PI shared that they did not provide their contact information because they "did not think they have much to share with me," while others thought that "I should talk to the unit managers as they are the ones responsible for students." After explaining that their experiences as

staff nurses were important the study, three of them agreed to participate in the study and appointments were made with them.

The attitudes of the staff nurses at site A were intriguing for the purpose of this study. The PI reflected on the influence their attitudes might have on their behaviour towards nursing students. The fact that the staff nurses believed they had nothing to contribute on the topic of nursing students' PD within their unit could be linked to their limited commitment and involvement in students' support, leaving it to the unit manager. It may also illustrate how values and assumptions within this particular ACP environment might have contributed to the staff nurses' adoption of such an attitude towards students' PLE and PD.

The recruitment in the academic program went as planned; students were approached at the end of a theory class and those who were interested in participating approached the research assistant at the end of the meeting. In total, 17 fourth-year students and 10 third-year students expressed an interest in participating, and a total of 12 students were included. Email contact information of all the CIs in the program was obtained from the administrator of the academic program, and an electronic invitation was sent to each of the 15 CIs. Seven out of 15 CIs responded to the request and were willing to participate in the study. A second email reminder was sent to the eight participants who did not respond to the first email, but none of them responded. After that reminder, only those who responded initially were approached for interview planning. For the category of nurse leaders, including the unit manager and or the director of nursing in the PLE, and the department/faculty leader in the academic setting, the PI requested appointments with them to invite them to participate. All eight nurse

leaders approached were interested and scheduled a time for an interview. Table 6

summarizes the recruitment process.

Table 6

Recruitment Process

Site	Category of Individual Interviewed	Recruitment Method	Successfully Recruited
Site A	Nurse leader (Directors of Nursing division and unit managers)	Direct invitation	2
	Staff nurses	Approached individually	4
Site B	Nurse leader (Directors of Nursing division and unit managers)	Direct invitation	2
	Staff nurses	Recommended by the coordinator of education	3
Site C	Nurse leader (Directors of Nursing division and unit managers)	Direct invitation	3
	Staff nurses	Meeting with available staff	4
Academic	Nurse leader (Dean or Head of department)	Direct invitation	1
	CIs	Email invitation	7
	Students	Invitation	12
Total			N=38

Sampling Strategies

A combination of purposive and snowball sampling techniques was used to select

participants, activities, and documents to uncover beliefs, values, assumptions, practices,

and behaviours within the ACP environments that shape nursing students' PD.

According to Richards and Morse (2013), purposive sampling consists of recruiting

participants based on their knowledge of the topic under study, while snowball sampling

consists of using participants who are already in the study to indicate another participant

known to have a similar experience to be recruited into the study. This was also in line

with focused ethnography assumptions that by concentrating on very specific questions,

participants should have specific knowledge about the issue under study (Higginbottom et al., 2013; Roper & Shapira, 2000).

Purposive sampling was used to select nursing students, CIs, and nurse leaders based on the pre-determined inclusion criteria. Nursing students were included in the study if they were in the senior levels of their nursing program. This was because students in the third and fourth levels are approaching the completion of their nursing program and have been exposed to multiple practice settings, enabling them to draw on their practice experiences and to have a basis from which to share how ACP environments contributed to their PD. Students were also required to have recently completed or to be currently engaged in a professional practice course in the medical or surgical units of one of the three practice settings involved in the study.

Clinical instructors were included if they were faculty members at the nursing program who had been working in the academic setting for at least one year and if they had been involved in practice teaching for at least two clinical rotations in the selected practice settings. CIs with less than a year of teaching experience, and who had not taught students in the medical and surgical rotations in the selected practice settings, were excluded from the study. The category nurse leaders included nurse leaders at the nursing division level/unit management level in the practice settings or at the department/school level in the academic program. Nurse leaders were included if they had at least one year of experience in their role as unit/division manager in the practice setting or at the school/department level in the academic setting. Nurse leaders with less than a year of experience were excluded from participating in the study.

Snowball sampling was used to select staff nurses. Once nurse leaders at the unit level were recruited into the study, they recommended to the PI other staff nurses they

thought would be interested in nursing education and willing to participate in the study. Staff nurses were included if they had at least an advanced diploma in nursing, had been working in the medical or surgical unit of the selected practice setting for at least one year, and if during that period they had been assigned to work with students during their practice-based learning. Staff nurses who did not have an advanced diploma in nursing or had less than one year of experience at the time of data collection were excluded from the study. As data collection progressed, the PI consistently requested that the nurses already in the study recommend additional staff nurses who might fulfill the inclusion criteria.

Activities for observation were identified through conversational observation conducted during the recruitment phase and throughout individual interviews. Specific events to include in further focused observation were identified and added to the observation checklist (Appendix C). Documents were included on the basis that they appeared to reflect the beliefs, values, and assumptions of PLEs/academic setting related to education in practice and students' PD. Documents from selected practice settings, as well as documents from the academic setting used as guidelines for students' education in practice, were selected through purposive sampling as they were identified through interviews with participants.

Sample

The sample size for this study was initially proposed to be approximately between 30 and 45 for the four groups combined, namely nursing students, CIs, staff nurses, and nurse leaders. This was based on estimated sample size for conventional ethnography, estimated between 25 to 50 interviews (Moser & Korstjens, 2018). However, focused ethnography uses a smaller sample size than conventional ethnography (Higginbottom et

al., 2013; Roper & Shapira, 2000).   Therefore, based on the limited scope of this focused

ethnography study and the multiple sources of data collected, 38 participants were

included in the study: third- and fourth-year nursing students (n=12); CIs (n=7); staff

nurses (n=11), and academic and practice setting nurse leaders (n=8).

Including different categories of participants aligned with constructivist

theoretical underpinnings which require accessing multiple views of reality in order to

understand experiences of the people being researched in as deep a way as possible

(Patton, 2002). The experiences from these different groups of participants represented

the multiple views of the people concerned with practice education of nursing students

within the ACP environments.

Six activities were observed, totaling approximately 15 hours of observation, and

a total of 11 documents and texts were included in the analysis (Table 7).

Table 7

Observation Done, and Document Reviewed at Each Site

Data Collection Method	Site A	Site B	Site C	Academic
Observations (*n=6*)	- Morning staff meeting - Observation of artifacts	- Observation of artifacts	- Orientation on the first day of clinical placement - Pre-conference session - Observation of artifacts	-No observation
Document review (*n=11*)	- Mission & vision statements (doc 1, A) - Nurse job description (doc 2, A)	- Mission & vision statements (doc 1, B) - Clinical placement guidelines (doc 2, B) - Nursing division statement (doc 3, B)	- Mission & vision statements (doc 1, C) - Clinical placement policy (doc 2, C) - Performance appraisal form (doc 3, C) -Student registration form (doc 4, C)	- Clinical training guidelines (doc 1, academic) - Academic regulations (doc 2 academic)

Data Collection and Analysis

In keeping with the iterative, cyclic, and inductive nature of focused ethnography (Higginbottom et al., 2013; Roper & Shapira, 2000), data collection was done concomitantly with data analysis. This process is also referred to as recursive analysis by LeCompte and Schensul (2013) and consists of a cyclical process through which the researcher goes back and forth between data collection and data analysis and engages in analysis while still collecting data. The feedback from the field allows the researcher to reorient the fieldwork, formulate new questions to ask, find new answers that clarify the previous formulations, and identify new instances that may support or disqualify the initial findings (LeCompte & Schensul, 2013; Roper & Shapira, 2000).

In this study, three data collection methods were employed: individual in-depth interview, participant observation, and document review. This aligned with focused ethnography's recommendation of using multiple data collection methods to capture rich and essential patterns of values, behaviours, and assumptions prevalent in an organization, group, or individual (Higginbottom et al., 2013; Roper & Shapira, 2000). A demographic questionnaire (Appendix D) was used to collect additional sociocultural and professional background information about the participants.

Interviews are considered the most important data collection method used in ethnography (Fetterman, 2010). Hence, in this study, individual semi-structured interviews constituted the primary data source. In-depth semi-structured interviews used open-ended questions from the researcher-developed interview guide (Appendix E) and were adapted as data collection progressed to elicit values and assumptions held by members as they related to students' PD. Table 8 provides a sample of the interview questions used in the study. At the end of each interview, participants were asked if they

had any other information, they wanted to share that was not covered in the interview. The PI conducted most of the interviews, while the remaining interviews with some students were conducted by a research assistant who had been prepared in advance and had signed a confidentiality agreement (Appendix F).

During the data collection period, all fourth-year students were in clinical placement in hospitals in Kigali, and most of the students stayed in the school hostels. A quiet office was provided to the PI at the school and students were interviewed in the evening hours after they had completed their day in the practice setting. Third-year students were interviewed by the research assistant at their clinical placement sites outside of Kigali. A room was provided for the research assistant at the practice site where the students were located, and they were interviewed at the end of their shift.

Table 8

Sample Interview Questions

Category of Participants	Sample Questions
Students	1. What is it like to be a student in the medical/surgical ward/unit of the practice setting (name)? 2. How do nurses in the ward/unit guide students in acquiring knowledge, skills, clinical competencies, values, and attitudes required of a nurse? 3. What do you see as facilitating/hindering your PD during your practice placement?
Staff nurses	1. Please share with me your experiences of having students from the school [name] in your ward/unit. 2. What takes place in your unit to support students achieving their clinical learning goals and acquiring the necessary knowledge, clinical competencies, and values required of a nurse? 3. What do you see as hindering you in creating an environment supportive student PD during clinical placement?
CIs	1. Please share with me about your experiences of being a CI in the medical/surgical ward/unit of the clinical setting [name]. 2. What do you see as facilitative for you in creating an environment supportive of student PD during clinical placement? 3. What do you see as hindering you in creating an environment supportive of student PD during clinical placement?

Nurse leaders	1. Please share with me how practice placements for students are organized at the school level and at the medical/surgical ward/unit level.
	2. What procedures, policies, or guidelines are available in the ward/unit to assist nurses and clinical teachers in supporting students' acquisition of the knowledge, clinical competencies, values, and attitudes required of a nurse?
	3. What facilities, resources, materials, and supplies are available in the ward/unit/academic to support students' learning and PD when in the clinical placement?

All CIs chose to be interviewed at school. Each one arranged to get a room of their choice. Most staff nurses chose to be interviewed in their wards. A few staff nurses chose to be interviewed during their weekend shifts, while other nurses were interviewed during the afternoon hours of their shifts. This was challenging since some of the sites such as site A and B did not have appropriate quiet rooms convenient for interviews. Whenever interruptions occurred, the audiotape was put on hold and fieldnotes were written to keep track of ideas. Two staff nurses went for their annual leave after they had committed to participating in the study; thus, their interviews took place in an office that was provided by the PI's colleague after working hours, away from the clinical settings and the school.

All interviews were audio-recorded after participants received the Letter of Information (Appendix G) and signed the Consent to Participate and Consent to Record forms (Appendix H). One interview was conducted with each participant and it lasted from 30 minutes to one hour and 30 minutes. Interviews were conducted in English and in Kinyarwanda depending on the choice of the participants. All interviews were transcribed verbatim and interviews conducted in Kinyarwanda were then translated to English by the PI. This allowed the PI to closely study the data and achieve extensive

data immersion, one of the critical features of ethnographic studies (Roper & Shapira, 2000). In order to retain the original meaning of what participants expressed, both Kinyarwanda and English versions of the translations were kept and checked during data coding. Whenever there were doubts about the translation, a colleague fluent in both languages and familiar with qualitative research methods, but not involved in this research as a participant, was asked to validate the translation before data analysis proceeded.

In focused ethnography, observation may be limited or even not used. The argument is that a study using focused ethnography concentrates on specific issues that might be experienced by people who do not belong to the same culture, but the researcher is interested in their shared experiences (Cruz & Higginbottom, 2013; Richards & Morse, 2013). Similarly, participants in this study belonged to different cultural contexts (academic and practice settings) and only met in the PLEs for teaching and learning purposes. Therefore, observation was limited and focused on interactional moments between students, CIs, and staff nurses such as during post-conference sessions and observable behaviours that could indicate the practices that influence students' PD. Additionally, artifacts of the ACP setting were observed, such as the physical facilities that accommodate students, space for students and their belongings, and items that impact the learning and PD of students (e.g., learning objectives). A checklist for artifacts, observable artifacts, and behavioural patterns was developed using the literature (Chan, 2001) and was adapted using ideas that emerged during interviews and from the PI's own experience and knowledge (Appendix C).

Regular field notes were written immediately after interviews and observations. Field note writing requires the ethnographer to document in detail information, situations,

and events occurring during fieldwork, which allows the researcher to perceive observations with accuracy and to bring new perspectives to what was observed (Emerson, Fretz, & Shaw, 2011). The field notes were transcribed, coded, and analysed along with data collected from interviews, observations, and document review. Table 9 gives an example of a recorded field notes.

Document review provides additional information on the background and the cultural context within which behaviours occur and can offer further insight into questions to ask during interviews or behaviours and artifacts to observe (Bowen, 2009). In this study, relevant documents such as academic regulations and clinical education guidelines, student clinical placement policies and guidelines, organization vision and mission statements, nurse job descriptions, and performance appraisal policies and procedures were analysed to identify documented beliefs and assumptions about clinical teaching within ACP environment. Interview transcripts, along with data from documents and observation field notes, were de-identified and entered into *NVivo 11* computer-assisted data management software to facilitate data management, storage, and coding (Welsh, 2002).

A data analysis framework for ethnographic studies proposed by Roper and Shapira (2000) guided the analysis process. The framework includes four analytical steps: (1) coding fieldnotes and interviews, (2) sorting to identify patterns, (3) generalizing constructs and theories, and (4) memoing to note personal reflections and insights. In addition, information from documents and texts were extracted using a content analysis strategy. This consisted of analysing documents to discover meaningful and relevant texts and sentences related to the research question and the frequency they have within a document (Bowen, 2009; Fetterman, 2010). Fetterman (2010) further

elaborates that the more patterns and sentences are expressed in the document, the more important these are in the culture of the organization. Similarly, the absence or limited frequency of sentences in the document signify the lesser importance they have within that culture (Fetterman, 2010).

Table 9

Fieldnotes of Observational Activity

Date of observation: 28.03.2017   Place of observation: **Site C, staff room**

Activity observed: **Pre-conference**   Duration of observation: Start and end time: 9h-10h10

People involved: 6 Students, 1 clinical instructor, the PI

Characteristics of the setting (size, space, noise, equipment)	Interactional processes, actions (who says what, what is being said, how, in which order, how many people are involved, verbal and non-verbal interactions)	Any key or unexpected event	Observer impressions and reflections
Site C surgical ward The staff room is crowded, with 5 other medical students in the room. Some are on a desk computer, while others are using their laptops. Nurses come and go from the room.	I made an appointment with the clinical instructor to attend a pre-conference session with their students. I wait at the nurses' station from 8:00am to 8:30am. Nurses come and go as they check documents, get materials, wash their hands, etc. No student is seen in the office. They are all in the ward attending to patients. As I sit there, I read many notes on the board, and only the learning objectives from one school appear to indicate they have students. One of the nurses engages me in conversation about the students. I explain the purpose of my presence. She spontaneously shares that it is rare to have the CI that early with students, then she invites me to join them in the ward for patient care. I explain that I am there to attend the pre-conference with students and their CI. The CI had been with students on the ward helping them complete patient assessments. They briefly explain to me how things were going to be done and invite me to join the students in the other office. We	While I am waiting at the nurses' station, I make significant observations that are not planned: the absence of student learning objectives in the unit and the unplanned conversation with the nurse who seems happy to have the CI.	This seems to be an important learning activity for students. It appears to be a safe moment to learn with their CI. Communication between the CI and the nurses is observed as lacking. One student approaches his assigned nurse to inform her that he will be absent while in discussion with the CI. My thoughts are the CI should have informed the nurses; this needs to be explored during the individual interview with the CI. Did the observation prompt the CI to be early that day? This needs further exploration. The involvement of nurses in pre-conference sessions seems important, but it appears difficult

| | join the students in the staff room (there is a computer, another group of medical students seated in a corner next to us chatting, nurses coming and going and working on the computer). The noise and activity are manageable and do not seem to interrupt us.
Six third-year students from different campuses who are allocated to the surgical ward are in the room. The CI introduces me and asks me to briefly explain my presence. Once done, I distribute the letter of information and students are asked if they mind me being there. Then, I provide them with the informed consent forms to sign.
The CI invites one student to present a case he has been working on and the others listen attentively. Then the students ask him questions and he answers them correctly. The CI from time to time intervenes to correct or compliment the student presenter. Students seem interested by the learning experience. One student brings up a difference in what the nurses are told in practice and what they were taught in class regarding fluid intake being categorized in the cardio-vascular assessment versus in the medication history. The CI uses the opportunity to explain the correct approach and builds common understanding.

At the end of the session, the CI takes the time to give the students information on history taking and assessment and invites the students to return to their patients to start implementing their care plans. | | to implement given the nature of work for nurses in the ward at the time. |

Adopted from: Emerson, Fretz, & Shaw (2011)

Given Fetterman's (2010) perspective, it was anticipated that ACP environments in this study that consider students' PD in their goals would also have official documents such as policies and mission and vision statements that reflect that goal. However, as Bowen (2009) cautions, for most organizations, documents tend to align with organization-specific missions and principles. Therefore, in reviewing these documents, attention was paid to the fact that patterns in documents reflecting students' PD may not echo the enactment of these beliefs and assumptions in practice. Similarly, the absence of patterns related to students in documents may not necessary mean that the organization is not committed to students' PD. Hence, data from the documents reviewed were analysed along with interviews and observation data to increase their validity, to determine their consistency, and to compare the information collected from different sources.

The unit of analysis in this study consisted of the category of participants, namely staff nurses, CIs, students, and nurse leaders. After collecting at least an interview per category of participants, coding started by intensive, repeated line-by-line reading of the transcribed interviews and fieldnotes, gathered documents, and noted observations to identify words and sentences that described the realities of participants in relation to values, assumptions, practices, and behaviours supporting or hindering students' PD within ACP environments. Initially, this was done by grouping together meaningful ideas from statements within each category of participants separately and assigning them to a node. Next, nodes from each category of participants that seemed related were compared, grouped together, and assigned descriptive codes. Through this process, new codes emerged, others were merged, while others were split into separate nodes. This process yielded a codebook of descriptive codes.

As data collection and analysis progressed, the identified codes were further explored to uncover the realities that might explain the shared and non-shared values, assumptions, as well as practices and behaviours across and within the categories of participants. Such a process enabled explaining the similarities and differences occurring among people from different groups of participants and within categories, which guided the formulation of preliminary patterns that were explored as data collection progressed (Roper & Shapira, 2000). This process was done by moving back and forth among the first phase of assigning descriptive codes to identify the emerging patterns that needed to be deepened in the subsequent interviews.

As new patterns emerged, they were used to shape the subsequent interviews. For example, the code "umwana" only emerged within the first interview with the staff nurse category. This prompted a follow-up question in subsequent interviews with staff nurses and CIs to further deepen the meaning behind this assumption, until the "novice raising" pattern emerged. This process continued and patterns that had been identified were further compared with data and combined based on their resemblance, co-occurrence, and sequences (LeCompte & Schensul, 2013). This was done by reading the patterns several times and comparing them with data from observation fieldnotes, documents, and written memos.

Retained patterns were further analysed and grouped through a process of mixing and matching (LeCompte & Schensul, 2013; Roper & Shapira, 2000) to identify similarities and differences in patterns and note the relationships between them. At this phase, Roper and Shapira (2000) advise to find linkage between two perspectives—the participants' worldview or the emic understanding and the etic interpretation of the researcher—and construct a theoretical understanding of the data. Interrelated patterns

were grouped, which resulted in six conceptual themes. These themes were explored against existing evidence on nursing students' PD within PLEs to interpret the meaning embedded in the findings (LeCompte & Schensul, 2013; Roper & Shapira, 2000).

Memoing was done throughout the analysis process to note personal reflections and insights as they emerged (Roper & Shapira, 2000). Memos help to make connections and identify commonalities and discrepancies or differences between pieces of information and provide the basis for deep understandings of the data (Atkinson et al., 2001; Roper & Shapira, 2000). During this study, the PI kept memos throughout the entire process of data collection and analysis. The PI kept track of reflections that came to mind as she engaged in data analysis, such as new questions emerging, and new insights generated by the analysis.

The final six conceptual themes were grouped based on the research questions that this study sought to answer to: (1) what are the values, assumptions, practices and behaviours supporting nursing students' PD, and (2) what are the assumptions, practices, and behaviours hindering their PD. These formed the theoretical understanding (Roper & Shapira, 2000) of the shared and non-shared values, assumptions, as well as practices and behavioural patterns that support or hinder students' PD within ACP environments in Rwanda from the perspectives of key stakeholders involved in students' practice-based education.

Data collection continued until it reached the time when similar answers were being heard and no new information was being received from participants in each category, and no new patterns were emerging in the new data across the categories of participants. At this point, code saturation (Hennink, Kaiser, & Marconi, 2017) was deemed to have been achieved and data collection ended. However, data analysis

continued until the data presented a richer illumination of the varying perspectives held

by participants on the values, assumptions, practices, and behavioural patterns that

support or hinder students' PD within the ACP environments in Rwanda.

Measures for Establishing Rigour

Measures for establishing rigour in naturalistic constructivist inquiries were used

to ensure trustworthiness of the findings. These criteria have been defined by Lincoln

and Guba and include credibility, transferability, dependability, and confirmability

(Patton, 2002). Credibility consists of ensuring that the findings are congruent with

reality, and that they fit with respondents' answers (Korstjens & Moser, 2018; Tobin &

Begley, 2004). One of the methods to ensure credibility is through data source and

methods triangulation, which involves using data from different sources and various

people and using a variety of data collection methods to develop a comprehensive

understanding of the phenomena under study (LeCompte & Schensul, 2013).

To achieve credibility, multiple data sources, mainly interviews, observations, and

document review, were used, and data was collected from different participants including

students, CIs, staff nurses, and nurse leaders from both the academic and practice

settings. The complementarity of these methods and the multiple perspectives from the

key participants who held insightful experiences about nursing students' practice-based

learning provided a comprehensive picture of the shared and non-shared values and

assumptions within ACP environments and how these practices and behaviours likely

facilitate or hinder students' PD. Although member-checking (Patton, 2002) was not

done by taking back the emerging patterns to participants in the study, I consistently

ensured that the findings represented participants' worldview by frequently rephrasing

their responses during the interviews and checking with them if I captured what they expressed.

Transferability consists of demonstrating that the findings and conclusions from the study can have applicability in other contexts and situations (Korstjens & Moser, 2018). This can be achieved through thick description, which consists of keeping field notes and reporting findings in ways that contain advanced description of events, details about verbal and non-verbal behaviours, conversations, observed activities and the researcher's interpretation of these events in a more detailed account (Fetterman, 2010; LeCompte & Schensul, 2013). In this study, transferability was established by maintaining field notes with detailed description of the research process, how participants were recruited, the methods used, the context within which data collection occurred, and the contextual factors that might have influenced the findings, to enable other researchers to gain an understanding of the context surrounding the study.

Dependability demonstrates that the findings are consistent and that the study could be repeated (Tobin & Begley, 2004). Dependability can be achieved through an audit trail, which provides details on the process of the study, the methods used, and how analysis has been performed, to enable future researchers to repeat the work (Tobin & Begley, 2004). To achieve dependability, an audit trail of the conduct of the study, the rationale for the choice of design and method, and the analysis process was maintained using *NVivo 11* codebooks to show how codes, patterns, themes, and sub-themes emerged from data, and how these were consistent with the research design and the theoretical lens guiding the study. In addition, emerging codes and patterns were regularly reviewed by the dissertation supervisor to enhance the dependability of the findings and the recommendations that emerged from the study.

Confirmability consists of ensuring that the findings reflect the respondents'

perspectives and are derived from data instead of being driven by the researcher's

preconceived assumptions and biases (Tobin & Begley, 2004). In ethnography,

reflexivity, a self-aware and reflective approach, is recommended to delineate these

boundaries, thus enhancing the truthfulness and the confirmability of the findings (Cruz

& Higginbottom, 2013; Roper & Shapira, 2000). A declaration of self was done before

entering the field to delineate potential assumptions that the PI's familiarity with the

culture being studied could affect the conduct and her experience of the study.

Throughout the study, the PI consistently reflected on her own responses and

preconceptions on the topic and kept questioning its potential interference on her

interactions with participants and the interpretation of the findings, and measures were

taken to maintain a trustful relationship with research participants and an unbiased

perspective on the findings. The following section provides a reflexive statement of

moments that were identified and how they were managed to maintain the rigour of the

findings from this study.

Reflexivity

In terms of focused ethnography, Cruz and Higginbottom (2013) refer to

reflexivity as an important approach to explicitly delineate and make transparent the

influence that the researcher's preconceptions, the research methodology, and the data

collection instruments have on the research findings. Reflecting back on the research

process, I noticed that my previous relationships with participants influenced our

interactions in different ways.

My familiarity with the nurse leaders of the PLEs helped me navigate the

unexpected and complicated procedures of "getting in" the practice settings. They

supported me in obtaining necessary approvals and in the recruitment of potential

participants. Previous discussions we shared prior to this study related to nursing

education likely encouraged them to support the study and helped to build the positive

connections needed to carry out this study. On the other hand, the nurse leaders from

ACP settings were more likely to refer to me as one of the "academic members" and

tended to see me in my former roles. Participants often referred to me "as part of the

school" and these were documented and reflected on in my memos. Whenever this

occurred, I reminded them of my current role as the study PI, someone trying to

understand their perspectives and not merely acting as a member of the academic

setting. I had to keep reminding them that the purpose of the research was to uncover

values and assumptions that might be shared or non-shared; hence, the focus was more

on the current practices.

Contrary to my previously held assumptions, in general the other participants

openly and freely shared their experiences with me. Although I informed them a research

assistant had been hired and trained to interview participants in case they were

uncomfortable being interviewed by me, none of the participants chose that option. All

of the students who participated in the study were previously unknown to me but came to

know me as the study PI; therefore, I found that they were open in their interactions.

Except for four nurses with whom I had previous relationships either as colleagues or

former students, all of the staff nurse participants came to know me as the PI, and all the

CIs who participated had previous relationships with me, but this did not seem to

interfere with the interviews. However, it is my assumption that my insider status in the

academic program affected the recruitment process. Some of the potential participants I

purposively believed to hold valuable insights into the topic did not return my invitation

to participate two consecutive times. I believe our previous relationship might have played a role in their decisions.

Ethical Considerations

Ethical approvals were sought and obtained from the Office of Human Research Ethics of Western University, the University of Rwanda Institutional Review Board, and the Institutional Review Boards that oversee each clinical site (A, B, and C) (Appendix B). Only individuals who voluntarily agreed to participate by signing the informed consent were interviewed and only those who provided consent to do so were observed. Participant privacy and confidentiality were observed by holding interviews in quiet and confidential places chosen by participants, and pseudonyms were used to protect participant identity. Participants were given the choice to pick their own pseudonyms, though in some cases they left this up to the researcher. The pseudonyms were then used throughout data collection and reporting.

Transcriptions of the recorded interviews were first de-identified and stored in a secure, locked location and on a password-protected laptop used by the PI. Sharing of transcripts was done between the PI and the dissertation committee through encrypted email communication after all the data had been de-identified. The research assistant signed a confidentiality agreement (Appendix F) and agreed to keep the information collected confidential. Only events that did not involve patients or other non-participating members were included in the observations. Documents collected were kept confidential and locked within a secure office.

Lessons Learned in Conducting Focused Ethnography

Focused ethnography is gaining popularity in health professional education research (Rashid, Hodgson, & Luig, 2019), and is an especially important alternative

methodology to explore specific topics within particular sub-cultural contexts in nursing education and practice (Cruz & Higginbottom, 2013; Wall, 2015). In this study, focused ethnography proved to be a well-suited methodology for providing rich and insightful understanding about the shared or not-shared values and assumptions held by different academic and PLEs stakeholders and how these shape the units' practices and unit members' behaviours towards nursing students' PD. Thus, focused ethnography richly revealed these cultural perspectives at both the micro (individual level) and the meso (organizational level) (Rashid et al., 2019).

The multiple settings and study population required to respond to the research questions explored in this study, and perspectives from participants who belonged to different cultural settings but shared the unifying cultural experience of being involved in nursing students' PD, presented an unconventional setting (Wall, 2015) that could not be studied using conventional ethnography. Nursing students are taught within both the cultural environments of academic and practice settings. Future researchers attempting to uncover how belief constructions from these multiple individuals involved in such a developmental process could benefit from using focused ethnography as a research method.

Although focused ethnography has been often characterised as "a quick and dirty" method (Knoblauch, 2005, p. 6), it requires an extensive amount of work before, during, and after the field work. For example, the complementarity of three data collection methods and four different data sources used in this study produced rich and intensive data, but this was also associated with intensive work, particularly after the field work. Hence, as recommended by Wall (2015), researchers contemplating using focused ethnography should move away from considering focused ethnography for its pragmatic

nature and its brevity, but rather consider its rich, yet labour-intensive potential to address research questions and contexts that could not be answered using other forms of ethnography.

In conducting this focused ethnographic study, I learned the importance of the investigator's background knowledge of the setting under study. My familiarity with the settings assisted in strengthening my relationships with key stakeholders, one of the requisites in understanding people's realities, why they do what they do, and the meanings they assign to what they do (Rashid et al., 2019; Roper & Shapira, 2000). The informal and formal meetings I held with key stakeholders before the start of the study enlightened the PI and facilitated the conduct of the study. At the same time, conducting this study improved my reflexive practice as a novice qualitative researcher. It taught me to continually ask myself *who* I am in relation to my participants, *what* I bring to the research process, and *how* these considerations may influence what I hear and observe in relation to the research aim and my interpretations. This self-reflection went beyond the research process itself—it challenged my worldview as a nurse educator.

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Chapter 4: Values, Assumptions, Practices, and Behaviours Supporting
the Professional Development of Nursing Students within
Acute Care Practice Environments in Rwanda

Preparing nursing students to enter the profession with relevant knowledge, skills, attitudes, and judgement depends in part on the quality of the practice-based education provided to them (Gaberson & Oermann, 2010). It is often within the practice-based learning environment (PLE) that the values, norms, and attitudes of the nursing profession are passed on to nursing students by nurses and clinical instructors (CI) as the "correct ways" to perceive, think, and feel in relation to the issues they face as developing soon-to-be professional nurses (Koontz, Mallory, Burns, & Chapman, 2010; Papathanasiou, Tsaras, & Sarafis, 2014; Young et al., 2014).

The process through which nursing students acquire knowledge, skills, judgement, values, and attitudes relevant to the nursing profession has been referred to as professional development (PD) (Benner, 2004; Dall'Alba & Sandberg, 2006). The PD of students during a nursing educational program is integrated via the experiential learning that they gain in practice-based learning environment (PLE) as they develop an embodied understanding of the profession through 'real-world', hands-on experience in practice settings (Benner, 2004; Dall'Alba & Sandberg, 2006; Day, Field, Campbell, & Reutter, 2005).

The findings reported in this dissertation are part of a focused ethnographic study undertaken to explore the values, assumptions, practices, and behavioural patterns in the acute care practice (ACP) environments in Rwanda and how these influence nursing students' PD. The findings reported in this study address the research question: What are the shared and non-shared values, assumptions, practices, and behaviours that support nursing students' PD in the ACP environments in Rwanda? These findings may be used

to generate further discussion and may assist in the positive transformation of PLEs for nursing students in Rwanda, which ultimately can contribute to improving the quality of patient care.

Background

In nursing, students develop significant professional attributes based on the behaviours of the people they most often observe and interact with during their learning experience, mainly nurse educators, staff nurses, other health professionals, fellow students, and patients and their families (Felstead & Springett, 2016). By observing others performing a desired behaviour, nursing students assimilate new ways of performing behaviours which are later translated into actions that can produce new behavioural patterns (Bahn, 2001; Bandura, 1971).

During the process of learning to care for others, nursing students express a desire of being cared for, feeling supported, and receiving guidance to cope with the mental and physical experience of learning in often-complex PLE settings (Meyer, Nel, & Downing, 2016). Caring interactions with significant individuals within the PLE influence students' internalization of caring values and behaviours towards patients, themselves, and others—key attributes for developing as professionals (Labrague, Mcenroe-Petitte, Papathanasiou, Edet, & Arulappan, 2015; Meyer et al., 2016).

The organizational culture of the PLE holds the potential to influence how teaching and learning are fostered in that environment, as well as how key members of the environment collaborate and engage in how nursing students develop as professionals (Henderson, Briggs, Schoonbeek, & Paterson, 2011; Saarikoski, Warne, Kaila, & Leino-kilpi, 2009). Practice based learning environments that have embedded welcoming and supportive values in their practice respect students as persons and learners, integrate them

as members of the team, are more likely to allow students to develop a variety of professional skills (Henderson et al., 2011). Students in such environments gain a sense of safety and increase their curiosity, commitment, and motivation to seek new learning situations, which supports their professional growth (Dale, Leland, & Dale, 2013; Hägg-Martinell, Hult, Henriksson, & Kiessling, 2014).

Clinical units in acute care hospitals represent the sub-cultural level of the overall PLE, and this sub-cultural level is one of the key organizational levels where values and assumptions are created, transmitted from the broader organizational level, and enacted (Schein, 2010). It is mainly within these clinical units that patient care is delivered and teaching and learning activities for PD are provided (Disch, 2006; Tomietto, Comparcini, Saarikoski, Simonetti, & Cicolini, 2014). The level of empowerment at this unit level affects both the unit and the individual's commitment to professional nursing practice and PD (Spence Laschinger, Nosko, Wilk, & Finegan, 2014).

Understanding how these practice settings have embedded beliefs and values into their interactions and student practices holds the potential to illuminate factors that shape the provision of a learning environment conducive to students' acquisition of required knowledge, skills, values, and attitudes to develop as professionals. While there exists a wealth of evidence on facilitators and barriers for a PLE supportive of nursing students' PD, much of this evidence is predominantly from western clinical learning contexts, which may not necessarily reflect the cultural reality of PLEs within a resource-limited context such as Rwanda.

Nursing Education in Rwanda

Rwanda is a landlocked country situated in east-central Africa, with a population of approximately 11, 274, 221 and an area of 26, 338 square kilometers (National

Institute of Statistics Rwanda, 2015). Nurses constitute the majority of healthcare

professionals in the country (Binagwaho et al., 2013). In Rwanda, nursing education is

university-based. Two programs that lead to nursing registration are offered: the

Advanced Nursing Diploma, a three-year post-secondary program, and the Bachelor of

Nursing, a four-year post-secondary program.   Nursing education is organized into

classroom blocks of theory learning alternating with practice-based learning. For the

Bachelor of Nursing program, practice-based learning starts from the second semester of

the first year until the fourth year and takes place in different healthcare setting contexts

including district, national referral, and teaching hospitals, as well as community health

settings. During practice-based learning in the PLEs and in the simulation laboratories,

students are supported by CIs who are university-based educators. In the practice

settings, staff nurses are required to undertake students' teaching, supervision, and

evaluation as part of their responsibilities (Republic of Rwanda, 2012).

It is, therefore, relevant to understand how values, assumptions, practices, and

behaviours within PLEs and educational setting influence the creation of an ACP

environment conducive to prepare nursing students for professional practice.

Investigating these elements from the perspectives of the key people involved in the

teaching and learning process, namely students, staff nurses, CIs, and nurse leaders from

both the academic and practice settings, would provide a comprehensive understanding of

what supports nursing students' PD within the ACP environments in Rwanda.

Methodology and Methods

This study was guided by a constructivist theoretical lens. According to Patton

(2002), constructivism explores the perceptions, beliefs, worldviews, truth, and

explanations constructed by people, and the consequences these constructions have on

their behaviours as well as the people they interact with. We argue that the interactions

and behaviours of stakeholders involved in practice-based education are often grounded

in values and assumptions embedded in official documents, such as vision statements,

policies, and guidelines, as well as in implicit, unwritten rules based on experiences, and

on personal and sociocultural backgrounds of the significant individuals within the ACP

environments. The interactions clinical teachers and staff nurses have with students can

be associated with how these values and assumptions give meaning to the roles of

teaching and learning, and how they are interpreted and enacted into practice by

stakeholders. These values and assumptions may be shared or not shared by the key

stakeholders involved in students' PD, and can both facilitate and hinder students' PD.

Focused ethnography was chosen as a naturalistic research design (Higginbottom,

Pillay, & Boadu, 2013) to explore the values, assumptions, practices, and behaviours

within ACP environments as co-constructed by the key people involved in nursing

students' PD. The focused ethnography approach allows for the exploration of the

"*what*" and the "*how and why*" (what do people know and believe, how and why do they

do what they do) (Roper & Shapira, 2000). Focused ethnography preserves essential

principles of conventional ethnography, such as understanding cultural meanings held by

a specific group in the context of their culture and conducting the study within a

naturalistic setting in which the experience happens (Higginbottom et al., 2013; Richards

& Morse, 2013).

In contrast to conventional ethnography which focuses on entire social groups,

communities, social institutions, or social events, the focused ethnographic approach is

framed within a discrete, specific context and setting such as the PLE, in a given culture

or sub-culture, to explore selected and explicit actions, interactions, and social situations

(Cruz & Higginbottom, 2013; Knoblauch, 2005; Richards & Morse, 2013). Focused ethnography offers a suitable approach to explore the realities that people from different cultural contexts (e.g., staff nurses and nurse leaders from PLEs and CIs from an academic setting) hold regarding their shared experience of being involved in developing nursing students for professional roles (Cruz & Higginbottom, 2013; Roper & Shapira, 2000). Focused ethnographies save time as they do not require extended time and continual field work like conventional ethnography; however, the short duration is compensated for by the extensive amount of data collected (Cruz & Higginbottom, 2013; Knoblauch, 2005).

As the aim of this study was to explore the values, assumptions, practices, and behaviours within ACP environments regarding nursing students' PD, focused ethnography was the appropriate approach to elicit these different culturally bound perspectives from various cultural groups. The focused ethnographic approach provided insights on how cultural values and assumptions influenced unit practices and individual behaviours that facilitate or hinder the creation of ACP environments supportive of students' PD.

Settings and Participants

The primary settings of this study included two acute care units (medical and surgical) from three hospital settings in Rwanda (referred to as sites A, B, and C), and one associated academic setting where students were enrolled in a nursing program. All three clinical settings are mandated to provide education for the purpose of developing qualified health professionals (Ministry of Health Rwanda, 2017). The settings were purposively chosen because they serve as the primary PLEs used by the majority of nursing students in Rwanda in their practice-based education. The academic setting in

this study is a public learning institution that provides post-secondary education in a variety of health professional programs, including nursing.

Purposive and snowball sampling strategies (Richards & Morse, 2013) were used to select participants, activities, and documents. These sampling strategies were in line with focused ethnography's recommendation that since the approach focuses on specific questions, participants should have specific knowledge of the subject under study (Higginbottom et al., 2013). Nursing students were required to be in their senior levels of the nursing education program as students in their third and fourth levels are approaching the completion of their program and have been exposed to multiple practice settings, enabling them to draw on their practice experiences and to have a basis from which to share how ACP environments contributed to their PD. Students were also required to have recently completed or to be engaged in a professional practice course in the medical or surgical units of one of the three practice settings participating in the study.

Clinical instructors were included if they had at least one year of work experience in the academic setting during which they had been involved in facilitating learning in the practice environment. Staff nurses were included if they had at least an advanced diploma in nursing, and if they had been working in ACP settings for at least one year during which they had been assigned to support students during practice-based learning. The category nurse leaders included either the directors of nursing at the nursing division level or the unit managers in the practice settings, and the head of the department or the program leader in the academic program. Nurse leaders were included if they had at least one year of leadership experience at the nursing division/unit level in the practice setting or at the school/department level in the academic setting.

Data Collection

Three data collection methods were employed: individual in-depth interviews, participant observations, and document review. These were consistent with focused ethnography's recommendation of using multiple data collection methods to capture rich and essential patterns of values and assumptions prevalent in an organization (Higginbottom et al., 2013). In this study, individual semi-structured interviews constituted the primary data source, complemented by participant observation and document review. An interview guide developed by the primary investigator (PI) was used to elicit values, assumptions, practices, and behaviours held by participants as they related to students' PD. An example of an open-ended question asked is: what takes place in the unit to support students' acquisition of knowledge, skills, clinical competencies, values, and attitudes required of a nurse? Follow-up probe questions included: how are students welcomed and oriented to the unit; how are students involved in activities that take place in the unit; and how do nurses and other healthcare professionals behave and interact with students?

One interview was conducted with each participant and lasted from 30 minutes to 90 minutes. All interviews were audio-recorded after permission was granted by participants. Interviews were conducted in English and in Kinyarwanda depending on participant choice. All interviews were transcribed verbatim by the PI and interviews conducted in Kinyarwanda were translated to English by the same PI.

In a focused ethnographic study, observation may be limited or not even used (Cruz & Higginbottom, 2013; Richards & Morse, 2013). Therefore, in this study, observation was limited and focused to interactional moments between students and the CIs and staff nurses for the purpose of PD. A checklist for artifacts and behavioural

patterns was developed using the literature (Chan, 2001) and was adapted from ideas that emerged during the interviews. Some examples of artifacts observed are student names included on the shift board with nurse names for patient allocation and private space made available for students and their CIs/nurse for reflection and discussions. Regular and detailed observation field notes were written and updated as data collection progressed and were coded and analysed along with data from interviews and documents. Documents relevant to practice-based education such as academic regulations, clinical education guidelines; student clinical placement policies and guidelines, organization vision and mission statements, nurse job descriptions, and performance appraisal policies and procedures were selected through purposive sampling after they were identified through interviews with participants. Table 10 illustrates the type of data collected at each site and the methods used.

Table 10

Type of Data Collected Per Site

Data Collection Method	Site A	Site B	Site C	Academic
Individual in-depth interview (N=38)	-4 staff nurses -2 nurse leaders	-3 staff nurses -2 nurse leaders	-4 staff nurses -3 nurse leaders	-12 students - 7 CIs -1 nurse leader
Observations (*n=6*)	- Morning staff meeting - Observation of artifacts	- Observation of artifacts	- Orientation on the first day of clinical placement - Pre-conference session - Observation of artifacts	-No observation
Document review (*n=11*)	- Mission & vision statements (doc 1, A) - Nurse job description (doc 2, A)	- Mission & vision statements (doc 1, B) - Clinical placement guidelines (doc 2, B) - Nursing division statement (doc 3,)	- Mission & vision statements (doc 1, C) - Clinical placement policy (doc 2, C) - Performance appraisal form (doc 3, C) -Student registration form (doc 4, C)	- Clinical training guidelines (doc 1, academic) - Academic regulations (doc 2 academic)

Ethical Considerations

Approvals to conduct this study were obtained from the Office of Human

Research Ethics of Western University, the Institutional Review Board of the University

of Rwanda, and the Institutional Review Boards of clinical sites A, B, and C. Participant

privacy and confidentiality were observed by holding interviews in confidential places,

and pseudonyms chosen by participants were used to protect their identities. Only

participants who voluntarily agreed to participate and to be audio-recorded were

interviewed and observed. Transcriptions of recorded interviews were first de-identified

and then stored in a password protected laptop used by the PI. De-identified transcripts

were shared between the PI and the dissertation committee through encrypted email

communication.

Data Analysis

Audio-recorded interviews were transcribed verbatim by the PI. Transcription

was conducted by carefully listening to the audio-recordings several times, then reading

the transcribed interviews while listening to the audio-recordings to check for

completeness and to allow the PI to achieve extensive immersion with the data, which is

one of the critical features of ethnographic studies (Roper & Shapira, 2000). All

transcribed interviews, along with data from documents and observation field notes, were

entered into *NVivo 11* computer-assisted data management software (Welsh, 2002). A

data analysis framework for ethnographic studies, as proposed by Roper and Shapira

(2000), was used to guide this study. It includes four analytical steps: (1) coding for

descriptive labels, (2) sorting to identify patterns, (3) generalizing constructs and theories,

and (5) memoing to note personal reflections and insights. This approach has also been

found to be an appropriate analytical framework for studies using focused ethnography design (Higginbottom et al., 2013).

The unit of analysis consisted of the categories of participants—staff nurses, CIs, students, and nurse leaders—as well as documents and observation fieldnotes. After collecting at least one interview per category of participant, analysis started to identify words and sentences that described the meaning participants assigned to their experiences; these were then assigned to a code. During the process of assigning codes, the PI looked into statements that described the *what* was done and the *how* and *why* it was done (Roper & Shapira, 2000) within ACP environments regarding nursing students' PD. Initially, assigning codes was done by grouping together meaningful statements within each category of participants separately. Next, codes from each category that seemed related were compared and grouped together. As data collection and analysis progressed, the identified codes were further explored to uncover ideas that might explain the shared and non-shared values, assumptions, practices, and behaviours supportive of students' PD across and within the participant categories.

Several codes that seemed repeated and occurred regularly were grouped into smaller and more abstract concepts referred to as patterns (Roper & Shapira, 2000). As patterns emerged, they were further compared with data and combined based on how similar or different they were to one another, and how often they occurred within data (LeCompte & Schensul, 2013). Retained patterns were further analyzed and grouped through a process of mixing and matching (LeCompte & Schensul, 2013; Roper & Shapira, 2000) to identify similarities and differences in patterns and to note the relationships between them. Table 11 gives an example of how codes, patterns, and themes were generated.

Table 11

Example of Generation of Codes, Patterns, and Themes

Themes	Patterns	Codes	Statements
Profession gatekeeping	Profession advancing	Educating future nursing generation	*"They (students) are our future nurses"* (Nurse leader). *"They (students) are our future replacement"* (Staff nurse). *"I teach them (students) as the nurses for tomorrow"* (CI). *"They (nurses) should teach us, because in their near future, we will be their colleagues"* (Student). *"Clinical trainers and supervisors from the school and mentors from clinical practice sites have an obligation to provide regular clinical training and supervision for students, to promote learning, and to safeguard the public from incompetent health workers"* (Documents).

At the phase in the analysis when patterns become stable, Roper and Shapira (2000) advise to find linkage between the "emic" understanding, or the worldview expressed by participants, and the "etic" understanding, or the researcher's interpretation of the findings, to construct a more abstract and higher level understanding of the phenomena under study. For instance, staff nurses and CIs' experience (emic understanding) of considering students "children" was interpreted as mentoring and caring for the novice students (etic understanding), which was supported by the literature on mentoring nursing students from a caring perspective (Hodgson & Scanlan, 2013).

Interrelated stable sets of patterns were aggregated together into more significant broader patterns of meaning, resulting in three themes. Throughout the analysis process, memos were taken to note personal reflections and insights as they emerged (Roper & Shapira, 2000). For example, the code "students considered as children" only emerged

during the first interviews with the staff nurses category. A memo was written to explore

this emerging code in the subsequent interviews with nurses and CIs to further

understand the meaning behind this assumption, resulting in the emergence of the

"novice raising" pattern.

Rigour

Measures for establishing rigour in naturalistic constructivist inquiries, namely

credibility, transferability, dependability, and confirmability, were used to ensure the

trustworthiness of this study's findings (Patton, 2002). These measures of rigour have

been found to be consistent with the focused ethnographic approach (Higginbottom et al.,

2013). Credibility ensures that the findings represent plausible information and are an

accurate reflection of participants' perspectives (Korstjens & Moser, 2018; Maher,

Hadfield, Hutchings, & de Eyto, 2018). Credibility was ensured by means of

triangulating (LeCompte & Schensul, 2013) multiple data sources (individual interviews,

participant observation, and document review), and data were collected from different

categories of participants from both the academic and practice settings. The

complementarity of these methods and the multiple perspectives from key participants

who held insightful experiences about nursing students' practice-based learning provided

a wider representation of culturally bound values, assumptions, practices, and behaviours,

and how these influence students' PD.

Transferability, which demonstrates that findings and conclusions from the study

can have applicability in other contexts and situations (Korstjens & Moser, 2018; Maher

et al., 2018), was established through thick description (Fetterman, 2010). Field notes

with detailed descriptions of the research process, how participants were recruited, the

methods used, the context within which data collection occurred, and the contextual

factors that might have influenced the findings were recorded to enable other researchers to gain an understanding of the context surrounding this study.

Dependability demonstrates that the findings are consistent and that the study could be repeated (Maher et al., 2018). To ensure dependability, an audit trail (Tobin & Begley, 2004) of the conduct of the study, the rationale for the choice of design and method, and the analysis process was created to show how codes, patterns, and themes emerged from data, and how these were consistent with the research design and the theoretical lens guiding the study. In addition, emerging codes and generated patterns were reviewed by the dissertation supervisor to enhance the dependability and consistency of the findings.

Confirmability consists of ensuring that the findings reflect the respondents' perspectives and are derived from the data instead of being driven by the researcher's preconceived assumptions and biases (Tobin & Begley, 2004). In ethnography, reflexivity, a self-aware and reflective approach, is recommended to delineate these boundaries, thus enhancing the truthfulness and the confirmability of the findings (Cruz & Higginbottom, 2013; Roper & Shapira, 2000). Throughout the study, the PI consistently reflected on her own responses and preconceptions on the subject and kept questioning her potential influences on interactions with participants and interpretation of the findings. In addition, extensive quotes from participants were provided when reporting findings to demonstrate that the findings are grounded in participants' responses rather than the PI's own preconceptions (Tobin & Begley, 2004).

Findings

This focused ethnographic study involved four categories of participants (N=38): nursing students (n=12), CIs (n=7), staff nurses (n=11), and nurse leaders (n=8). The

nurse leaders category included four directors of nursing divisions, three unit managers, and one academic leader. Table 12 details the demographic characteristics of participants. Furthermore, participant observation (n=6) and document review (n=11) provided additional information regarding beliefs, values, assumptions, and observed practices and behavioural patterns within the ACP environments in relation to nursing students' PD.

Events observed included a morning staff meeting at site A, a welcoming and orientation session for students on the first day of their clinical placement at site C, and a pre-conference session with the CI and students at site C, and observation of unit artifacts (in sites A, B, C). Documents reviewed included site A' mission and vision statements and nurse job descriptions; site B's clinical placement guidelines, mission and vision statements, and nursing division goal statement; site C's student clinical placement policies, student registration forms, performance appraisal forms, and mission and vision statement; and the academic setting's academic regulations and clinical training guidelines.

Values, Assumptions, Practices, and Behaviours Supporting the
Professional Development of Nursing Students

The present study revealed that nursing students' PD within ACP environments in Rwanda is supported by interrelated sets of values, assumptions, practices, and behaviours, adopted and enacted within practice settings and the participating academic program. Generally, the majority of the values and assumptions were shared across and within categories of participants. In comparison with other categories of participants, staff nurses and CIs shared most of the values and assumptions.

Table 12

Demographic Characteristics of Participants

Participants	Age	Gender		Level of Study/Qualification					Years of Professional Experience	Site			
(N=38)	(Mean/Range)	F	M	3rd	4th	A1	A0	Grad	(Mean/Range)	A	B	C	Acad.
Students (n=12)	25.3 (r:23-28)	6	6	3	9	-	-	-	-	-	-	-	12
Staff nurses (n= 11)	34 (r:27-38)	7	4	-	-	5	5	1	8 (r:2-17)	4	3	4	-
CIs (n=7)	32 (r: 27-40)	2	5	-	-	-	4	3	6.3 (r:1.5-17)	-	-	-	7
Nurse leaders (n=8)	47 (r: 43-56)	8	0	-	-	-	3	5	15.6 (r:13-22)	2	2	3	1

Notes. A1: Advanced Diploma; A0: Bachelor's degree; Grad: Master's & PhD degree; Acad.: Academic setting

The analysis of these shared and non-shared values, assumptions, practices, and behaviours revealed 16 codes: *novice raising, role modeling, guiding, respecting, advocating, securing professional practice, educating future nursing generation, knowledge sharing, continuous learning, developing structures, providing support, welcoming, involving, supporting learning, showing willingness,* and *building positive relationship.* These codes were aggregated into seven patterns: *mentoring, caring, profession advancing, life-long learning, institutional engagement, unit engagement,* and *individual engagement.* These patterns in turn revealed three interrelated themes: *nurturing, professional gatekeeping,* and *engagement.* Table 13 summarizes the aggregation of codes, patterns, and themes, and the extent to which the identified patterns of values and assumptions were shared or not shared across categories of participants from interviews, observation, and document review.

Theme 1. Nurturing

Pattern 1.1. Mentoring. Non-student participants, namely staff nurses, CIs, and unit managers, shared the values and assumptions that students were novice learners coming to the PLE to gain additional clinical skills and, hence, they needed to be nurtured. In describing their mentoring roles, staff nurses and CIs commonly used expressions such as *"being like parents to students."* Marvin, a male nurse in site B, shared: *"If you're teaching students you need to teach them, but at the same time you are like a parent to them. You show them the way. Indeed, they are students, but they are also young. They need to be parented."* The same view was echoed by Sibo, a male CI from the academic program. He said, *"… being a teacher is like being a parent…. A parent will always believe in his children."*

In their mentoring roles, staff nurses and CIs considered students "juniors" in the profession who needed to be nurtured to grow professionally. Novice raising was a common pattern that translated into how they enacted their roles into practice. They consistently referred to students using words like "abana," a Kinyarwanda name used to designate "children" and to express their mentoring assumptions towards their "young." When prompted further to explore the meaning behind the use of the word "children" to refer to students, Xavier, a male nurse at site A, explained: *"They are children because they have not yet reached professional maturity. They have not yet obtained their nursing degree…We need to work hand-in-hand with their schools to raise them."*

Table 13

Summary of Themes, Subthemes, Patterns of Shared and Non-shared Values, Assumptions, Practices, and Behaviours

Themes	Patterns	Codes	Nurse leaders				Staff nurses			CIs	Students		Documents				Observation			
			A	B	C	Acad.	A	B	C	Acad.	3rd	4th	A	B	C	Acad.	A	B	C	Acad.
Nurturing	Mentoring	Novice raising	Y	Y	N	N	Y	Y	Y	Y	N	N	N	N	N	N	NA	NA	NA	NA
		Role modeling	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
	Caring	Guiding	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Respecting	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	NA	Y	NA
		Advocating	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y	NA	NA	NA
Professional gatekeeping	Profession advancing	Securing professional practice	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
		Educating future nursing generation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
	Life-long learning	Knowledge sharing	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	Y	Y
		Continuous learning	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
Engagement	Institutional	Developing structures	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
		Providing support	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA
	Unit	Welcoming	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	NA	Y	NA
		Involving	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA
		Supporting learning	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA
	Individual	Showing willingness	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA
		Building positive relationships	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	NA	NA	NA	NA

Notes. Y: Shared; N: Not shared; NA: Not Applicable (no observation was done)

Assumptions of students as juniors in need of being nurtured was, however, not shared by the academic program and appeared in contradiction with the academic program's values. Contrary to the parenting and novice raising assumption held predominantly by nurses and CIs, the nursing school, through its clinical training guidelines, recommended that CIs view students as "mature" (doc 1, academic).

The assumptions that students were novices in need of being mentored and nurtured shaped staff nurse participants' behaviours towards not only students, but also towards novice staff nurses, as Liza, a female nurse at site B, explained:

> We consider anyone less familiar to our unit as a "child." Be it a student or a new nurse. It helps us to acknowledge that we have something to offer them, as if we are helping a little child learning a new skill.

Although they considered students "children," staff nurses and CIs paid attention to their students' individual needs in terms of confidence, proficiency level, and familiarity with units. Unlike a graduating student, their interactions were different when interacting with a first-year student, or a student at the beginning of a clinical rotation, from closely guiding them as they acquire clinical competencies to allowing them some degree of autonomy. Laura, a female nurse at site A, described how she enacts this in practice:

> I don't treat a first-year "child" the same as a third-year student, or "a child" on her first day of rotation similar to when they have been here for a week. During their first days, I really guide them in everything, but when they have been here many times or are in their third year, I know they have gained some confidence. They are nearly completing, and I let them do things independently. I even involve them in helping their juniors.

Students' fear of making mistakes and anxiety related to being in an unfamiliar environment motivated Kamala, a male CI, to value what can come from offering nurturing support to his students: *"At the beginning, they are afraid of everything, even*

touching a table.... They even need to be taught how to learn. We need to encourage

them, to be there for them, until they feel free to be on their own."

Providing feedback to students, appraising what they did, correcting their

mistakes, and offering them opportunities to reflect on their work were practices

appreciated by students as they helped them develop their reflective practices, learn from

their mistakes, improve their critical thinking, and develop as professionals. Marianne, a

fourth-year nursing student, expressed:

> The nurse assigned to me would let me observe her first, and then she
> would let me do the procedure. Afterward, she would show me what I did
> not do correctly and teach me how I should do it the next time. Her
> feedback allowed me to learn from my own mistakes and to correct them.

All categories of participants across settings shared the value that in order to

create an environment conducive to PD, nursing students needed positive role models to

learn from and to have opportunities to observe appropriate professional values,

behaviours and attitudes. Role modeling was reinforced as a shared value by the

academic program through its clinical training guidelines that highlight role modeling as

a key responsibility of the CIs and the nurses (doc 1, academic). Similarly, nurse leaders

across settings had made role modeling a priority, as illustrated by Bella, a nurse leader at

site C:

> We speak about role modeling for the students, the best practices we
> share, and how you present yourself as a professional person such that
> students can learn from you. We reinforce the good behaviour we want
> from nurses and we ask them to help the students and the staff be aware
> that students are there. They must be taught the right attitude, the right
> values.

Students shared that they encountered some nurses who discouraged them;

however, the positive role models helped them acquire professional values, behaviours,

attitudes, and confidence required for them to become nurses. Clara, a fourth-year

nursing student, said, *"They [nurses] encouraged me to be a better nurse."*

Consequently, the positive role models who valued nursing as a profession and conveyed

their passion to students contributed to the students' decision to remain in the nursing

profession as illustrated by Bonette, a fourth-year nursing student:

> One of the nurses made a difference in my education and it's one of the
> reasons I am still here... She was always with patients, she greeted them
> with a smile…She advocated for her patients... That one made me think of
> nursing differently.

Pattern 1.2. Caring. Respecting students as learners, guiding them, advocating

for them, and accepting their mistakes were identified by staff nurses and nurse leaders as

necessary values for a caring environment for students. All non-student participants

expressed that respecting students as learners should be associated with accepting that

making mistakes is part of learning and should be considered as a learning opportunity.

Fifi, a nurse leader at site B, explained, *"Let them be free, they are learning, they have a*

right to make mistakes. Let them make mistakes and correct them."

Assumptions that students should be respected as learners and their mistakes

considered learning opportunities were, however, not experienced by all students in

practice. On the one hand, some students, especially those who were on rotation at sites

B and C, expressed that these values were reflected in their units' practices and supported

their PD because they were respected as learners who had learning goals to achieve.

Consequently, their patients' assignments were adjusted to allow them time for reflection

and time to respect and enact the standard procedures as taught in the classroom. Clara

recounted her experience:

> In [site B], the [unit managers] kept telling nurses that these are students,
> they are not nurses, they are here to learn, not to work. They shouldn't be
> given 10 patients. They should be given few patients to allow them to
> perform complete assessment.

On the other hand, some students who were on rotation at site A did not often experience these values in practice. They often felt considered as an extra pair of hands to cover the shortage of nurses, not as learners, resulting in being given tasks unrelated to their learning needs, as described by Bonette, a fourth-year student: *"Some nurses at [site A] consider students as their 'main d'oeuvre.' They sit down and give you instructions, do this, do that... Everyone wants to use you for their purpose, and no one is interested in your learning goals."*

Recognizing students' limits and encouraging them to overcome their fears were identified by students as caring values that helped them to feel safe and confident in their development as professionals. Students expressed how nurses who assigned them procedures commensurate to their skills level contributed to their sense of confidence and improved their practice, as experienced by Martin, a fourth-year student:

> In the surgical ward [site B], we had a patient who had staples, nurse [name] asked me if I knew how to remove them, and I said no. They explained to me all the steps, then they accompanied and guided me as I removed them. Afterward, they showed me what I did not do well. I think staple removal is one of the procedures I feel more confident with because of that nurse.

Theme 2. Professional Gatekeeping

Pattern 2.1. Advancing the profession. There was widespread agreement from all categories of participants that both the practice and academic settings share a responsibility and obligation to prepare students for their future roles as nurses who will advance the profession, through equipping students with professional qualities and attributes required for the next generation of nurses. Nurses and CIs expressed their responsibilities towards developing students into competent professional nurses of the future by sharing statements such as *"The students today are the nurses tomorrow"*

(Benita, site C); "*We are getting old, they are our future replacement*" (Louise, site B); "*These are the future nurses of our country*" (Xavier, site A); and "*Just within a short time, the student today will be a colleague*" (Kamala, CI).

Staff nurses in particular considered students' PD as a professional responsibility to contribute to shaping the next generation of nurses who will benefit the Rwandan population with their focus on patient safety. Liza, a surgical nurse at site B, highlighted: "*These students, wherever they will work, they will be caring for Rwandans... It is our duty to make sure that when they are here, they get adequate training. And by the time they start working, they will be fully qualified.*" Similarly, nurse leaders in all units held assumptions that students are the potential future professional workforce; hence, teaching them was an investment strategy expected to deliver a return through employment and improvement of the future of the nursing profession and practice. Units across settings ensured that they facilitated students' learning by supporting their competence for practice, which is a key requirement they assess during the recruitment and hiring process. This was emphasised by Olga, a nurse leader at site C:

> I always tell my colleagues that these students are the nurses who will be recruited by [site C] tomorrow. If they come here, why should you go back to teach them when they were here as students and you didn't teach them? I tell them let us teach them …because we recruit them, these are our colleagues. Today they are students, but tomorrow they will be staff. We will be working with them. If you work with staff who cannot perform care well, it is a burden to our patients and to the unit. We don't need to go back to teach them when we had the chance to teach them when they were students here.

These values were supported by the clinical training guidelines of the academic program, which specify that "safeguarding of the public from incompetent nurses is a priority obligation of CIs and staff nurses" (doc 1, academic).

Pattern 2.2. Life-long learning. Commitment to life-long learning emerged as an identified value that supported students' PD within ACP environments. In units where continuous learning had been made a regular practice, staff nurses and nurse leaders believed that everyone is a learner; hence, they considered the presence of students as another learning experience and opportunity for knowledge-sharing. In such settings, commitment to learning was not only ascribed to students, but also to healthcare professionals. These units set aside time dedicated to staff in-service PD education, and students were encouraged to attend such learning opportunities.

Commitment to life-long learning was a shared value between clinical settings and the academic setting. For example, site A aims at continuously training health professionals striving for excellence (doc 1, site A), site B aims to provide an environment of learning where there is room for PD and growth for all nurses (doc 3, site B), identifying training needs for oneself and others and taking part in in-service education opportunities for PD is a required indicator for nurse performance at site C (doc 3, site C), and the academic program outlines regular continuous PD to staff as a responsibility of both the academic program as well as the practice settings (doc 1, academic).

Learning within units that support and include continuous learning as part of their values offered students opportunities for deepening their knowledge and improving their critical thinking skills. Bonette, a fourth-year student, outlined the positive nurses' behaviours that stem from the value of life-long learning:

> Nurses in [site C] keep learning. They read a lot. Like, in A & E ward, there is a table that displays all of the clinical protocols. When nurses and students are done with patient care, we go and check them for references. The nurses keep learning….and they consider having us in their ward as an opportunity to keep learning. We learn a lot from them too.

The presence of students in the ACP environment was perceived by staff nurses across the three settings as an opportunity for knowledge-sharing and learning from one another.   Nurses appreciated the contribution of students and CIs in terms of theoretical, updated knowledge, as they believed they learned and improved their practice, all while supporting students' professional growth. Liza, a nurse at site B, emphasised: *"Recently, students from [school name] noticed that our practice for collecting lab samples was inappropriate. They gave us recommendations for improvement, and we changed it…This also benefits new students observing us, as they observe the correct practice."*

Theme 3. Engagement

Pattern 3.1. Institutional engagement. This entails the engagement of clinical settings and of the nursing educational program by providing structures, policies, and resources to support PD. The clinical settings' mission and vision, structures, organization of work, policies, and guidelines related to teaching and learning were identified as institutional values that may support students' PD.

The vision and mission statements of site A include *"training of health professionals"* and *"contributing to the development of human resources"* as core values of the setting (doc 1, site A). Consistently, the job description of staff nurses at site A states that part of their responsibilities is to *"mentor nurse students in the clinical practice"* (doc 2, site A). Sarah, a surgical nurse at site A, relayed how such values have shaped staff nurses' assumptions and practices towards students:

> Knowing that our institution is called a teaching hospital became part of our everyday practice values. As a nurse working here, you know it is part of your responsibility to mentor students. We are reminded of it every time and we know that our institution carries that name. We feel it is in our role to help our institution achieve its goals.

In its commitment to facilitate student learning, site B created clinical placement guidelines that outlined expectations for students during practice-based learning. Emphasis on *"having a professional appearance, getting involved in ward activities, and collaborating with the primary nurse assigned to students"* were among the highlighted expectations (doc 2, site B). Site B also established a training and research office to facilitate the coordination of students' practice learning. Specifically, site B appointed two staff nurses who serve as nurse educators to oversee the teaching and learning of students within the different units and to coordinate clinical learning conferences for students. Students who did rotations in this setting identified this practice as supporting their PD by offering them opportunities to learn from other students, as Fortunate, a fourth-year student alluded to: *"Mentors in (site B) plan different learning sessions whereby all students who are in that hospital meet in one room and discuss a case. This helps us a lot because we get to learn from one another."*

Clinical setting C's vision and mission statements include *"clinical education"* and *"clinical training"* as part of its values (doc 1, site C). These values have been embedded into practice through the establishment of an office dedicated to education, the creation of a policy on clinical education, and the protection of education times for health professionals. In line with the site's mission, the performance contract document of staff nurses at site C includes teaching students as part of staff nurses' responsibilities (doc 3, site C). Hence, in their performance appraisals, staff nurses at site C are assessed on how they contribute to the learning of others, including students and colleagues.

Policy on clinical teaching and learning was another structure identified as influencing the creation of a PLE likely to support students' PD, although only site C had a formal written policy. Site C's policy aimed to allow units and educational institutions

to effectively plan mentoring, monitoring, and follow-up of students on clinical placement. The policy emphasises the need for collaboration between practice settings and educational institutions by providing students opportunities that respond to their learning needs (doc 2, site C). Both sites A and B had unwritten expectations and implicitly established norms of supporting students that have been validated by unit members. Participants at site A used expressions such as *"because we are a teaching hospital, it is assumed that each nurse has a teaching responsibility"* (Yasmine, nurse leader, site A) and *"it is not written anywhere, but we have been doing this all along"* (Suzy, unit manager, site A) to express the 'unwritten' norms that guide their units in supporting students' PD. Overall, students found the written and implied policies helped them adapt to different settings and clarify expectations. This in turn helped students to experience conducive environments for their professional growth, as explained by Bonette, a fourth-year student: *"At [site C) they have policies and procedures for everything they do, and that makes it easier for a student to adapt and learn."*

In the academic program, clinical education guidelines (doc 1, academic) provide guidance about expected roles and responsibilities of CIs and staff nurses towards students, and vice versa. The academic nursing education program also facilitates CIs supporting students' PD by providing access to educational resources and opportunities to update knowledge. For example, three out of seven CI participants in this study were enrolled in graduate studies, an opportunity that was believed to equip them with further knowledge and skill needed to fulfill their role in supporting students' PD, as expressed by Belartine, a CI: *"The fact that I am doing a graduate degree in [name of program] has improved my clinical skills. Now I can say that I feel confident to support students in their practice-based learning."*

Pattern 3.2. Unit engagement. Nurse leaders involved in this study considered mentoring students as every nurse's responsibility as highlighted by Olga, a nurse leader at site C: *"...it is their [nurses'] responsibility, yes, it is their responsibility. When you are an RN, it's your responsibility to mentor students despite the heavy workload you have."* These leaders' values were shared with staff nurses and enacted into practice by offering a conducive learning environment to students. This included welcoming students, involving them in ward activities, and structuring ward activities to ensure that students receive the guidance and support necessary to help them acquire the required competencies to function as professional nurses. For example, at site A, students are added to the task allocation board along with nurses (observation of artifacts site A), while at site B, the students' schedule appears on the notice board next to the nurses' schedule (observation of artifacts site B).

All categories of participants across settings agreed that a welcoming unit, where staff members appreciate the presence of students and are attentive to their needs, was an important factor for the successful learning experience of students. Generally, the first day of clinical placement across settings was dedicated to student orientation. The orientation helped students become familiar with the unit and its people. Students considered this welcoming practice important as it allayed their anxiety associated with being in an unfamiliar environment and facilitated comfort and confidence to learn. Emmanuel, a fourth-year student, stated:

> On the first day in [site A], I was frightened. But the unit manager and the nurses gave us orientation to the unit... then we were assigned to a nurse. This was very helpful because I already felt reassured and ready to start learning.

Once students were oriented, being involved in different activities on the wards such as patient care, rounds with nurses and physicians, educational sessions, and writing patient progress notes were identified by students as helping them achieve the integration necessary to prepare them for professional practice. This increased students' comfort to ask questions and to take initiative and contributed to their PD by enhancing their self-confidence and autonomy. For students nearing the completion of their nursing program, getting involved in unit activities prepared them to work independently as professional nurses upon graduation, as illustrated by Clara, a fourth-year student: *"In the surgical ward [site B], nurses involved us in every activity….and throughout, they were available to guide and answer our questions. At the end of a day like this, I felt I was ready to work on my own."*

The enactment of the practice of involving students in unit activities was also observed at site A and highlighted in the fieldnote below. This practice was particularly appreciated by students, as by listening to others reflecting on cases, they were better able to link practice to their theoretical knowledge and their own practice experience, reinforcing their critical thinking skills.

> It is Friday morning in surgical ward at site A. The night shift team is giving a report to the day shift team. Fifteen students from different schools are in attendance. A discussion is occurring about patient treatment plans, new cases admitted and their needs, and the nurses' concerns about cases. During the discussion, staff nurses often point to a case as *"an interesting case for students,"* encouraging students to follow up on the case with their assigned staff nurses. During another discussion about a post-op patient with a persistent fever, students are asked to reflect on the possible reasons. Students ask questions as the discussion continues, and nurses take turns answering them. At the end of the meeting, the unit manager gives assignments to students.

Pattern 3.3. Individual engagement. Individual commitment towards nursing students' developing into professional nurses emerged as an important attribute that supported the enactment of institutional and unit values into practice. This involved students' commitment towards their own PD, staff nurses' willingness to support students, and CIs' willingness to collaborate with nurses. Staff nurses, students, and CIs shared that while learning should be a collaborative effort, developing as professional nurses also required students' own commitment and willingness to seek support. Emmanuel, a fourth-year student, highlighted this: *"If you have clear goals and make them known to nurses, demonstrate seriousness in your attitude, and take initiative, nurses become eager to support you."*

Staff nurses who embraced student teaching drew from their own experience when they were students, informing their commitment to developing other professionals by sharing their clinical experiences and protecting students from experiencing the negative experiences they had as students. Narratives such as *"The skills I have gained since I became a qualified nurse I must share with these students"* (Xavier, site A), *"I am a student too, and that's not how I would want to be taught"* (Ganza, site C), and *"All of us went through the same process of becoming nurses"* (Blessings, site C) were used by participants to express what shaped their commitment.

For some of the staff nurses who participated in the study, their interactions with students were driven by their desire to transmit their nursing passion and values to others. Narratives such as *"I ensure that I instill in them the passion for the nursing profession while they are still in their junior years* (Benita, site C), *"I make sure that these students love the profession"* (Luck, site B), and *"I use the opportunity with students to make them love the nursing profession and to encourage their choice of nursing* (Xavier, site

A) were commonly used by staff nurses to express their commitment to developing students into competent professionals.

Discussion

The findings reported in this dissertation explored the shared and non-shared values, assumptions, practices, and behaviours supporting nursing students' PD in Rwanda's ACP environments. Three core themes emerged from the findings: *nurturing, professional gatekeeping,* and *engagement,* encapsulating the constructed sets of values and assumptions that interact to support nursing students' PD within ACP environments in Rwanda. This discussion section is divided into subsections stemming from the three themes: *nursing students' PD is facilitated by a nurturing and caring environment*, *nursing students' PD is a shared professional responsibility*, and *nursing students' PD requires shared institutional, unit, and individual engagement*. These themes will be discussed by linking them to previous research related to nursing students' PD within the PLE.

Nursing Students' Professional Development Is Facilitated by
a Nurturing and Caring Environment

Narratives expressed by participants in this study revealed a commitment of nurses and CIs to mentor junior students by providing them with a nurturing and caring environment for their PD. Modeling the appropriate behaviours to students, raising them as novices, guiding them as they learn, correcting their mistakes, respecting them as learners, and advocating for them dominated the narratives of the nurses, CIs, and nurse leaders. These were also consistent with the values reflected in institutional documents such as clinical training guidelines, vision and mission statements, and clinical training policies.

In line with previous studies, findings from this study suggest that mentoring, an empowering practice based on a supportive interpersonal relationship between an experienced nurse (a mentor) and a novice (a mentee) (Hodgson & Scanlan, 2013), is a valuable tool in creating a supportive learning environment for students' development of professional values (Ali & Panther, 2008; Jokelainen, Turunen, Tossavainen, Jamookeeah, & Coco, 2011). When a mentoring relationship is guided by the mentor's commitment to care, support, role model, guide, coach, and counsel the mentee, it respects the student's developmental needs as a human being in the learning process with potentialities to grow and reach their full potential (Jokelainen et al., 2011; Wagner & Seymour, 2007). From that perspective, participants in this study embraced nurturing values and assumptions, and enacted them through caring, supporting, directing, respecting, and advocating practices towards nursing students, similar critical mentoring attributes (Ali & Panther, 2008; Hodgson & Scanlan, 2013) and empowering behaviours (Wiens, Babenko-Mould, & Iwasiw, 2014) required to foster students' PD.

Student participants in this study shared that caring and nurturing values demonstrated by nurses and CIs during their learning interactions enabled them to feel involved, increased their freedom and confidence to ask questions and take initiative, and ultimately facilitated their professional growth as nurses. Consequently, these caring behaviours from nurses contributed to students deciding on the nursing profession as their career. This finding supports previous research (Dyess, Boykin, & Rigg, 2010; Labrague et al., 2015; Meyer et al., 2016; Wagner & Seymour, 2007), which uncovered that caring attitudes of nurses and CIs increased students' caring, confidence, and compassion for their patients.

Considering the traditional emphasis given to psychosocial and cognitive skills, and the limited emphasis on caring values in the nursing education curricula (Brown et al., 2011), findings from this study underscore the need for creating and sustaining a nurturing and caring PLE within which students acquire necessary competencies and values as professionals.   Interactions that students have with significant individuals within the PLE, such as nurses and CIs, constitute the caring occasions that facilitate the internalization of caring attitudes towards patients, students themselves, and others (Labrague et al., 2015; Meyer et al., 2016). In the present study, such a transformation was facilitated by nurses and CIs modeling caring behaviours towards patients and students.

One culturally-bound expression of caring for and mentoring students that emerged from this study was expressed through the consideration of students as "children" who needed to be nurtured, while nurses and CIs considered themselves as "parental figures" for these students who supported their professional growth. These culturally-bound narratives could be rooted in Rwandan education discourses and are less about nurses and CIs being condensing and paternalistic towards students and more about them supporting students as they develop professionally. Rwandan cultural norms and values naturally expect adults to be concerned with the wellbeing of the younger generation, while education is an expected responsibility of every adult (Adekunle, 2007). Similarly, most African societies, Rwanda included, adopt the *Ubuntu* philosophy of life, which places a great importance on the individual in relation to community through a societal obligation towards others, a form of interdependence, and a desire to care for others and be considerate of and sensible to the needs of others (Venter, 2004). From the perspective that culture is socially learned (Schein, 2010), it is appropriate to

assert that nurses and CIs in the present study have been socialized into Rwandan cultural and societal expectations, and their interactions with students likely become shaped not only by their institutional beliefs and their nursing professional values, but also by their previously internalized cultural values.

Approached from an empowering perspective, nurturing narratives in this study may be reflective of staff nurses' and CIs' caring and mentoring values and responsibilities aimed at coaching both novice nursing students and novice professional nurses for their professional roles, instead of being perceived as an unacceptable paternalistic approach to educate nurses. Accordingly, nurturing values from a mentoring perspective neither contradict the principles of adult learning (Knowles, Holton, & Swanson, 2012) nor maintain students in a subordinate and dependant position (McKenna & Wellard, 2009) that may ultimately hinder their PD. Rather, as argued by Lopez (2002), parental approaches may guide nursing students from a normal state of dependence on the teacher to a state of independence once students have reached maturity and gained confidence. At this stage, students would have gained a sense of self-efficacy, a perceived ability and confidence that they can successfully perform an action (Townsend & Scanlan, 2011; Zhang et al., 2015; Zimmerman, Bandura, & Martinez-Pons, 1992). The need for caring and mentoring support is supported by Benner's (2004) viewpoint that students at the novice developmental stage have no experiential background to refer to when managing clinical situations; thus, they require clear rules, directions, and coaching from attentive clinical teachers who play a significant role in guiding them as they explore new situations and move through to more of an advanced developmental stage.

While constructions that connect the roles of staff nurses and clinical teachers in preparing nursing students for their professional roles with those of parents may at first seem unique to the Rwandan context, they are in fact not new to clinical nursing education. In a qualitative study, Australian nurse clinical teachers and preceptors used "maternal discourses" (p.278) to describe their roles as nurturing, protecting, supporting, guiding, and providing discipline to their students (McKenna & Wellard, 2009). Similarly, in a transcultural qualitative study with Jordanian undergraduate nursing students, students described their clinical teachers as "caring mothers" (p. 59) who demonstrated various mothering behaviours such as guiding, supporting, informing, reinforcing, and releasing students as they become more independent (Lopez, 2003). In a South African context (van Rensburg, 2019), nurse educators included a "mother figure" role (p. 45) in describing their roles with students in the PLE, while the nurturing role of the educator was expressed in a metaphorical expression by Chinese students who compared the nurse-educator relationship to the "parent and children" (p. 51) relationship (Chan, Chien, & Henderson, 2018).

All of these protective roles are closely linked to the roles identified in the present study, including novice raising, role modeling, and guiding, respecting, and advocating for students and supporting their learning. These roles can also be equated with protective roles identified in a Canadian sample of nurses and preceptors who felt responsible to protect students in their units by "taking them under wings" (p. 306) to support their professional socialization (Hegenbarth, Rawe, Murray, Arnaert, & Chambers-Evans, 2015). Although the present study did not uncover students' experience of "being parented," existing research on students' perspectives by Lopez

(2003) supports that the parent-child type of relationships students formed with their clinical teachers facilitated their preparation to become professional nurses.

Therefore, it is proposed that the nurturing values embraced by participants in this study were grounded in a mentoring and caring standpoint and were adapted to the PD needs of individual students, their proficiency and confidence levels, and their ability to learn independently. These roles may likely facilitate internalization of caring values in students' attitudes and contribute to a sense of security and encouragement in students, which is foundational as they learn to be independent professionals. Particularly, the complex, unpredictable, and unfamiliar nature of the PLE may accentuate students' desire for dependence on a nurturing, protective figure for security and for coping with uncertainty and helplessness (Lopez, 2003). Thus, offering nurturing and caring support geared at mentoring and coaching these nursing students as they navigate the uncertainties associated with learning how to nurse within PLEs may lay the foundation for progressive transformation into adult learners, and later into mature, independent, and caring professionals (Bankert & Kozel, 2005; Wagner & Seymour, 2007). In this way, nursing education would embrace a caring pedagogy (Bankert & Kozel, 2005; Brown et al., 2011) and would take an "ontological turn" (Hartrick Doane & Brown, 2011, p. 22), where the subject of education becomes the student as a person and a nurse, and the focus is on the student's personal and professional transformation to become a skillful, knowledgeable, independent, caring, and competent professional (Hartrick Doane & Brown, 2011).

Nursing Students' Professional Development Is a Shared Professional Responsibility

Nurses in this study embraced a culture of preparing nursing students for their professional roles as a professional responsibility, and a means of securing the nursing

profession. These assumptions were shared across settings and were supported by institutional documents, suggesting a shared commitment to the professional practice of preparing the future nursing workforce. Rwandan nursing professional standards, like many other international organizations for nurses, have embedded expectations that registered nurses have a professional responsibility to contribute to the PD of nursing students (International Council of Nurses [ICN], 2012; Republic of Rwanda, 2012).

The finding that nurses considered students' PD a professional responsibility is consistent with previous studies (Anderson, Moxham, & Broadbent, 2018; Hegenbarth et al., 2015). Nurses in a Canadian PLE adopted a culture of providing quality learning opportunities to students and integrating them as members of the nursing team, because, by so doing, they were fulfilling their professional responsibility of educating future nurses and upholding the nursing profession (Hegenbarth et al., 2015). Similarly, Australian nurses shared a sense of responsibility for supporting the next generation of nurses to become competent professionals. For these nurses, mentoring and supporting students during their practice learning was "the right thing to do" (Anderson et al., 2018, p. 232).

Although participants in this study demonstrated an awareness of the professional responsibility to teach students, some of them also reported not being adequately prepared to assume this teaching expectation (finding reported in chapter five). This finding requires further exploration to assess nurses' preparedness to fulfil this teaching requirement. In a qualitative study that explored Australian nurses' readiness for the teaching role, nurse participants reported being unaware that teaching was such an important role in their nursing professional experience, and many lacked confidence in their ability to teach others (McKenna, Irvine, & Williams, 2018).

Assumptions such as "everyone is a learner" held by participants in this study suggest that when units embrace student mentorship as an opportunity for knowledge sharing, it contributes to the continuous learning and professional growth of both students and staff nurses. Within that learning culture, learning becomes a collaborative undertaking where nurses and CIs share clinical competencies accumulated over their practice experience with students to foster their PD, all the while improving their knowledge and learning from the students. In so doing, PLEs sustain a learning culture which recognizes the reciprocal learning between nurses and students. The validating and trusting attitude students bring to the clinical setting has been identified as a practice that contributes to the development of a sense of professionalism in students (Newton, Henderson, Jolly, & Greaves, 2015). In that sense, when students feel valued as persons, learners, and team members, they feel empowered and gain a sense of control and self-efficacy in their professional growth (Bradbury-Jones, Sambrook, & Irvine, 2010).

Nursing Students' Professional Development Requires Shared

Institutional, Unit, and Individual Engagement

Findings from this study identified that creating a supportive PLE for students' PD required a shared commitment between institutions (academic and practice settings), unit leaders, and individuals. Practice-based learning environments and academic institutional values, structural support, unit leadership's commitment to learning, and individuals' assumptions and commitment towards students' PD were interconnected in shaping how units either facilitated or hindered nursing students and their PD. This finding substantiates those made in previous studies.

According to Henderson et al. (2011), three important factors interact to create and maintain a positive learning environment: leadership, management, and partnership.

Leadership involves the development of structures and processes that support learning; management includes the establishment of management strategies that promote and facilitate learning; and partnership suggests a positive working relationship and collaboration between the academic institutions and the health service organizations (Henderson et al., 2011).

This study found that the commitment of unit leaders was an important factor in determining the level of commitment nurse leaders had for the creation of a learning culture that values nursing students and fosters their professional growth. According to Saarikoski (2002), ward managers set the ward atmosphere, which creates the setting for a positive ward culture for nursing care provision and a positive learning culture in the ward. Within some units in this study, a unit culture of learning was established and practices of welcoming, supporting, and involving students were embraced by unit members. Students who were on rotation in such units were afforded opportunities for critical thinking and were valued as learners, which increased their sense of responsibility.

This finding confirms previous findings about the role of unit leadership and the ward managers' leadership styles in creating a PLE supportive of students' PD and in determining the ward atmosphere towards learning (Hegenbarth et al., 2015; Schein, 2010; Walker, Cooke, Henderson, & Creedy, 2011). Hence, findings from this study suggest that creating and sustaining a PLE environment likely to support nursing students' PD requires a collaborative effort involving institutional, unit, and individual commitment. As such, the multifaceted nature of the ACP environment must be considered when designing strategies to improve ACP environments for nursing students' PD.

Implications and Recommendations

This is the first known study within the African nursing education context to have explored the shared and non-shared values, assumptions, practices, and behaviours supporting nursing students' PD in ACP environments, and to have included perspectives from key stakeholders situated in various practice settings and an academic context. The findings contribute empirical evidence and also provide a valuable contribution to policy, nursing education, and practice.

Implications for Policy

Findings from this study highlight the need for formal institutional policies pertaining to practice-based learning within PLEs. Out of the three PLEs participating in this study, only one had a formal policy, while others referred to unwritten guidelines regarding supporting students in practice-based learning. At the academic program, existing academic regulation did not provide much guidance concerning practice-based learning. Policies at the institutional and unit level should be developed and amended based on the perspectives in this study, and shared within practice organizations, academic programs, and individual units to guide stakeholders towards achieving their shared goal of developing nursing students into professionals. Such policies should clarify the best practices expected for a PLE supportive of students' PD, and the structures and processes to support its creation. Some of the policies suggested in the literature to incorporate include preparing registered nurses for their teaching roles and planning manageable workloads to give nurses the time to mentor students (Henderson et al., 2011).

Implications for Nursing Education and Practice

A shared value across categories of participants in this study was the value that students' PD is every nurse's responsibility and a professional standard to develop the profession. This shared commitment for the advancement of the nursing profession constitutes an important unifying value that can contribute to sustaining a culture of learning for PD for both nurses and students. Consequently, practice and academic settings should collaborate to reinforce and sustain this shared goal. While all registered nurses in Rwanda are required to undertake student teaching and mentoring as part of their responsibilities (Republic of Rwanda, 2012), some nurses in this study felt inadequately prepared for this role, and whether all Rwandan nurses have the necessary skills required to undertake this role remains unclear. The nursing education program should collaborate with practice settings to develop educational programs or online modules for nurses and CIs to increase their teaching proficiency. Content such as adult learning principles, communication strategies, conflict management, clinical judgement, clinical reasoning, and clinical thinking have been suggested in the literature as important content to include in such programs (Nash & Flowers, 2017).

Formal recognition mechanisms for rewarding nurses committed to mentoring others should be put in place by practice settings in collaboration with educational institutions, so as to encourage those committed to supporting students. Different ways of rewarding nurses who mentor others are suggested in the literature and can be adopted in Rwanda. These include certificates of recognition and awards, honorary academic positions, reference letters, library privileges, and considering student mentoring as a criterion for admission into graduate programs and as a form of continuing education points for nurses' professional licensure renewal (Campbell & Hawkins, 2007).

Nurses who do not demonstrate commitment to mentoring others require attention by their unit leaders to explore the barriers and address them. Some hindering factors identified in the literature include feeling a lack of preparation and confidence to assume a teaching role and the personal belief that teaching is not part of their role (McKenna et al., 2018). Strategies to encourage their commitment may include offering them opportunities to attend seminars about teaching methods and assigning them to work in teams with more committed nurses.

Implications for Research

The culturally-bound expression of considering nursing students as "children" that emerged from this study requires further exploration to understand its meaning and how these assumptions may support or hinder students' PD. Particularly, these expressions did not emerge during student narratives, suggesting the need for further studies to explore these narratives from their perspective. An assessment of the readiness of Rwandan undergraduate nursing students to learn as adults, and of the staff nurses and CIs' proficiency with adult learning principles, is warranted to guide the adoption of a curriculum philosophy and instructional approaches that take into consideration the students' needs and abilities to learn as adult learners and the abilities of nurses and CIs to support students as independent learners. This was a focused ethnographic study and its findings should be applied within the focused context it was conducted. Hence, recommendations from this study could benefit from further studies with the aim to replicate these initial findings on a larger scale. Then, the findings may subsequently inform national policy changes on practice-based education for nurses.

Strengths and Limitations

Strengths

This study is the first study conducted in Rwanda to explore the topic of nursing students' PD, and from varying perspectives including both the practice and educational setting, involving key individuals who hold insightful experiences about nursing students' practice-based learning and PD. Findings from this study and from these multiple perspectives provided a comprehensive information regarding facilitators and barriers of the creation of a supportive PLE for students' PD.

Limitations

All three clinical settings involved in this study are ACP environments in referral teaching hospitals from urban areas. As a result, these settings are better equipped in terms of infrastructure, policies, and human resources than decentralized rural settings (Ministry of Health Rwanda, 2017), yet district hospitals in rural regions are also used by many nursing students over the course of their nursing program as PLEs. Further studies could explore these other settings.

Conclusion

This focused ethnography study identified that nursing students' PD within ACP environments in Rwanda is facilitated by an interconnected set of values, assumptions, practices, and behaviours, mostly shared by participants at the institutional, unit, and individual levels. Nurturing, professional gatekeeping, and engagement values and assumptions guided participants from the clinical settings and the academic program to nurture, care for, welcome, role-model, guide, integrate, respect, involve, and support nursing students' development into future nursing professionals.

Creating a culture that supports learning in the ACP environment is dependent on the shared commitment of institutions, unit leadership, and individual members. If during their practice-based learning students are placed in nurturing and caring environments in which they benefit from positive role-models to guide and mentor them in the learning process, they will likely feel better empowered and more motivated to learn and develop professionally. Students will integrate caring attitudes into their interactions with patients and colleagues, and nursing practice will be improved, likely resulting in enhanced patient care.

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Chapter 5: Assumptions, Behaviours, and Practices Hindering the

Professional Development of Nursing Students within

Acute Care Practice Environments in Rwanda

Educating nursing students to become proficient practitioners contributes to supporting the Rwanda healthcare system, which heavily relies on nurses for care delivery (Binagwaho et al., 2013). As in many other nursing programs, learning within practice-based learning environments (PLEs) constitutes an important part of the nursing curriculum in Rwanda as it accounts for approximately 50% of the total duration of undergraduate nursing education (University of Rwanda, 2016). Yet, to date, little is known about how the broad organizational context of acute care practice (ACP) environments in Rwanda shapes the professional development (PD) of nursing students.

The purpose of this chapter is to report the findings from a focused ethnographic study undertaken to explore the assumptions, behaviours, and practices that constrain nursing student's PD in the ACP environment in Rwanda. Findings from this study provide practice and academic leaders with information on organizational cultural factors that might hinder the practice and academic settings from securing a positive PLE that fosters the PD of nursing students. This constitutes a crucial step towards transforming the PLE to become more welcoming and supportive. If the PLE is enhanced, this will likely improve the quality of practice-based education offered to students and students will graduate equipped with the clinical competencies, attitudes, and values essential for their professional role, which ultimately can contribute to improving the quality of patient care in Rwanda.

Background

Practice-based learning environments are of paramount importance in engaging students in developing the fundamental skills, attitudes, and values of nursing for their professional practice roles (Young et al., 2014). Included within PLEs are several elements, such as the physical characteristics, the organizational culture of the setting, as well as the psychosocial and interactional dynamics of the people in the environment (Flott & Linden, 2016). All these elements can interact to influence learning outcomes and support students in developing their knowledge, skills, attitudes, and judgement as nurses (Flott & Linden, 2016; Papp, Markkanen, & von Bonsdorff, 2003).

In contrast to the classroom, which is a more structured and controlled environment, the PLE offers an unpredictable, complex, social context in which the activities of teaching, learning, and patient care overlap (Chan, 2001). Such complexity within the PLE can often be coupled with diversity among values and beliefs across various stakeholders, as in some settings, nursing staff priorities are dominated by providing patient care, while faculty priorities focus on facilitating student learning (Chuan & Barnett, 2012; Young et al., 2014). In addition, the presence of students and their teachers constitutes a temporary system within an established, permanent culture of the practice setting (Gaberson & Oermann, 2010). Students being seen as "guests" is often associated with role confusion and discrepancies between what is academically considered ideal versus the reality of what is enacted within the PLE (Curtis, Horton, & Smith, 2012). Such discrepancies may potentially influence the way nursing students acquire knowledge, skills, judgement, values, and attitudes within both the classroom and the practice setting, thus affecting their PD (Benner, 2004; Dall'Alba & Sandberg, 2006).

Gaps between expected PLE and what is often experienced by students in practice have been continuously reported in the literature (O'Mara, McDonald, Gillespie, Brown, & Miles, 2014; Papathanasiou, Tsaras, & Sarafis, 2014; Phillips, Mathew, Aktan, & Catano, 2017) and within Sub-Saharan African PLEs (Anarado, Agu, & Nwonu, 2016; Bvumbwe, Malema, & Chipeta, 2015; De Swardt, 2019; Msiska, Smith, & Fawcett, 2014). Barriers reported to hinder the creation of supportive PLEs include organizational barriers such as the context and the culture of the organization (Henderson, Briggs, Schoonbeek, & Paterson, 2011; O'Mara et al., 2014); relational barriers such as the nature of the supervisory relationship between students and teachers or nurses; the extent of collaboration between academic and practice settings (Flott & Linden, 2016; Phillips et al., 2017); and individual barriers such as the attitudes of students, teachers, and nurses towards learning (Chuan & Barnett, 2012; Dale, Leland, & Dale, 2013). Unsupportive PLEs result in lost learning opportunities, expose students to unprofessional role models, increase feelings of uncertainty and anxiety in students, lead to a sense of detachment and disengagement in learning, and may result in students being inadequately prepared for the professional role (Anthony & Yastik, 2011; Babenko-Mould & Laschinger, 2014; Kern, Montgomery, Mossey, & Bailey, 2014; Melincavage, 2011).

While most of the barriers constraining the PD of nursing students may be largely consistent across the globe, PLEs from poor resource environments such as Rwanda likely face additional specific challenges. Inadequate infrastructure and resources, such as insufficient basic medical equipment, supplies, and protective materials and inadequate, old, or malfunctioning equipment, have been highlighted as hindering PLEs from establishing supportive learning environments for students within Sub-Saharan Africa contexts (Anarado et al., 2016; Bvumbwe et al., 2015; De Swardt, 2019; Msiska et

al., 2014). In Rwanda, barriers constraining practice and academic settings from creating

supportive PLEs for the PD of nursing students are still unknown.

Nursing Education in Rwanda

Nursing education in Rwanda is university-based. Two nursing programs lead to

nursing registration: the advanced diploma in nursing, which is a three-year post-

secondary program, and the bachelor's in nursing, which is a four-year post-secondary

program. Nursing education is organized into classroom blocks of theory learning

alternating with practice-based learning. Practice-based learning takes place in different

clinical learning contexts including district, national referral, and teaching hospitals, as

well as in community health settings. ACP environments, particularly the medical and

surgical units within these practice settings, constitute the most commonly used settings

by the majority of nursing students. During practice-based learning, students are

supported by clinical instructors (CIs) who are university-based teachers. Generally, one

CI is assigned to approximately 15 students during a clinical placement block of

approximately eight to 10 weeks (University of Rwanda, 2016). In practice settings, staff

nurses are required to teach, supervise, and evaluate students as part of their role

(Republic of Rwanda, 2012).

This focused ethnographic study aimed at exploring the perspectives of the

different stakeholders, namely students, staff nurses, CIs, and nurse leaders from practice

and academic settings, to understand the assumptions, behaviours, and practices that

hinder the PD of nursing students within the ACP environments in Rwanda.

Methods

Design

This study was guided by a constructivist theoretical lens. Constructivism emphasises the existence of multiple realities, all of which are socially constructed by individuals (Denzin & Lincoln, 2011). It was assumed in this study that the degree to which ACP environments are perceived to facilitate or hinder the PD of students would be a result of the co-construction of reality by the key stakeholders involved in developing students for professional practice, such as staff nurses, students, CIs, and other members of multidisciplinary teams.

Focused ethnography was chosen as the study design. Similar to conventional ethnography, focused ethnography's principle focus is on understanding what is happening within a specific group in the context of their sub-culture (Richards & Morse, 2013). However, focused ethnography differs from conventional ethnography in that it uses a situation-focused framework and is framed within a discrete, specific context (Higginbottom, Pillay, & Boadu, 2013; Roper & Shapira, 2000) such as the ACP environment. Thus, focused ethnography does not require extended time and continual field work, as does conventional ethnography, and can be accomplished in a shorter time (Knoblauch, 2005). However, the multiple data collection methods used in focused ethnography allow for the collection of an extensive amount of rich data to compensate for the shortened length of time (Cruz & Higginbottom, 2013; Knoblauch, 2005). The use of focused ethnography allowed this study to focus on assumptions, practices, and behaviours of more discrete contexts—the ACP and the academic contexts that hinder the PD of students within three specific ACP settings and an associated academic program.

Settings

The settings of this study included two ACP units (medical and surgical units) from three hospital settings in Rwanda (referred to as sites A, B, and C), and the associated academic setting offering a nursing educational program. The three hospital settings were purposively chosen because they serve as the primary PLEs for the majority of nursing students in Rwanda. The academic setting is a public learning institution that provides post-secondary education to a variety of health professionals, including nursing. Including the nursing program facilitated the exploration of organizational factors and barriers originating from the academic setting and how they interrelate with those from the practice settings to hinder the PD of students.

Participant Recruitment

Four groups of participants were recruited using a combination of purposive and snowball sampling strategies to enable the selection of participants with specific knowledge about the issue under study as recommended in focused ethnographic studies (Higginbottom et al., 2013; Richards & Morse, 2013). Nursing students were required to be in their senior levels of the nursing education program and to have recently completed or to be engaged in a professional practice course in the medical or surgical units of one of the three ACP settings. Clinical instructors were included if they had at least one year of work experience in the academic setting during which they were involved in practice teaching. Staff nurses were included if they had at least an advanced diploma in nursing, and if they had been working in ACP settings for at least one year during which time they were assigned to support students in their practice-based learning. Nurse leaders included either the directors of nursing at the nursing division level or the unit managers in the practice settings, and the head of the department or the program leader in the

academic program. They were included if they had at least one year of leadership

experience at the nursing division/unit level in the practice setting and at the

school/department level in the academic setting.

Data Collection

In keeping with focused ethnography (Higginbottom et al., 2013), a combination

of three data collection methods were employed: individual semi-structured interviews

constituted the primary data source, complemented by document review and observation.

The in-depth interview guide developed by the primary investigator (PI) was used to ask

open-ended questions such as: What do you see as hindering your acquisition of

knowledge, skills, clinical competencies, and values required of a nurse during your

practice placement? The same question was rephrased and asked of staff nurses and CIs:

What do you see as hindering you in creating an environment supportive of students' PD

during clinical placement?

Interviews took place in offices chosen by participants, except for students who

met in an office that was provided to the PI at the academic setting. One interview was

conducted with each participant and lasted from 30 minutes to 90 minutes and interviews

were conducted in English and in Kinyarwanda based on participant choice. Interviews

were audio-recorded after permission had been granted by participants. All interviews

were transcribed verbatim and translated by the PI. A checklist for artifacts, practices,

and behavioural patterns was developed using the literature (Chan, 2001) and was

adapted using ideas emerging during interviews. Some examples of artifacts observed

included the availability of space for students and the CIs/nurses for reflection and

discussion. Practices observed included the orientation of nursing students on their first

day of clinical placement, a pre-conference session, and a morning staff meeting.

Regular and detailed observation field notes were written and updated as data collection progressed. This consisted of documenting in detail information, situations, and events occurring during fieldwork to allow the PI to perceive observations with accuracy and to bring new perspectives to what was observed (Emerson, Fretz, & Shaw, 2011). An example of observation field notes is displayed in the following table (table 14). Field notes were coded and analysed along with data from transcribed interviews and documents and were entered into *NVivo 11* computer-assisted data management software (Welsh, 2002).

Table 14

Fieldnotes on Observational Activity

Date of observation: 17/03/2017   Place of observation: Site A
Activity observed: Morning staff meeting   Duration of observation: start and end time: 7:30 am-8:30 am
People involved: nurses (9), unit manager (1: chair of the meeting), students (15), the research PI

Characteristics of the setting (size, space, noise, equipment)	Interactional processes, actions (who says what, what is being said, how, in which order, how many people are involved, verbal and non-verbal interactions)	Any key or unexpected event	Observer's impressions and reflections
The meeting is held in the nurse meeting room. The room is too small, so only 10 people are seated while the rest stand	The night shift team of nurses is giving their report to the dayshift team. The meeting is chaired by the unit manager. Discussions are had concerning current patient treatment, new cases admitted and their needs, and nurse concerns about specific cases. Students in attendance are encouraged to ask questions and every nurse takes the time to provide answers. Senior students are encouraged by the unit manager to provide answers to some of the questions. Assignments are given to each student in attendance.	At the end of the meeting, the unit manager checks if all the students have the required materials. Students are asked to display their materials (particularly for vital signs). Those who do not have them (there are many compared to those who have them) are asked to report to the unit manager at the end of the meeting for further action. The unit manager stresses the need for students to have their own materials.	The crowded meeting room may suggest inadequate facilities to accommodate both students and staff nurses.

It does not seem appropriate that no CIs were in attendance. This is an opportunity for a CI to pick procedures that may be used for learning.

Materials seem an issue in this site, and this also emerged during interviews. This observation supports this study finding.

Check to see if this is happening in other settings. |

Adapted from Emerson, Fretz, & Shaw (2011).

Data Analysis

A data analysis framework for ethnographic studies proposed by Roper and Shapira (2000) guided the analysis process. This analytical approach has been found relevant for studies adopting a focused ethnography design (Higginbottom et al., 2013). In keeping with the iterative and inductive nature of focused ethnography (Higginbottom et al., 2013), data collection was done concomitantly with data analysis. The unit of analysis was category of participant, namely staff nurses, CIs, students, and nurse leaders. After collecting at least one interview per category, the PI proceeded with the transcription and translation of audiotaped interviews. This was achieved by listening to the recordings several times, then reading the transcribed interviews while listening to the recordings again to check for completeness and accuracy. This process also allowed the PI to achieve extensive immersion with, and thus an in-depth understanding of, the data, one of the critical features of ethnographic studies (Roper & Shapira, 2000).

Descriptive words and sentences from each category of participants that seemed to reflect the assumptions, practices, and behavioural patterns that constrain the PD of students were grouped together and assigned a code. Codes from each category of participants that seemed related were grouped together. These codes were further explored and compared, and those that seemed repeated and occurred regularly were grouped into more abstract concepts, that is, into patterns (Roper & Shapira, 2000). Next, based on the co-occurrence and resemblance of the identified patterns, these were further grouped through a process of mixing and matching (LeCompte & Schensul, 2013; Roper & Shapira, 2000) to identify similarities and differences in patterns and the relationships between them were noted.

Interrelated sets of patterns were aggregated together into more abstract and high-level patterns of meaning, resulting in three themes. These themes were discussed using existing literature on PLEs to interpret the meaning embedded in the findings (LeCompte & Schensul, 2013; Roper & Shapira, 2000). Throughout the analysis process, memos, ideas, and insights the researcher had about the data (Roper & Shapira, 2000) were included to note personal reflections and insights as they emerged. Table 15 provides an example of how codes, patterns, and themes were generated.

Table 15

Example of Generation of Codes, Patterns, and Themes

Themes	Patterns	Codes	Statements from participants
Collaboration barriers	− Communication − Coordination	− Lack of information − Ineffective information- sharing − Irregular dialogue − Absence of a meeting forum − Uncoordinated activities − Absence of agreements − Failure to respect guidelines	- "*We don't know what you expect from us*" (nurse leader) -"*We don't get communication on time*"(nurse) -"*We know nothing until we see students on wards*" (nurse) -"*They come on Monday and start planning*" (nurse leader) -*Blaming cycle* (CI) -"*We told them, but they are not complying with our requests*" (nurse leader) -*Lack of coordinated planning* (observation fieldnotes) -"*We were refused because the site had not been informed on time*" (student)

Measures for Establishing Rigour

Measures for establishing rigour in naturalistic constructivist inquiries were used to ensure trustworthiness of the findings from this study (Patton, 2002). These measures include credibility, transferability, dependability, and confirmability, and have been found consistent with the focused ethnographic approach (Higginbottom et al., 2013).

Credibility ensures that the findings are consistent and represent plausible information (Maher, Hadfield, Hutchings, & de Eyto, 2018). To ensure credibility, this study used triangulation—collecting data from different sources and using different data collection methods to develop a comprehensive understanding of the phenomena under study (LeCompte & Schensul, 2013). Individual in-depth interviews, observation, and document review were the three data collection methods used in this study to achieve triangulation.

Transferability consists of demonstrating that the findings and conclusions from the study can be applicable in other contexts and situations (Maher et al., 2018). In this study, transferability was established through thick description, which consists of keeping field notes that contain advanced description of events, verbal and non-verbal behaviours, conversations, observed activities, and the researcher's interpretation of these events to enable other researchers to gain an understanding of the context surrounding this study (Fetterman, 2010; LeCompte & Schensul, 2013).

Dependability demonstrates that the findings are consistent and that the study could be repeated (Maher et al., 2018). Dependability was sought through maintaining an audit trail (Tobin & Begley, 2004), providing details on the process of the study, the methods used and their rationale, and how codes, patterns, and themes emerged from data. Additionally, emerging codes and patterns were reviewed by the dissertation supervisor to enhance the relevance of the findings.

Confirmability consists of ensuring that findings reflect respondents' perspectives and are derived from data instead of being driven by the researcher's preconceived assumptions (Tobin & Begley, 2004). Reflexivity, a self-aware and reflective approach (Cruz & Higginbottom, 2013), was used. A reflexivity statement was completed before

entering the field and after data collection. In addition, extensive quotes from participants were provided when reporting findings to demonstrate that the findings are grounded in participant responses rather than the PI's own preconceptions (Tobin & Begley, 2004).

Ethical Considerations

Approvals to conduct this study were obtained from the Office of Human Research Ethics of Western University, the Institutional Review Board of the University of Rwanda, and the Institutional Review Boards of the three participating clinical sites. Participant privacy and confidentiality were observed by holding interviews in confidential places, and pseudonyms chosen by participants were used to protect their identities. Only participants who voluntarily agreed to participate and to be audio-recorded were interviewed and observed. Transcriptions of recorded interviews were first de-identified and then stored in a password-protected laptop used by the PI.

Findings

Characteristics of Participants

This focused ethnographic study involved four categories of participants (N=38): nursing students (n=12); CIs (n=7); staff nurses (n=11); and nurse leaders (n=8). The nurse leaders category included four directors of nursing division, three-unit managers, and one academic leader. Table 16 details the demographic characteristics of participants.

Participant observation (n=6) and document review (n=11) provided additional information on documented values, assumptions, and observed practices and behavioural patterns within the ACP environments in relation to the PD of nursing students. Table 17 provides details on activities observed and documents reviewed.

Table 16

Demographic Characteristics of Participants

Participants	Age	Gender		Level of Study/Qualification					Years of Professional Experience	Site			
(N=38)	*Mean (Range)*	*F*	*M*	*3rd*	*4th*	*A1*	*A0*	*Grad*	*(Mean/Range)*	*A*	*B*	*C*	*Acad.*
Students (n=12)	25.3 (23-28)	6	6	3	9	-	-	-	-	-	-	-	12
Staff nurses (n= 11)	34 (27-38)	7	4	-	-	5	5	1	8 (2-17)	4	3	4	-
CIs (n=7)	32 (27-40)	2	5	-	-	-	4	3	6.3 (1.5-17)	-	-	-	7
Nurse leaders (n=8)	47 (43-56)	8	0	-	-	-	3	5	15.6 (13-22)	2	2	3	1

Notes. A1: Advanced diploma; A0: Bachelor's degree; Grad: Masters & PhD degree; Acad.: Academic setting

Table 17

Observation and document review

Activities	Site A	Site B	Site C	Academic
Observations (*n=6*)	- Morning staff meeting - Observation of artifacts	- Observation of artifacts	- Orientation of the first day of clinical placement - Pre-conference session - Observation of artifacts	-No observation
Document review (*n=11*)	- Mission & vision statements (doc 1, A) - Nurse job description (doc 2, A)	- Mission & vision statements (doc 1, B) - Clinical placement guidelines (doc 2, B) - Nursing division statement (doc 3, B)	- Mission & vision statements (doc 1, C) - Clinical placement policy (doc 2, C) - Performance appraisal form (doc 3, C) - Student registration form (doc 4, C)	- Clinical training guidelines (doc 1, academic) -Academic regulation (doc 2, academic)

Assumptions, Behaviours, and Practices Constraining

the Professional Development of Nursing Students

Three types of barriers were identified in this study as hindering the creation of a

supportive ACP environment for the PD of nursing students in Rwanda: *collaboration*

barriers, *structural barriers, and interpersonal barriers.*

Theme 1. Collaboration Barriers

Communication. Nurse leaders in particular shared that poor communication

and a lack of information on important aspects of practice-based learning hindered the

PD of students and resulted in unclear expectations, as expressed by a nurse leader at site

C: *"Let us know what you expect from us. Because we don't know what you expect from*

us...we do what we think can help students." That assumption and need for clarification

of expectations was reinforced by a nurse academic leader: *"We need to collaborate with*

the clinical sites, to clarify what they expect from us, and to explain what we want from them."

Ineffective information sharing concerning student placement emerged as particularly hindering unit managers from establishing a welcoming environment for students, as stated by a unit manager at site C: *"In the wards, we don't get communication on time. Students would arrive today, and that's the day we know we're getting students."* Staff nurses echoed this claim and added that they felt ill-informed about the intended learning outcomes for students. This practice impacted the support provided to students, as a surgical nurse at site C noted: *"It is challenging not having student learning objectives. On which basis are we helping them? What are their learning needs? We are not aware of these objectives."*

Coordination. Participants from mainly the practice settings observed that planning for student placement was inadequate, uncoordinated among different nursing programs, and did not involve practice settings, which constrained them from offering a supportive learning environment for students as highlighted by a nurse leader at site B:

> We told them [schools] let's plan before. Bring your requests at least a month before... But they are not complying with our requests. They come on Monday with students and start planning. It takes four hours sitting outside with students while they were supposed to be on wards and learning.

This assumption, however, was not shared by the academic setting. Participants from the academic setting and its documents revealed that coordinated planning was done regarding the places available in the practice settings, and the settings were informed on time, as reported by an academic nurse leader: *"With all our campuses we make one plan. That plan is shared with different hospitals."* The document review revealed that

clinical placement plans from different campuses were communicated to practice settings within the required time (Document 3, academic).

Ineffective communication was also observed as an issue as described in the following fieldnote:

> It is the first day of clinical placement at site C. First-year and fourth-year students are accompanied by two CIs. The clinical site informed the school about the limited space available for students due to the large number of students from other schools. However, on the first day, the CIs brought all of the students and the clinical site was unable to accommodate them all. After discussion, site C only accepted the fourth-year students (fieldnotes observation, site C).

Communication and coordination barriers constrained collaboration between the academic and clinical settings and challenged the establishment of a conducive learning environment for the PD of students. This resulted in stakeholders blaming each other for the barriers. Clinical sites blamed the academic program for not respecting the student placement policies of practice settings, whereas the academic setting blamed the clinical settings for their lack of commitment to nursing education. One CI summarized it: *"It is very challenging, students are blaming CIs, CIs are blaming the school, the school is blaming the hospital, the hospital is…. it is a blaming cycle which affects the learning process."*

From the students' perspectives, collaboration barriers affected how they were welcomed and integrated into unit activities, which subsequently affected their preparation for professional practice. In some instances, students were turned away because they exceeded the available places in the ACP setting. Alternatively, clinical settings sometimes received students beyond their capacity, resulting in students overcrowding the wards, making learning difficult as students had to compete for learning opportunities or were unable to achieve their intended learning goals, as shared

by this fourth-year student: *"Last time, we were refused by [site B] and others were put on night duties because the site had not been informed of the numbers of students to expect."*

Theme 2: Structural Barriers

Resource barriers. Participants identified infrastructure, as well as financial, material, and human resources, as important resources for students to develop as professionals. However, resource constraints hindered the creation of an ACP environment conducive to developing students into professionals and limited the ACP environments from enacting their teaching goals, as expressed by a nurse leader at site B:

> What we currently do is we ask schools to bring their own materials. But this wouldn't be ideal for a teaching hospital. A teaching hospital should have a budget dedicated to teaching whereby students are allowed to use more than a cannula instead of asking them to bring their own. They are learning! Resources are not being considered in that spirit... We need to arrive to a point of understanding that this is a teaching hospital. Yes, the student is messing up, and yeah, that's how it should be, and the budget should cater to that.

In terms of resource constraints, ACP units within sites A and B were particularly identified by participants as lacking resources as compared to site C. Limited vital sign materials such as thermometers and blood pressure machines, as well as a lack of protective materials such as protective gloves and masks and supplies required for everyday patient care, interfered with the students' acquisition of appropriate clinical skills, as observed by one nurse at site A: *"…a student wanting to perform a bed bath cannot find clean sheets. In this ward, we only have one blood pressure machine and four thermometers for 32 patients. Students can't learn properly in those conditions."* Consequently, students were often denied the opportunity to perform some procedures

because of material constraints, as shared by a nurse at site B: *"If I have only two line catheters, I can't afford to give one to a student to avoid misusing it."*

Learning within resource-limited ACP settings led to students either avoiding performing procedures for their safety or complying with the practices of staff nurses, which often resulted in using "short-cut practices" as opposed to "standard practices" to perform a procedure, as expressed by a fourth-year student who explained, *"You end up using nonsterile gloves for a sterile procedure."* Students found learning in such conditions hindered their professional growth. They expressed frustrations as they reflected on their internalized ideal learning environment, as this fourth-year student shared: *"I kept asking myself if I was a student or a nurse. It didn't help me. I would have wished to learn to perform standard procedures as I had been taught."*

Human resource shortage in terms of the nurse-patient ratio affected the support offered to students during their practice-based learning, as explained by this nurse at site B: *"Today we are 7 nurses for 70 patients. With 10 patients, you are unable to provide patient care and [also] teach students. You are left with no time for students."* Similarly, the number of CIs and their competing responsibilities hindered them from offering appropriate support to students in their professional growth, as one CI shared: *"I have 3 sites and 22 students in total. I have many sites and many services to attend. At the same time, I am teaching at school. Some students may rotate from one service to the other without seeing me."*

Education barriers. Education-related factors, such as the sequencing of theory and practice-based learning and the clinical facilitation models used, were identified as challenging the creation of a supportive ACP environment that fostered the PD of students. Participants from practice settings shared how the block system in which

students alternate between blocks of classroom teaching and clinical placement led to student congestion in wards and resulted in inadequate supports for students, as this nurse leader at site C questioned:

> Why should we have 100 students at one time for 3 months, then another time we don't see them through the year?... that chaos of moving every two weeks in every ward so that all students can have a share…It's like, they pass through ICU, but when you ask a student what did you learn in ICU? Oh! we only saw the machines!

Students also believed that short placement times were disruptive, did not allow them time to feel integrated into the team, and hindered their clinical skills acquisition because their practice-based learning was more observation-based rather than hands-on, as one fourth-year student indicated: *"We had two weeks. The first week we were still finding our way within the hospital. By the second week, when we had settled and were starting to learn, we had to rotate."*

With the current facilitation approach used, CIs from schools primarily support students during practice-based learning, while staff nurses in the practice settings are required to collaborate with CIs in supporting students. However, there were shared assumptions from all categories of participants that such clinical facilitation was inadequate. Clinical instructors were not regularly available to support students, and the frequency and duration of supervision sessions were limited. CIs also shared that the shortage of CIs, the large numbers of students, and the CIs' competing responsibilities were barriers that constrained them from guiding students adequately, as highlighted by the following CI: *"I have students in [site A], but I also have other students in district hospitals, and I will be having another group in community health centers as well."*

Students acknowledged missing some important learning opportunities because of limited support from CIs. They felt abandoned by their CIs, and this reinforced their

tendency to copy inappropriate nursing practices like not following all of the required steps to perform a procedure. The following third-year student said: *"Clinical teachers don't come regularly. We only learn from nurses, and they often perform procedures differently than we were taught. If I had my CIs, they would have helped me understand that difference."* The irregularity of CIs in the practice settings was also confirmed during the observation of the student orientation at site C and during the observation of a morning staff meeting at site A. During both activities, no CI was present, yet they are considered important activities in which students are oriented to settings and learning opportunities are identified.

All categories of participants identified that limited competencies of both staff nurses and CIs constrained them from adequately guiding students. Most CIs in the study acknowledged having limited clinical practice experience. On this basis, they felt that they lacked updated clinical competencies to adequately support the clinical skills acquisition of students, as expressed by one CI: *"To be honest, previously, even to look at the ventilator machine or other electronic syringe was challenging."* Similarly, except for one staff nurse who had taken a student mentorship course and another who had completed a nursing education degree, all nurse participants had no formal training on student mentoring. Consequently, they felt inadequately prepared for the mentorship role, as a nurse at site C reflected: *"We are being asked to teach students, but we have no skills on how to teach them."*

Practice-based barriers. The unprofessional behaviour of some of the staff nurses, such as verbal abuse and neglecting patients, and the nurses' heavy workloads, limited opportunities for continuous learning, inadequate institutional support, and lack of appreciation for their work were identified as affecting the PD of students. Students

mainly identified that a lack of alignment between how procedures were taught and how they were practiced in units resulted in confusion and learning inappropriate skills, as the following fourth-year student shared:

> You might have learnt a procedure in theory, and in practice you find that every nurse is doing [it] differently. When you ask why, they reply that those are "students' ideal theories." As a student, you don't know which way to go.

These theory-practice inconsistencies were termed "shortcut practices" by staff nurses and CIs, who believed that heavy nursing workloads affects the quality of care provided to patients. Nurses resolved to getting the job done, resulting in a lack of compliance to quality care standards. This exposes students to observing inappropriate practices in their professional preparation, as one nurse at site A expressed: *"You can't have 10 or more patients and be able to do all the standard procedures, assessments, and so on... You make priorities, and the students observing you learn poor practice."*

Students and CIs shared the perception that the working conditions of nurses within ACP environments were not conducive to supporting the PD of students. Several participants stated that the work of nurses was not recognized or valued, and that many nurses were unhappy with their job, which affected the support they offered to students and impacted whether students chose nursing as a career, as shared by a fourth-year student: *"Nurses are not valued in the hospitals… They have no autonomy… I really hate that one day I will be called 'Umuforomo' [a local name to designate a nurse]."*

This lack of recognition and failure to value the work of nurses was also perceived by CIs, who believed that the resultant low confidence and lack of motivation among nurses hindered the transmission of appropriate nursing values to students. One CI stated: *"Nurses are not inspiring students…. Nurses are not motivated. They are not*

even inspired themselves. If they are not empowered themselves, inspiring students so that they can value and love the profession is not happening."

While generally staff nurses across settings served as positive role models for students in terms of their professional growth, a few discouraged them. Through their practices, behaviours, and lack of interest in the nursing profession, those nurses served as negative role models for students, as articulated by a fourth-year student *"Some nurses were questioning our choice of nursing, telling us that nursing is a burdensome profession, that there is no recognition for what nurses do, that there are more risks than the benefits. It was discouraging…."*

Clinical instructors shared the perceptions of the students, mentioning that some nurses acted as negative role models for students. In their clinical facilitation experiences, CIs encountered staff nurses with unprofessional behaviours and practices who verbally abused patients, compared the nursing profession to a *"domestic job,"* and described their work as *"stool management, just cleaning up patients"* (Sibo, CI). Being mentored by such nurses negatively impacted the students' motivation to become nurses and denied them opportunities to observe appropriate professional behaviours, making them question their intentions to remain in the nursing profession.

In some ACP units, students felt that they were considered as a form of workforce to cover the shortage of nurses rather than as learners, resulting in students being involved in tasks that did not relate to their learning goals, as described by this fourth-year student: *"Some nurses, especially at [site A], consider students as their 'main d'oeuvre'. They sit you down and give you instructions…do this, do that. Everyone wants to use you for their purpose, and no one is interested in your learning goals."* Staff nurses and CIs shared this perception. They believed that the individual attitudes of

nurses towards nursing education, as well as their heavy workloads, resulted in

(*mis*)using students to cover staffing shortages, which impacted the quality of learning for

professional preparation. While students were used to cover staff shortages in some

units, they were also considered a burden in other units. Students were seen as increasing

nurse workload and wasting time and unit resources, as this third-year student expressed:

"You ask nurses to let you do a procedure and they refuse, telling you that you don't do

[it] fast and it delays them. They only let you observe." Within such an atmosphere,

learning was achieved through observing nurses practising rather than being allowed to

practice, and this hindered the ability of students to develop the skills and self-confidence

required for their professional growth.

Theme 3. Interpersonal Relationships Barriers

      Unsupportive relationships. Interpersonal relationships between students and

some staff nurses in the ACP settings were often described as unsupportive, characterized

by lack of rapport, condescension, hostility towards students, and an unwillingness to

support them. This negatively impacted the clinical experience of students, making them

vulnerable and affecting their self-confidence and motivation to become nurses. In some

units, students were victims of occasional bullying attitudes from staff nurses; they were

called names and their questions were ignored, as reported by one third-year student:

> I asked my assigned nurse (at site A) why they were using different types
> of wound dressing materials, and they turned to me with an angry look and
> said, "You should be asking this of your CI." They blame us for the
> absence of CIs, as in, "Your CI just brought you here and threw you in our
> hands."

      These interpersonal difficulties resulted in the lack of trusting relationships

between students and staff nurses. Some students reported getting emotional, stressed,

and fearful. One fourth-year student said: *"You feel so ignored and sad."* Another

fourth-year student characterised the clinical placement period as stressful: *"It has been the most stressful moment in my nursing education.* While a third-year student discussed avoiding further interactions with their assigned nurses due to fear: *"From that time, I felt so afraid whenever I was assigned to the same nurse."* Unhealthy interactions inhibited the PD of students as they felt disappointed in the profession, lost the motivation to seek learning opportunities, and experienced lower self-confidence.

Limited interactions. Staff nurses pointed out ineffective interactional exchanges between themselves and CIs concerning students, which affected their willingness to get involved in supporting students. Limited communication from CIs about student issues was raised as affecting the nurse-CI working relationship, as the following nurse at site B expressed:

> A student came and said yesterday I was sick and could not come in, but I reported it to my CI. And you are here wondering what type of communication is this? I am here in the unit, and you did not report this to me? Neither did your CI! Regular mutual communication from the CI is not smooth.

Most staff nurses across the three sites reported feeling excluded from some activities such as evaluating the clinical performance of students. Some considered the non-involvement of nurses in student evaluations as a lack of trust from CIs, as the following nurse at site C alluded to: *"We are no longer allowed to participate in student evaluations. This means that either our contribution to educating students has no value, or CIs don't trust our evaluation abilities."*

Participants, mainly from the practice settings, expressed that their contribution to supporting students during practice-based learning is often ignored and not recognized as being valuable. A nurse leader at site C shared: *"I have never once seen that they appreciate what nurses do. Even saying thank you, we recognise what you do for our*

students." That feeling of a lack of acknowledgement de-motivated some staff nurses

from being involved in student mentoring, as a nurse at site B explained: *"Some nurses*

once asked me: why should we continue supporting students when no one from their

school ever recognizes our support?"

Discussion

This focused ethnographic study explored assumptions, behaviours, and practices

within ACP environments that hinder the PD of nursing students. Three interconnected

sets of barriers—collaboration, structural, and interpersonal—emerged from participant

descriptions across groups. These barriers prevented or limited the ACP environments

and the academic program from enacting positive values and assumptions in relation to

the PD of nursing students, and, as a result, constrained them from creating and

sustaining an enriched and positive ACP environment to prepare students for professional

practice. It emerged from this study that there are many positive values promoted within

the ACP environment to support the PD of nursing students, but in practice, students did

not often experience the enactment of these positive values, producing unsupportive unit

practices and damaging individual behaviours towards students. Such a disconnect

between the values within PLEs and the actual enacted practices and behaviours within

units and by individuals calls for the creation of a more supportive ACP environment for

students. This discussion section is structured into subsections corresponding with the

three identified themes: collaboration barriers, structural barriers, and interpersonal

barriers. These themes will be discussed alongside available research in the literature.

Collaboration Barriers

The most cited barrier that emerged from this study is the limited collaboration

between institutions (e.g., between practice-based learning settings and the academic

program) and between individual stakeholders (e.g., between staff nurses and CIs involved in preparing nursing students for professional roles). The limited collaboration between academia and practice has been consistently identified as a long-standing barrier that hinders the adequate preparation of nursing students for their professional roles both internationally (Hägg-Martinell, Hult, Henriksson, & Kiessling, 2014; Jessee, 2016) and within PLEs in sub-Saharan Africa contexts (Bvumbwe et al., 2015; Iita, Alberts, Van Dyk, & Small, 2002; Neshuku & Justus, 2015; Rajeswaran, 2016; Setati & Nkosi, 2017).

The limited collaboration identified between the practice settings and the academic program involved in the current study resulted in inadequate communication, a lack of coordinated planning for student placements, a fragmentation of efforts and resources, a lack of respect for policies and guidelines, and ambiguity and confusion regarding expectations and responsibilities for guiding students. These issues constrained the clinical setting from fulfilling its educational values and from effectively planning PLEs that are welcoming and offer appropriate learning opportunities for student PD. Existing literature supports that optimal academic-practice partnership leads to the shared vision, resource optimization, joint planning and synergy, open communication, respect, and commitment (Bvumbwe, 2016; Pearson, Wyte-Lake, Bowman, Needleman, & Dobalian, 2015) crucial for creating a supportive learning environment for both students and staff nurses. Therefore, academic and practice organizations in this study could benefit from clarifying roles and responsibilities, developing mutually shared goals, and involving stakeholders in coordinating activities for a strong partnership. This could break down the identified communication and coordination barriers, leading to a successful collaboration that is mutually beneficial to nursing education and practice and will best prepare the future generation of nurses.

Creating opportunities for relationships, connection, and networking constitute an important source of informal power and information (Wiens, Babenko-Mould, & Iwasiw, 2014) that may enable staff nurses and nurse educators to feel empowered to mentor and guide students. This is particularly important in the context of PLEs in Rwanda where staff nurses expressed limited autonomy and decision-making capacities regarding practice-based learning.

Although some forms of informal partnerships between the practice and academic settings involved in this study were identified, evidence supports that the more formal and structured the partnerships, the more likely they are to produce effective results (Beal, 2012; Bvumbwe & Mtshali, 2018). Particularly, in PLEs from resource-poor settings like Rwanda, the absence of a formal academic-practice partnership is likely to worsen the impact of limited infrastructure and lack of financial and human resources on the PD of nursing students. Hence, findings from this study offer new insight on the necessity of a more formalized and structured academic-practice partnership in Rwanda.

Structural Barriers

Structural barriers in terms of limited material resources, inadequate institutional support, heavy workloads for nurses, poor student-teacher and student-mentor ratios, and the diminished sense of power felt by nurses and CIs to support nursing students were identified as hindering the PD of nursing students within PLEs in Rwanda. These findings may suggest that workplace environments in Rwanda are likely low in the empowering dimensions of access to necessary support, resources, information, and opportunities (Kanter, 1993). When individuals have low access to these structural conditions, they have low empowerment and are unable to perform their work effectively or reach their organizational goals (Kanter, 1993).

Nursing studies have found connections between empowerment and job satisfaction and lower burnout and turnover among nurses and nurse educators (Baker, Fitzpatrick, & Griffin, 2011; Sarmiento, Spence Laschinger, & Iwasiw, 2004; Spence Laschinger, Nosko, Wilk, & Finegan, 2014). There is a need for creating PLEs where staff nurses and CIs are provided with necessary materials, resources, and support to be able to fulfill their role as student mentor so the students can professionally develop. Empowering workplace environments create conditions in which employees have access to support, resources, information, and opportunities that enable them to accomplish their work in a meaningful way (Kanter, 1993; Laschinger, Gilbert, Smith, & Leslie, 2010).

The current organization of the curriculum in Rwanda, including alternating between theoretical blocks and practice-based learning and the length of clinical placements, was judged by participants in this study as ineffective and disruptive as it leads to a congestion of students in the ACP environments and reduces the time for students to develop professional relationships, attributes, and values. The time spent by students rotating and moving between wards did not allow them to build sustainable relationships with the nurses, and some students did not have enough time to practice what they had learnt. Previous international and Sub-Saharan Africa studies (Ali & Ali, 2017; Corlett, 2000; Lee, Clarke, & Carson, 2018; Mwale & Kalawa, 2016; O'Mara et al., 2014) have consistently revealed that curriculum design and delivery and theory-practice sequencing affect student achievement of clinical learning outcomes and do not allow students to achieve a sense of belongingness, vital for achieving professional growth, empowerment, and self-efficacy (Bradbury-Jones, Sambrook, & Irvine, 2010; Levett-Jones, Lathean, Higgins, & Mcmillan, 2008).

The consideration of students as extra workers to relieve nurse workload instead

of as learners found by this study might be a result of limited structural resources such as the poor nurse-patient ratio observed in some of the ACP settings in this study. This finding substantiates those of previous studies done in other developing countries such as China (Shen & Spouse, 2007), Malaysia (Chuan & Barnett, 2012), and Malawi (Msiska et al., 2014). When students are (*mis*)used in tasks unrelated to their learning goals, superficial learning focusing on mechanical task performance takes precedence over reflective learning and students are not given time to reflect on their learning. Additionally, the PD of students is constrained as they "do not learn how to practice" but "do practice," often unsupervised, resulting in learning mistakes, and likely putting patient safety at risk. The majority of students in this study expressed role confusion as a result of being considered nurses and, therefore, tasked to perform procedures unsupervised.

Confusing clinical learning activities performed by students with caring for patients hinders role clarification, as the central role of nursing education becomes doing instead of learning, hindering the PD of students (Gaberson & Oermann, 2010). Consequently, the "utilitarian" approach (Newton, Henderson, Jolly, & Greaves, 2015) of considering students as nurses does not allow students to develop critical thinking, ethical and effective practice, and confidence in their ability, and as result they may lose the motivation to seek learning opportunities for their professional growth.

Assuming that student learning can always take place while caring for patients brings to the forefront the existing discrepancy between the educational goals and values of practice settings and academic settings. It has been identified by other nursing studies that when there is a discrepancy between the practice culture, which predominantly focuses on patient care, and the academic culture, which focuses mainly on student

learning, the needs of students are unlikely to be met and their PD and socialization into the nursing profession is hindered (Baxter, 2007; Curtis et al., 2012; Newton et al., 2015). According to Gaberson and Oermann (2010), students in the PLE are learners, not nurses, and should be considered *nursing students* and not *student nurses* to emphasise their roles as students. Therefore, the findings from this Rwandan study underline the necessity of practice and academic settings to find strategies to balance service needs and the PD needs of students and to ensure that the central purpose of student placements in PLEs is for learning and not for providing patient care in order to relieve nurse workloads.

Interpersonal Barriers

Previous studies have revealed that effective student-nurse and student-educator relationships grounded in egalitarian, liberating connections and open dialogue are particularly important for students to achieve a sense of belonging, professional socialization, and professional growth (Gillespie, 2002; Lee et al., 2018; Sander et al., 2015). Unfortunately, students in this study experienced negative interactions with some nurses and CIs and viewed these interactions as barriers to their self-confidence and motivation to become nurses. They expressed feeling abandoned, vulnerable, often unwanted by nurses, and let down by their CIs. This feeling of abandonment and vulnerability highlights a paradox between the nurturing values and assumptions expressed by nurses and CIs in this study (discussed in Chapter 4) and their negative interpersonal interactions with students. The finding raises concerns given the inherently stressful nature of nursing programs and learning within PLEs. Anxiety associated with unsupportive PLEs has been reported to decrease student performance and their capacity to form healthy relationships with patients (Reeve, Shumaker, Yearwood, Crowell, & Riley, 2013). When coupled with the incivility experienced within PLEs as revealed in

this study, students are exposed to burnout and self-doubt, which may dissuade them from selecting nursing as their career (Anthony & Yastik, 2011; Babenko-Mould & Laschinger, 2014; Melincavage, 2011), and ultimately hinders their professional growth. Additionally, nurses exhibiting unprofessional behaviours towards patients and students serve as negative role models for students who are developing professional attitudes and values (Felstead & Springett, 2016). Students in this study expressed discouragement and ineffective learning resulting from being mentored by nurses who acted as negative role models through their behaviours towards students and patients.

Students feeling as though they are a burden to nurses in units was repeatedly found in this study and has been consistently identified in previous nursing studies in Sub-Saharan Africa practice-based environments (Engelbrecht, Heyns, & Coetzee, 2017; Neshuku & Justus, 2015; Solum, Maluwa, Tveit, & Severinsson, 2016) and elsewhere (Hanson, MacLeod, & Schiller, 2018). Stressful workplace environments within these PLEs caused by heavy nurse workloads, limited and unqualified nurse educators, and limited resources and support may hinder nurses from appreciating the benefits of having students in their units. For example, in two ACP units that participated in this study, issues of limited physical space, lack of material and equipment, and low nurse-patient ratios were highlighted. Having students in these units means that staff nurses have to share their already limited space, materials, and equipment with students, and nurses have to find the time in their busy schedules to devote to students, whose CIs are rarely available. According to Hanson et al. (2017), when these unstable working conditions are coupled with the presence of students, nurses feel both physically and psychologically exhausted, diminishing their willingness to support students and increasing the likelihood of transmitting unprofessional values.

Therefore, the negatives experiences students have with nurses and CIs provide additional evidence for the necessity of creating empowering PLEs in which staff nurses and CIs feel structurally and psychologically empowered (Wiens et al., 2014), have the willingness and commitment to empower future professionals, and see mentoring others as a rich opportunity for their own personal growth and learning. As a consequence, they will be able to demonstrate acceptable professional behaviours during the delivery of patient care and during their interactions with students and will feel supported to reach their professional obligation—preparing proficient future nurses.

Implications and Recommendations

Building a competent nursing workforce for the future depends heavily on the quality of nursing education provided to nursing students (Benner, Sutphen, Leonard, & Day, 2010). Particularly, minimizing barriers that constrain the development of nursing students into competent professional nurses constitutes an important step towards ensuring that how students learn, who they learn from, and the PLEs within which they become acquainted with nursing values are more welcoming and supportive.

Implications for Policy

Structural barriers related to financial, human, and infrastructure resources identified by this study corroborate previous evidence from resource-poor contexts that demonstrates that the allocation of educational budget, particularly for the nursing group, is often inadequate, hindering teaching hospitals from meeting the learning needs of nursing students (Safarani, Ravaghi, Raeissi, & Maleki, 2018). There is a need for policy for enriched and adequate resource allocation for teaching hospitals to support them in achieving their education mission such that the PD of nursing students is considered an inherent and integrated responsibility that goes hand-in-hand with care provision. This

can be in the form of a consistent budget line devoted to educational activities for all hospitals designated as teaching hospitals. A collaborative policy approach in which teaching hospitals and academic programs commit to appropriately spend this budget on the PD of nurses and other health professionals, such as the recruitment of adequately prepared staff nurses and CIs and the purchasing of materials and equipment required for student learning, is recommended.

The limited collaboration between practice and academia revealed in this study requires a policy on academic-practice partnership. Practice and academia must establish formal collaboration agreements regarding practice-based learning. This can be in the form of formal memorandums between academic and practice settings that detail shared expectations, shared goals and responsibilities, joint policies on student guidance, and the joint implementation and monitoring of these strategies. The reviewed academic regulation document only contained limited guidance regarding clinical placement, and the existing clinical guidelines reviewed were still in the draft form. It is recommended to the academic program to design a formalized policy and updated clinical placement guidelines to guide activities related to students' PD within PLEs.

Implications for Education and Practice

Preparing nursing students for their professional role is a shared responsibility between academic and practice settings. Practice and academic settings in Rwanda must avoid the blame shifting that takes place during practice-based learning as revealed in this study, and instead should draw on their combined expertise, resources, and experience to collaborate in designing empowering PLEs that foster the PD of nursing students. This may involve creating collaborative guidelines for planning and organizing clinical placements, enacting collaborative strategies for mentoring and evaluating students, and

participating in ongoing communication and information sharing and feedback strategies on matters concerning the PD of students within PLEs. Regular meetings prior to, during, and at the end of student placements between academic and practice settings will support shared coordination of clinical placement planning, clarify student learning goals, roles, and expectations, and allow stakeholders to mutually manage student placement and PD-related issues.

Individuals directly involved in student mentoring (e.g., staff nurses and CIs) could also create opportunities for collaboration, communication, and ongoing information sharing about the PD needs of students. For example, prior to student clinical placement, the CI allocated to the setting can plan meetings with staff nurses to familiarize themselves with the setting, clarify student learning objectives, roles, and expectations, and jointly identify learning opportunities for students. This type of nurse-instructor relationship creates the synergy, opportunities, power, and information (Wiens et al., 2014) required for effectively mentoring students and the development of student professional growth. Other opportunities to forge effective relationships between nurses and CIs may include inviting staff nurses to give guest lectures to students based on their clinical expertise or inviting nurse educators to share their clinical expertise in practice settings, as well as identifying opportunities for interprofessional collaboration in research activities.

Practice and academic settings in Rwanda are required to invest in necessary structural support and resources to support the PD of students PD within PLEs. Within the realities of their work, unit managers can, for example, adjust the workload of nurses involved in mentoring students for a given period of time, so as to allow them to have some flexible time to spend with students. Academic leaders can create opportunities for

CIs to maintain their clinical competencies. These opportunities may include providing a mandatory one-year clinical internship for newly recruited CIs or allowing them to have a regular clinical day in their allocated practice settings. Such initiatives will help CIs to familiarize with unit policies and procedures and will likely constitute opportunities for forging professional relationships with staff nurses. Joint in-service learning programs such as a mentor preparation course can be provided to nurses and CIs. This will likely increase the teaching confidence of staff nurses, familiarize CIs with teaching strategies in the practice-based settings, and offer opportunities for mutual learning.

In this study, inadequate clinical support and supervision was revealed to be a barrier to student PD. Practice and academic settings must review the current clinical teaching approach in use and consider alternative approaches to clinical support that would enhance effective mentorship for students during their PD journey. The preceptorship approach, in which a designated staff nurse is assigned to guide several students for an extended period of time, was perceived as more supportive of Sub-Saharan Africa students in their PD and in the overall clinical experience than was the traditional model where CIs directly guided students (Asirifi, Mill, Myrick, & Richardson, 2013; Phuma-Ngaiyaye, Bvumbwe, & Chipeta, 2017). Similarly, new collaborative clinical teaching approaches, such as establishing a specific unit dedicated to nursing education within the practice setting where staff nurses work in collaboration with a nurse educator from the academic setting who has a liaison role to support and guide nurses, have proven successful in bridging the practice-academic partnership gap through enhancing the commitment of professional nurses to student guidance and fostering the development of common goals between staff nurses and clinical teachers (Bvumbwe, 2016; Evans, Costello, Greenberg, & Nicholas, 2013; Jeffries et al., 2013).

These approaches can potentially serve as alternative frameworks to reform the clinical teaching approach currently in use in Rwanda, and may likely improve the collaboration, supervision, and guidance offered to nursing students for their PD.

The findings from this study revealed that staff nurses in some ACP settings in Rwanda are less satisfied with their working conditions and with their profession. These nurses serve as negative role models for the students who learn from them, resulting in students being inadequately prepared for professional practice. Staff nurses, CIs, and nurse educators are called upon to embrace their professional responsibilities to model sound professional behaviours to students. This may include nurses and CIs being mindful of the presence of students and demonstrating adequate professional attitudes and respect when dealing with patients, students, and colleagues, giving and receiving feedback in a constructive way, and showing accountability and professionalism in their work and in their attitudes. Professional nurses and nurse educators must make deliberate efforts to portray a positive image of the nursing profession. They can achieve this by being actively involved in professional associations such as the Rwanda Nursing and Midwifery Union and by attending professional advancement courses. Practice and academic settings are also required to engage collaboratively in creating empowering opportunities for nurses and CIs.

Evidence exists that an empowering workplace environment in which nurses have opportunities to accomplish their work goals with autonomy strongly influences professional practice and improves nurse satisfaction (Spence Laschinger et al., 2014). By extension, the more empowered and satisfied nurses and CIs are, the more committed they become to mentoring and empowering future nurses, leading to a more empowered workforce of nurses, nurse educators, and future nurses (Babenko-Mould, Iwasiw,

Andrusyszyn, Laschinger, & Weston, 2012). Otherwise, if professional nurses lack job

satisfaction and professional pride, it is unlikely that they will inspire the PD of students

who learn under their guidance.

Implications for Research

This focused ethnography was limited to one academic setting and three urban

situated ACP settings. Future research should be conducted and involve different settings

and various academic programs to provide a wider picture of the values, assumptions,

practices, and behaviours that support or hinder the PD of nursing students within

different settings. Findings from this larger study could lead to recommendations that

improve the practice-based education for nurses in Rwanda. Also, this study only

explored barriers affecting the PD of nursing students within ACP environments. More

research is also required to explore the barriers identified in this study within classroom

environments. The reported lack of job satisfaction and unprofessional behaviours of

staff nurses requires further investigation so that measures can be taken to build an

empowering workplace environment for staff nurses and students alike.

Instances of incivility and bullying were identified by student and CI participants

in the present study, but these were not clearly delineated within the limited scope of this

focused ethnographic study. Further investigation could explore the examples uncovered

in more detail to determine the common perpetrators, the typical forms of incivility and

bullying, the contexts most conducive to this damaging behaviour, and if incivility and

bullying occur between professional nurses as well. Learning more about the acts of

incivility and bullying experienced by nursing students will help in formulating adequate

recommendations for reducing these behaviours among the nursing profession in

Rwanda, leading to a positive PLE experience for nursing students and enhancing their

PD.

Some CIs in this study alluded to having low levels of confidence in facilitating learning within complex clinical settings such as intensive care units. An assessment of the clinical confidence of CIs could clarify their needs and challenges and contribute to the design of educational programs that increase their confidence.

Conclusion

Although the academic and practice settings involved in this study hold different core goals—a focus on patient care versus student education—they still share the mission of preparing nursing students for their professional role as future nurses. Yet, a lack of optimal collaboration and partnership emerged as the key barrier to establishing supportive PLEs that foster the PD of nursing students. Particularly, in a resource-limited context like Rwanda, the potential benefits of the academic-practice partnership cannot be overemphasised. The synergy stemming from such a collaborative approach offers opportunities for students, staff nurses, and nurse educators to learn from and to leverage the combined competencies and knowledge found within the clinical and academic settings.

The development of key clinical competencies and professional values, whether for students or for professional nurses, occurs within the practice environment. Hence, there is a need to foster a culture of learning within practice units, to embrace the value that every practice workplace environment is also a learning environment, and to consider everyday nursing care as a learning moment in which expertise is shared and opportunities for learning is enhanced for both students, educators, and staff nurses.

The time is now for practice and academic settings in Rwanda to cast aside the patient care-student-teaching dichotomy within ACP environments and instead focus on

their common value and goal of furthering the nursing profession. Within a collaborative framework, a culture of learning will likely emerge and hopefully can be sustained, and PD will be nurtured for both students and staff nurses. The positive outcomes resulting from such a collaborative endeavour will help to shape the proficient, effective, and caring future nursing workforce required to deliver safe patient care in the predominantly nurse-based Rwandan healthcare system.

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Chapter 6: Discussion, Implications, and Recommendations

The purpose of this study was to explore the values, assumptions, behaviours, and practices within acute care practice (ACP) environments in Rwanda, and how they influence nursing students' professional development (PD). This study has sought to respond to two main questions: 1) what are the shared and non-shared values, assumptions, practices, and behaviours that support nursing students' PD in ACP environments in Rwanda and 2) what assumptions, behaviours and practices in ACP environments in Rwanda constrain nursing students' PD?

Guided by a constructivist theoretical lens (Patton, 2002), it was assumed that practice-based education is grounded in values and assumptions embedded in official documents and in implicit, unwritten rules and behaviours and practices based on experience and on the personal and sociocultural backgrounds of the individuals within the ACP environments. These values and assumptions can be shared or not shared by members of the ACP environments, and they may underpin unit practices and their members' behaviours and interactions with students, which can both facilitate or hinder students' PD.

Focused ethnography (Roper & Shapira, 2000) was used to elicit the cultural-bound values and assumptions co-constructed by key stakeholders in academic and practice settings who play a significant role in developing students for professional practice, such as students themselves, clinical instructors (CIs), staff nurses, and nurse leaders. Multiple data sources were used to represent varied perspectives. Individual semi-structured interviews were conducted with nursing students, CIs, staff nurses, and nurse leaders from three ACP settings and an academic setting. Interview data were complemented by a review of practice and academic documents such as vision and

mission statements, policies, guidelines, and regulations to identify documented values

and assumptions about nursing practice-based education within the ACP environments.

Participant observation helped to explore observable behaviours and artifacts within the

ACP environments as they related to nursing practice-based learning.

This chapter provides a summary of the study findings, highlighting the most

important insights originating from the study and their implications. Implications and

recommendations stemming from the study findings are formulated to support nursing

education, practice, policy, and future research.

Summary of Findings: Major Insights

Nurturing, professional gatekeeping, and engagement emerged as core sets of

positive values, assumptions, practices, and behaviours supporting nursing students' PD

within ACP environments in Rwanda. The majority of these values and assumptions

were shared within categories of participants and across settings involved in the study.

Particularly, commitment to preparing professional nurses for developing the nursing

profession was the most shared value across members and settings. On the other hand,

collaboration, structural, and interpersonal barriers were identified as assumptions,

practices, and behaviours constraining nursing students' PD within ACP. Table 18

outlines the main themes identified in this study.

Both of these sets of supportive and unsupportive values, assumptions, practices,

and behaviours appeared at three interconnected levels: the institution (academic and

practice), the unit, and the individual. These findings suggest the first major insight

drawn from this study: *The ACP learning environment is multifaceted, influenced by*

interconnected sets of values, assumptions, behaviours, and practices that intersect at

institutional, unit, and individual levels. Preparing nursing students for professional

practice must consider the multifaceted nature of the ACP environment.

Table 18

*Values, Assumptions, Behaviours, and Practice Supporting and Hindering Students' PD
in ACP Environments in Rwanda*

	Themes	**Patterns**
Supporting values, assumptions, behaviours, and practices	Nurturing	Mentoring Caring
	Professional gatekeeping	Profession advancing Life-long learning
	Engagement	Institutional Unit Individual
Hindering assumptions, behaviours, and practices	Collaboration barriers	Communication Coordination
	Structural barriers	Resource barriers Education barriers Practice-based barriers
	Interpersonal barriers	Unsupportive relationships Limited interactions

The enactment of nurturing, professional gatekeeping, and engagement values and

assumptions often led to supportive practices and behaviours towards students in their

PD, including mentoring junior students, welcoming them, respecting them as learners,

and guiding and supporting them as they develop into future nursing professionals.

However, in some instances, these positive values were not enacted into positive

practices and behaviours. Rather, they produced unsupportive practices and behaviours,

and, as a result, constrained the practice and academic settings from creating and

sustaining an enriched and positive ACP environment for PD. Students often felt

unwanted by overworked nurses and unsupported by their CIs. Similarly, staff nurses

and CIs expressed limited institutional collaboration and structural barriers related to

infrastructure and material and human resources as hindering them from adequately supporting students in their PD.

Thus, despite shared institutional commitment reflecting positive values to support students' PD, unsupportive and unwelcoming practices and behaviours were enacted and observed within the studied ACP environments. This produced the opposite of the intended goal of supporting students, instead hindering their PD. This constitutes the second major insight from this study: *There is a disconnect between values and assumptions within practice-based learning environments (PLEs) and the actual enacted practices and behaviours within units and by individuals that constrains nursing students' PD.* Re-designing a strengthened supportive learning environment for students' PD should work to eliminate this disconnection. In the following two sections, these major insights are situated within the literature and related implications and recommendations are discussed.

The ACP Learning Environment Is Multifaceted, Influenced by Interconnected Sets of Values, Assumptions, Behaviours, and Practices That Intersect at Institutional, Unit, and Individual Levels

Findings from this study support contemporary nursing literature on PLEs that suggests different forces come together to shape learning experiences of students and support their PD. Forces identified in the literature include the physical characteristics of the setting, organizational culture, ward atmosphere, psychosocial and interactional factors, and individual characteristics of the people within the environment (Flott & Linden, 2016; Jessee, 2016; Newton, Henderson, Jolly, & Greaves, 2015; Tomietto, Comparcini, Saarikoski, Simonetti, & Cicolini, 2014). Findings from this study confirm the multifaceted nature of the ACP environment.

Structural elements related to resources, learning structure and institutional collaboration, institutional values, unit members' internalized norms and professional values, and individuals' assumptions and commitment all contributed in shaping units' practices and members' assumptions and behaviours towards nursing students and their PD. Thus, findings from this study shed light on the interconnectedness of the micro (individual) level and the meso (organizational) level (Rashid, Hodgson, & Luig, 2019) in shaping a PLE conducive for students' PD. Such interconnectedness brings a heightened necessity for a holistic approach and multilevel strategies that consider the interdependent factors and dynamics affecting the creation of a PLE supportive of students' PD (Henderson, Briggs, Schoonbeek, & Paterson, 2011). recommend a "co-ordinated, multipronged approach" (p. 201) that integrates all relevant stakeholders through effective leadership, management, and partnership to create and maintain a supportive PLE for students.

There Is a Disconnect Between Values and Assumptions Within PLEs and the Actual Enacted Practices and Behaviours Within Units and by Individuals That Constrains Nursing Students' PD

The three ACP settings involved in this study are mandated as national referral and teaching institutions (Ministry of Health, 2017). Accordingly, supporting students for PD is reflected in their official missions, visions, and goals. In some instances, these reflected values and assumptions often translated into supportive practices and behaviours, but, in most other cases, students experienced the opposite practices and behaviours. Teaching appears in the official documents as a nurse responsibility, but the workload nurses were expected to take on did not provide much time to guide students, and opportunities for continuous learning were rarely available. In most units, the provision of patient care took precedence over students' PD needs. Students on rotation

in these settings were seen more as extra workers to cover the shortage of nurses and lighten the workload, or as a burden that wasted the limited time and resources of the units, instead of being respected as learners.

Collaboration was emphasised as a core value for both the practice and academic settings, but lack of collaboration and partnership across all settings involved in this study hindered communication and planning for student placement. This resulted in fragmentation of stakeholder efforts and ambiguity and confusion regarding expectations and responsibilities for the support of students. This constrained the clinical settings and the academic program from fulfilling their educational values and from effectively planning PLEs that offer appropriate learning opportunities for student PD.

Paradoxes were identified between the co-existence of nurturing values held by nurses and CIs and the actual unsupportive interpersonal relationships between staff nurses and students. Nurturing values were expressed through mentoring, guiding, and role modeling junior students, yet negative role models and uncivil behaviours like bullying and intimidating were also experienced by students during their practice-based learning. This demotivated students and left them doubting their abilities and their choice of nursing as a profession, and contradicted the intended results stemming from the mentoring and caring values expressed by nurses and CIs.

This finding lends evidence to there being a disconnect between the positive values and assumptions held by institutions, units, and individuals and the actual unit practices and individual behaviours regarding developing students into competent professionals within ACP in Rwanda. When there is a difference between professed values and enacted practices within the organization, it creates conflict, incongruity, demotivation, and poor transfer of the positive values to students (Power, 2017). Hence,

this finding reiterates the continued reported significant difference between what is preferred as a supportive environment for students' PD and what is often experienced by students in practice (O'Mara, McDonald, Gillespie, Brown, & Miles, 2014; Papathanasiou, Tsaras, & Sarafis, 2014).

Previous studies (Baxter, 2007; Newton et al., 2015) identified these incongruencies as rooted in the co-existence of two different cultures: the practice culture that predominantly focuses on patient care, practice, and completing work and the academic culture that promotes students learning professional values. Given the findings of this study, limited collaboration and a lack of resources and support likely brought these two cultures into opposition with one another, whereas if they were adequately supported and effectively collaborated, these divergent cultures would reinforce each another. Thus, strategies to create positive workplace and learning environments should aim at narrowing these discrepancies.

Recommendations

Findings from this study emphasise the complex, multifaceted nature of the PLE that is likely to nurture the professional growth of nursing students. Building and sustaining a nurturing and positive learning environment for nursing students' PD requires a multifaceted approach that engages every concerned stakeholder in *"co-creating"* a learning culture that can help to close the existing gap between the practice-based and academic environments that support positive professional values and the actual practices and behaviours occurring in the units that hinder students' professional growth.

Findings from this study and from a previous study done in Rwanda (Thuss, Babenko-Mould, Andrusyszyn, & Laschinger, 2016) report a diminished sense of empowerment of CIs and staff nurses to guide students in their PD. Hence, creating and

sustaining supportive PLEs requires providing conditions within PLEs that empower Rwandan professional nurses and nurse educators to empower their students and other nurses as they learn to care for patients. Empowering environments have been found to be associated with greater job satisfaction and lower levels of burnout and turnover among nurses (Laschinger, Finegan, Shamian, & Wilk, 2001; Spence Laschinger, Nosko, Wilk, & Finegan, 2014) and nurse educators (Baker, Fitzpatrick, & Griffin, 2011; Sarmiento, Laschinger, & Iwasiw, 2004). An empowered workforce of nurses and nurse educators is more likely to empower their patients (Laschinger, Gilbert, Smith, & Leslie, 2010), their students, and future nurses (Wiens, Babenko-Mould, & Iwasiw, 2014).

Based on this study's findings, and drawing from a caring, collaborative perspective (Bankert & Kozel, 2005; Baxter, 2007; Dyess, Boykin, & Rigg, 2010), a Co-CREATES framework is proposed by this study as a strategy to enhance the positive values of nurturing, engagement, and commitment to support PD while bridging the disconnect between expressed values and enacted practices and behaviours. This framework will allow for co-creating a nurturing and empowering workplace environment that enables nurses and nurse educators to effectively mentor and develop nursing students into future professional nurses.

The recommended Co-CREATES framework is a collaborative framework grounded in the shared stakeholders' commitment to advance nursing education in Rwanda that is revealed in this study. Hence, it calls on the practice and the academic settings, staff nurses, nurse leaders, CIs, and students to Collaborate, Care, Recognize, Empower, Actively-engage, Transform, Enhance, and Support (Co-CREATES) in order to foster and sustain a positive culture of learning within ACP environments in Rwanda. Given the collaborative nature of the approach, this section does not provide

recommendations for each stakeholder separately, but rather envisions a collaborative approach of engaging every stakeholder in the process.

At the centre of the Co-CREATES framework (Figure 2) is the goal of preparing nursing students for their professional roles as future nurses. The direct stakeholders involved in this process include students themselves, staff nurses, and nurse educators. Students' PD is embedded in both classroom and PLEs, where students interact with staff nurses and nurse educators for their PD. It is within these environments that values and assumptions are created and enacted by nurse leaders and academic leaders, and where activities for patient care delivery and students' PD are organized and implemented through the practices and behaviours of staff nurses and nurse educators.

A Co-CREATES framework engages all the above stakeholders through collaborating, caring, recognising, empowering, actively-engaging, transforming, enhancing, and supporting the current environment to co-create empowering structures, processes, and procedures that will enhance the positive values, assumptions, practices, and behaviours identified in this study, while addressing the identified structural, collaborative, and interpersonal barriers. The stakeholders' collaborative commitment will help to redesign and sustain an empowering and nurturing learning environment for students who are the future professional nurses of Rwanda. While all the eight strategies proposed in the framework are supposed to equally contribute towards creating and sustaining an empowering learning environment for students, structural strategies of support, collaborate, empower, and transform might have more weight than the remaining strategies, based on structural barriers identified by this study as hindering the creation of supportive environment.

Collaborate. Collaboration and partnership have been identified in this study as key barriers to creating and sustaining supportive PLEs for students' PD. It is recommended to practice and academic settings to recreate organizational structures, procedures, and processes that emphasise collaboration and partnership. Collaboration strategies may include formalizing the academic-practice partnership; clarifying goals, expectations, roles, and responsibilities; putting in place policies on information sharing; and holding regular communication and meeting forums. Practice and academic institutions have the structural power to build and optimize collaborative strategies to enhance effective mentorship for nursing students (Henderson et al., 2011; Jokelainen, Jamookeeah, Tossavainen, & Turunen, 2011).

Individuals involved directly in student mentoring, mainly nurse educators, staff nurses, and nurse managers, should also recreate opportunities for collaboration, networking, regular communication, and ongoing information sharing. For example, the school of nursing can hold regular debriefing meetings prior, during, and at the end of student clinical placements with the PLE. These meetings would facilitate shared coordination of clinical placement planning and clarify student learning goals, roles, and expectations. It could also allow these stakeholders to develop supportive relationships with each other and to mutually manage issues related to student placement. Clearly defined lines of communication between stakeholders need to be created, documented, and disseminated. A joint policy on practice-based learning can be developed and guidelines clarifying responsibilities and role expectations should be created collaboratively and approved by all concerned individuals and institutions to guide their collaboration. Structures for sharing feedback for the enhancement of the PLE at the

institutional level (academic practice) and at the individual level (nurse clinical instructor) should be developed and supported by institutions.
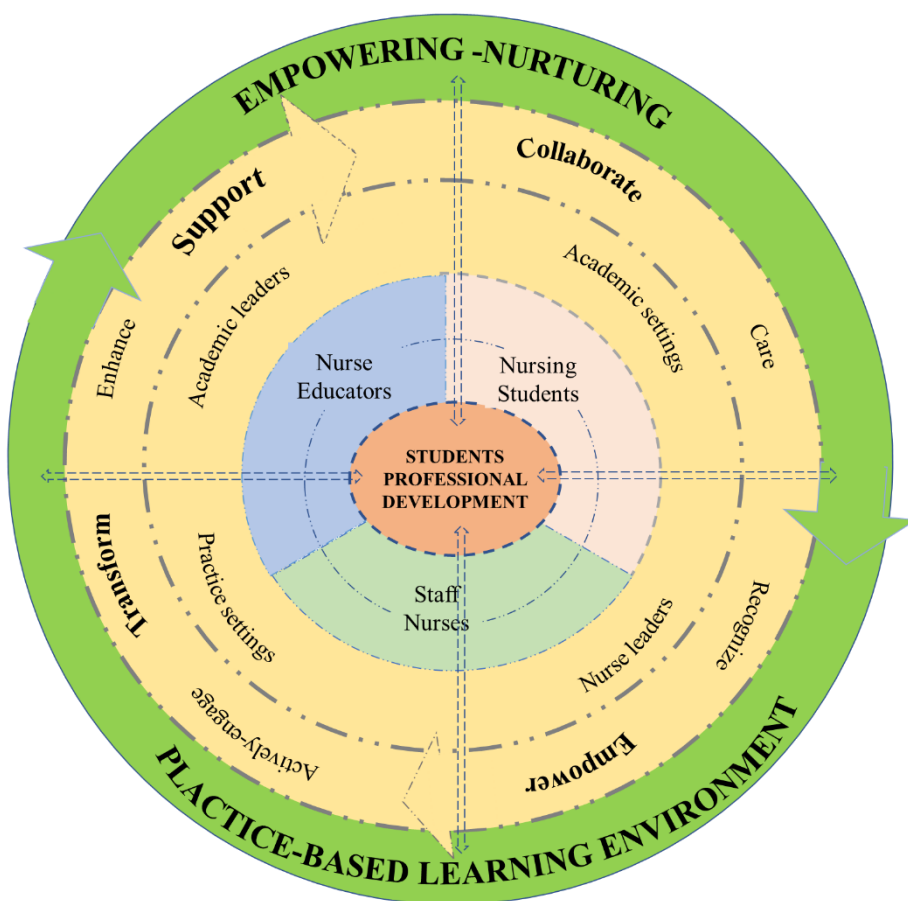
Figure 2. A Co-CREATES Framework for Creating and Sustaining a Nurturing and Empowering Practice-based Learning Environment

Creating opportunities for relationships, connection, and networking constitute an important source of informal power and information (Wiens et al., 2014) that may enable staff nurses, nurse educators, and nurse managers to feel empowered to mentor and guide students. These may entail opportunities to sharing of expertise and opportunities. Staff nurses can give guest lectures based on their clinical expertise, and during these lectures opportunities for interprofessional collaboration and research should be encouraged. It has been previously identified that academic environments that offer access to

collaborative opportunities often increase faculty empowerment (Singh, Pilkington, & Patrick, 2014) and the empowerment of nurses in their practice (Pearson, Wyte-Lake, Bowman, Needleman, & Dobalian, 2015).

Care. According to Baxter (2007), bridging the theory to practice gap in nursing education requires adopting caring attitudes and behaviours, while Bankert and Kozel (2005) recommend transforming nursing education pedagogy into a more caring learning environment for students. A caring PLE is characterized by student-educator interactions grounded in caring attitudes of valuing, respect, compassion, connectedness, encouraging, genuine dialogue, and an expression of interest in student well-being and a personalized attention to meeting their needs (Meyer, Nel, & Downing, 2016; Wagner & Seymour, 2007).

In the current study, participants characterized a caring environment as one that respects students as learners, guides them, advocates for them, and accepts their mistakes as learning opportunities. However, some students reported being bullied by nurses instead of feeling cared for and supported to grow professionally. This finding brings to the forefront the instances of bullying and the practice of nurses "eating their young" (Gillespie, Grubb, Brown, Boesch, & Ulrich, 2017) in the PLEs in Rwanda as revealed in this study. This is worrisome given that nursing education and the nursing profession are stressful by nature. If unaddressed, these bullying practices may put the nursing profession at risk, as they expose students to self-doubt and burnout, and can even dissuade them from remaining in the nursing profession (Anthony & Yastik, 2011; Babenko-Mould & Laschinger, 2014).

Practice and academic leaders, staff nurses, and nurse educators are called on to co-create caring environments in which everyone feels valued and respected in their roles

and contributions, students feel safe and valued in the learning process, and nurse educators and staff nurses feel respected, valued, and supported by their institutions. Rwandan cultural values are naturally based on human reciprocal interactions of harmony, respect, and concern for one another (Adekunle, 2007). This was reiterated in this study through the nurturing narratives expressed by staff nurses and nurse educators. These values might serve to shape caring environments while lessening interpersonal difficulties between students, nurses, and CIs. It has been found that involving students in the informal daily activities in units such as coffee and lunch breaks and other social occasions are seen by students as caring expressions that give them a sense of belonging to a caring community and of being valued (Jokelainen, Jamookeeah, Tossavainen, & Turunen, 2013).

Caring could be integrated as a key value in the philosophy and institutional policies of Rwandan nursing practice and academic environments. By embracing caring values, nurses and nurse educators can serve as positive role models that students will likely emulate in their PD and later when they become professional nurses.

Recognize. This strategy entails recognizing, valuing, and rewarding everyone involved in the nursing practice-based learning process for PD. This can be the practice settings recognizing and valuing the contribution of the academic setting in educating a qualified future nursing workforce, and the academic setting recognizing and valuing the practice settings' contribution of mentoring and providing learning opportunities to students. The recognize strategy also involves acknowledging and valuing the contributions nurse educators make when they mentor students and nurses and contribute to patient care, as well as valuing and rewarding professional nurses for their contribution to patient care and student mentoring.

Awarding honorary clinical degrees to staff nurses, recruiting them as adjunct CIs, recognizing them for graduate admission, inviting them as guest lecturers, and offering them library privileges are some of the methods education institutions and programs can use to value, recognize, and reward nurses who support students. Nurses educators can also be invited to take part in hospital committees and to collaborate on unit research and quality improvement initiatives. These forms of recognition and reward are known to increase professional satisfaction, positive self-worth, and feelings of accomplishment (Palmer, Cox, Callister, Johnsen, & Matsumura, 2005). This is important in Rwanda based on the findings revealed in the context of this study, as low motivation and lack of professional pride among nurses was identified as a barrier to nursing students' PD.

Students must be recognized for their contribution as learners to practice settings and patient care, instead of being considered as a burden or as additional workers to alleviate nurse workload. Forms of recognizing students may include providing them with tea vouchers, discounted rates in the hospital canteens, and free or discounted attendance to events organized by the practice settings. This recognition will likely reduce students' experiences of "feeling exploited" and the role confusion expressed by students in this study and will increase students' motivation to learn and to remain in the nursing profession.

Empower. There is strong evidence that the more empowered nurses and nurse educators feel, the more satisfied, willing, and committed they become to empowering students and other nurses (Baker et al., 2011; Sarmiento et al., 2004; Spence Laschinger et al., 2014; Wiens et al., 2014). Empowering strategies proposed in this framework may include providing nurses and nurse educators opportunities for self-development,

professional growth, and continuous learning, such as attending conferences, seminars, and upgrading their education. Nurses participating in this study said they lacked confidence in mentoring students and CIs expressed limited clinical proficiency, hindering the clinical facilitation provided to students.

To the Principal Investigator's knowledge, there is currently no formal orientation or mentorship support for CIs and junior nurse educators joining the academic environment in Rwanda. Therefore, it is recommended that nurse leaders create formal mentorship programs for nurses and nurse educators to be mentored by senior nurses and faculty as an empowering strategy for both the mentees and the mentors. A mentor preparation course can be provided to staff nurses to increase their teaching confidence. This can include an online student mentorship course offered to staff nurses that could be counted as credit towards fostering continuous PD. Orientation and faculty mentorship programs can prove to be important sources of information, opportunity, and support for the empowerment of nurse educators (Singh et al., 2014).

Opportunities to keep nurse educators' clinical proficiency updated such as having a weekly clinical day in their areas of expertise or being paired with an experienced nurse may increase their confidence levels. Recently, Rwanda initiated a "twinning model" that paired an experienced American faculty member with a Rwandan faculty for mentorship and support. The twinning model was successful in goal setting and skills transfer between the partners participating (Ndenga et al., 2016). Practice and academic settings in Rwanda may expand this twinning model to offer opportunities to newly recruited nurse educators and staff nurses to be paired with more senior nurses and nurse educators for ongoing mentorship and support.

Actively-engage. Developing nursing students into professionals involves different stakeholders, namely nursing students, professional nurses, nurse educators, and nurse managers. Yet, findings from this study suggest that planning for this process has often been performed by the academic program and the nurse educators, with minimal or little engagement from professional nurses, nurse managers, and students. One of the most widely shared values within this study was a shared commitment among staff nurses, nurse leaders, and CIs to mentoring students in order to advance the Rwandan nursing profession. This commitment calls for practice-based planning to actively engage all stakeholders in achieving this goal.

Before clinical placement, students should be actively involved in clarifying their placement needs and preferences so placement planners can effectively address their needs. During and at the end of the placement, student feedback could be an important source of information for the effective planning of future placements. It has been established that when students are actively involved in their learning, and are given a legitimate place within units as team members who provide patient care, they develop professionally and achieve a sense of self-efficacy and empowerment (Bradbury-Jones, Sambrook, & Irvine, 2010).

Professional nurses and nurse managers must be actively engaged in identifying student learning opportunities, planning student allocation, and providing student mentoring and assessment. Although the welcoming practice for students was identified as effective in this study, nurses in units felt less involved in preparing for their arrival. Adequate preparation of clinical placements could engage not only nurse leaders, but also bedside nurses. A placement planning discussion should be held in the practice setting before the start of student placement. This can be integrated into the usual morning staff

meeting attended by unit managers and nurses, and the assigned clinical instructor can also attend the meeting to inform nurses about the upcoming clinical placement and expected learning outcomes and to clarify expectations in relation to the students' clinical experiences and support needs.

In this study, unit nurses said that when they worked hand-in-hand with CIs in supporting students, their expectations were more aligned with educational goals and students were perceived more as beneficial to have in the units. Conversely, when nurses were less involved in student-educator discussions, students were considered a significant burden in units. Hence, it is recommended that whenever nurse workload allows, CIs strive to involve staff nurses in pre- and post-conference discussions, and nurse educators should be involved in nurse discussions and meetings about patient care, such as the morning staff meetings held in units and during ward rounds. These debriefing opportunities allow for the clarification of expectations and provide an effective learning opportunity for students (Hanson, MacLeod, & Schiller, 2018).

Transform. Transform strategy calls for the academic and practice leaders to review the current "ways of doing," what works well and what does not, and to come up with innovative, new ways of creating empowering learning environments for both students and nurses. Education-related barriers such as the clinical supervision model in use and the sequencing of theory and practice learning were identified in this study as hindering practice-based learning. Despite important changes in the Rwandan nursing education system and new developments in the healthcare system, nursing practice-based learning has been structured, planned, and conducted the same way and has used the same learning environments over the past decades. There is an urgent need to innovate and think of new models of practice-based learning, new clinical teaching strategies, and

new ways for allocating students within PLEs. Innovation is an important core dimension of an enriched PLE for students (Henderson et al., 2010).

These innovative approaches may include reducing the theory-practice sequencing period to allow for more immediate application of theoretical knowledge into practice, using non-traditional placement sites such as private hospitals and clinics instead of using the same limited number of public hospitals, and increasing the use of simulation laboratories not only as a pre-requisite for clinical placement but also as an integral part of practice-based learning. For example, instead of sending 40 students into a hospital at once, students can alternate between learning in the simulation laboratory and in the PLE. These innovations will give opportunities to students to become exposed to more complex cases that are hard to obtain in a traditional clinical environment and will minimize the identified barrier of students overcrowding the PLEs, leading to competition for limited available opportunities.

Using technology to support professional nursing development may also be explored as another innovative strategy. For example, practice settings and academic settings may initiate a centralized web-based system for student allocation to deal with clinical placements requests. This system could streamline the processing of clinical placement requests, which could improve student overcrowding in wards, reduce ineffective patient assignments, and enhance student learning. A growing amount of research attests that using video for clinical skills teaching is a promising and effective alternative to traditional methods of teaching clinical skills (Forbes et al., 2016; Holland et al., 2013). When used alone or in combination with traditional practice teaching, video improves student confidence and learning satisfaction, which increases their clinical performance outcomes and preserves patient safety (Barisone et al., 2019). These

technological innovations will likely be accepted and supported given Rwanda's technology-oriented society.

It is recommended that academic programs in Rwanda design and formalize strategies in which nursing students are given opportunities to learn with their juniors and from peers from other healthcare programs to increase collegiality among them and to reduce the feeling of inadequate mentorship expressed by students in this study. For instance, some clinical rotations might be organized in such a way that second-year nursing students are paired with fourth-year nursing students and/or physiotherapy or medical students to encourage students to learn from and with one another. The interprofessional mentoring approach (Lait, Suter, Arthur, & Deutschlander, 2011), peer interprofessional learning (Mcleod, Jamison, & Treasure, 2018), and peer learning (Pålsson, Mårtensson, Leo, Ädel, & Engström, 2017) have been proven to lead to positive outcomes in the PD of nursing students in Canada, the United Kingdom, and Sweden.

Enhance. Positive values of novice mentoring, welcoming, role modeling, supporting students, life-long learning, and educating nurses for the future were expressed by participants in this study. Academic and practice settings and all individuals involved in nursing practice-based learning are called upon to strive to enhance these positive values and assumptions, as well as the positive practices and behaviours stemming from these values, in order to sustain a caring and empowering PLE. For example, one clinical setting in this study adopted the practice of calling a clinical placement planning meeting with all of the schools of nursing to collaboratively plan for student placements. This practice needs to be enacted and enhanced in other clinical settings. For example, all of the nurses in this study demonstrated a commitment to student mentoring. Nurse leaders in practice and academic settings can enhance this

positive value by providing nurses with the time, resources, and competencies required to enact these values into practice. Alignment of workplace goals and purposes with employee beliefs, values, and assumptions constitutes a source of meaning, a critical component of psychological empowerment (Spreitzer, 1995). Such positive working conditions will likely enhance students' PD as well as nurses' satisfaction.

It is recommended to nurse leaders of practice and academic settings to enhance nurse and nurse educator autonomy, access to information, and engagement in decision making concerning issues affecting patient care and student PD. For example, nurses in this study felt uninformed about student arrival for clinical placements and uninvolved in student assessments. This reduced their commitment to student mentoring and affected their decision-making capabilities for matters regarding student practice-based learning. When nurses are involved in decision making concerning their organization's mission, goals, policies, and procedures, it enhances their self-determination and improves their ability to achieve organizational outcomes (Spreitzer, 1995).

Support. Support and resources are important dimensions for an empowering workplace and learning environment (Baker et al., 2011; Spence Laschinger et al., 2014). Limited institutional support such as heavy workloads and inadequate resources such as lack of equipment and material were identified by participants in this study as less empowering and hindering their engagement in students' PD. Practice-based and academic settings are called upon to co-create organizational structures, processes, and procedures that give provision to necessary material, financial, and human resources to enhance positive workplace and practice-learning environments.

This underscores a need to review the educational budget policy for teaching hospitals and for educational institutions with a practice-based component. It is

recommended that budget allocations for settings designated as teaching hospitals consider the mentoring of students as an inherent mission that goes hand-in-hand with the provision of patient care, instead of having to request educational institutions to provide clinical materials whenever they bring students in for practice-based learning. This will likely reduce the perception identified in this study that students waste hospital resources during their practice-based learning. Institutional support in terms of adjusting the nurse-patient and clinical instructor-student ratios and providing adequate financial support would reduce nurses' experiences of having limited time for student mentoring and would likely increase the clinical support provided to students by CIs, resulting in a more supportive learning environment for students.

Students also need to be adequately supported financially during their practice-based learning. Financial burdens related to clinical placements such as having an adequate place to live, affording basic needs, having access to healthy meals, and affording transport fees to reach practice settings emerged from participants in this study as added stressors affecting students' clinical learning experiences and PD. The financial difficulties associated with clinical placements have been cited by students in England as one of the reasons for discontinuing their studies and abandoning their nursing career (Hamshire, Willgoss, & Wibberley, 2012). Policymakers should design clinical facilitation policies that ensure nursing students are financially supported during their practice-based learning. These can include providing timely clinical fees allowance to all eligible students before their clinical placements and collaborating with funding agencies to set up special bursaries for students in practice-based academic programs who do not qualify for regular students loans.

Conclusion

This focused ethnographic study was timely given the existing gap in the literature on nursing PLEs and the PD of nursing students in Rwanda. The multiple perspectives from key stakeholders engaged in nursing students' practice-based learning such as students, staff nurses, CIs, and nurse leaders provided a comprehensive representation of the values, assumptions, practices, and behaviours that support or constrain the PD of nursing students in Rwanda.

Developing nursing students for their professional role occurs in a multifaceted PLE, with values, assumptions, practices, and behaviours that intersect at the institutional, unit, and individual levels. Creating empowering workplaces and PLEs for students requires a collaborative approach grounded in a caring and empowering lens. The recommended Co-CREATES framework that emerged from this study is based on the following actions: collaborate, care, recognize, empower, actively-engage, transform, enhance, and support. These actions are cost-effective, start from what already is working well, and invite the individual, unit, and institutional levels to collaborate in co-creating workplace and learning environments that offer resources, information, support, and opportunities (Kanter, 1993). This will help to create and sustain a culture of learning in which every practice workplace environment is also a learning environment and everyday nursing care is a learning moment in which expertise is shared and learning opportunities are enhanced for students, educators, and nurses.

If the strategies proposed within this framework are fostered and embedded within Rwandan nursing practice and the values and norms of nursing academic organizations are integrated into unit practices and the individual behaviours towards students, an effective and caring culture of learning will be cultivated and sustained

within nursing PLEs and nursing students in Rwanda. This will lead to an empowered

nursing workforce committed to role modelling the professional values required by

nursing students for their future professional roles.

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Appendices

Appendix A : Sub-Saharan Africa Countries

1. Angola	25. Liberia
2. Benin	26. Madagascar
3. Botswana	27. Malawi
4. Burkina-Faso	28. Mali
5. Burundi	29. Mauritania
6. Cabo Verde	30. Mauritius
7. Cameroon	31. Mozambique
8. Central African Republic	32. Namibia
9. Chad	33. Niger
10. Comoros	34. Nigeria
11. Congo Republic Democratic	35. Rwanda
12. Congo Republic	36. Sao Tome and Principe
13. Cote d'Ivoire	37. Senegal
14. Equatorial Guinea	38. Seychelles
15. Eritrea	39. Sierra Leone
16. Eswatini	40. Somalia
17. Ethiopia	41. South Africa
18. Gabo	42. South Sudan
19. Gambia	43. Sudan
20. Ghana	44. Tanzania
21. Guinea	45. Togo
22. Guinea Bissau	46. Uganda
23. Kenya	47. Zambia
24. Lesotho	48. Zimbabwe

Source. https://data.worldbank.org/region/sub-saharan-africa

Appendices B : Research Ethics Approvals

NMREB File Number: 107769
Study Title: Exploring the Organizational Culture of Acute Care Practice Environments and Nursing Students' Professional Development in Rwanda: A Focused Ethnographic Study

NMREB Initial Approval Date: April 25, 2016
NMREB Expiry Date: April 25, 2017

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Other	Confidentiality agreement	2016/02/14
Instruments	Data collection materials	2016/02/14
ocol	Received April 2, 2016	
Letter of Information	Students	2016/04/02
Letter of Information	Clinical Instructors and Nurses	2016/04/02
Other	Consent forms	2016/04/02
Letter of Information	Administrators	2016/04/02
Other	Script to be used with nurses.	2016/04/02
Other	Script to be used with students after class.	2016/04/02

) has reviewed and approved the above named study, as of the Initial Approval Date noted above.

pproval for this study remains valid until the B Expiry Date noted above, conditional to timely submission and acceptance of Continuing Ethics Review.

operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of

Members who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

/research/ethics

:e

Date: April 03, 2017

File Number: 107769
Study Title: Exploring the Organizational Culture of Acute Care Practice Environments and Nursing Students'
Professional Development in Rwanda: A Focused Ethnographic Study

Expiry Date:

Renewal Due -2018/03/31
Expiry Date -2018/04/25

3) has reviewed the
Continuing Ethics Review (CER) form and is re-issuing approval for the above noted study.

B operates in compliance with the Tri-Council Policy Statement
Ethical Conduct for Research Involving Humans (TCPS2), Part 4 of the Natural Health Product
Regulations, the A, 1990),
th), and the applicable laws
and regulations o

named as Investigators in research studies do not participate in
discussions related to, nor vote on such studies when they are presented to the REB.

.ali, 10/02/2017

R

Notice of Renewal of Approval for research project: No 128 /CMHS IRB/2017

Your Project title *"Exploring the Organizational Culture of Acute Care Practice Environments and Nursing Students' Professional Development in Rwanda: A Focused Ethnographic Study"* has been evaluated .... nal Review Board.

Name of Members	Institute	Involved in the decision		
			No (Reason)	
		Yes	Absent	Withdrawn from the proceeding
		X		
		X		
ra		X		
			X	
			X	
			X	
		X		
rien		X	X	
			X	
		X		
		X		
			X	
nine			X	
		X		
el			X	
		X		
al		X		

After reviewing your protocol, **Continuation of Approval has been granted to your study.**

Please note that approval of the protocol and consent form is valid for **12 months**.
You are responsible for fulfilling the following requirements:

1. Changes, amendments, and addenda to the protocol or consent form must be submitted to the committee for review and approval, prior to activation of the changes.

2. Only approved consent forms are to be used in the enrollment of participants

3. All consent forms signed by subjects should be retained on file.   may conduct audits of all study records, and consent documentation may be part of such audits.

4. A continuing review application must be submitted to the   in a timely fashion and before expiry of this approval.

5. Failure to submit a continuing review application will result in termination of the study.

6. Notify the   committee once the study is finished.

Sincerely,

Date of Approval: February 10, 2017
Expiration date: February 10, 2018
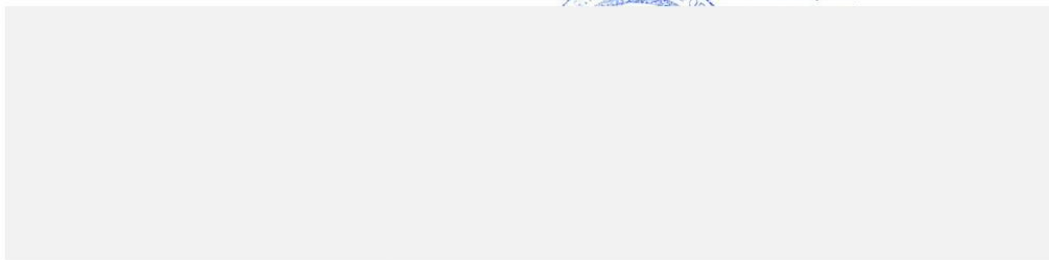
Ethics Committee / Comité d'éthique

September 13, 2016

Review Approval Notice

Dear

Your research project: "Exploring the Organizational Culture of Acute Care practice environments and Nursing students' professional development in Rwanda: A Focused Ethnographic study."

During the meeting of the Ethics Committee of that was held on 13/09/2016 to evaluate your protocol of the above mentioned research project, we are pleased to inform approved your protocol.

You are required to present the results of your study to publication.

PS: Please note that the present approval is valid for 12 months.

Yours sincerely,

September 23rd, 2016   Ref.: EC/   I/ 069/ 2016

REVIEW APPROVAL NOTICE

Your research project: **"Exploring the Organizational Culture of Acute Care Practice Environments and Nursing Students' Professional Development in Rwanda: A Focused Ethnographic Study"**.

With respect to your application for ethical approval to conduct the above stated study at
                    Hospital, I am pleased to confirm that   Ethics Committee has approved your study. This approval lasts for a period of **12 months** from the date of this notice, and after which, you will be required to seek another approval if the study is not yet completed.

You are welcome to seek other support or report any other study related matter to the Research office   the period of approval.

PS: You are required to present the results of your study to   Ethics Committee before publication.

Sincerely,

Em:

P.o Box:

Appendix C: Observation Check-list

Elements from the ACP environment	Observation
Observable artifacts	
1. Students are received with an attitude that conveys welcoming, respect, and consideration	
2. Students' names appear on the shift board with nurses' names for patient allocation	
3. A place is made available for students and their belongings	
4. A space is made available for students and their teachers/nurse for reflection and discussions	
5. Students wear uniforms and ID cards	
6. Clinical learning objectives are communicated and made accessible for everyone in the unit/ward to see	
7. Resources and facilities (educational dedicated facilities, library resources, materials, other amenities) for students' learning needs	
8. Pictures, educational posters, awards and other wall hanging artifacts	
9. Staffing levels (appropriate student-nurse and student-clinical teacher ratio) allowing time to mentor students	
10. Appropriate student -to- patient ratio, or overcrowded ward with presence of many students in the ward at the same time	
11. Availability of appropriate learning opportunities	
Involvement of students in the unit/ward activities	
1. Students are included in the activities of the ward: rounds, morning reports, in-services training sessions	
2. Students are allowed to note their assessment in the patient' file	
3. Ward activities are planed collaboratively with clinical teachers and organized in a way that allow students to participate as much as possible	
4. Students are consistently given assignments that are appropriate to their learning goals and are allowed to make decisions	
5.Students are respected, and there is a general positive attitude toward students in the ward/unit	
Supporting students in the acquisition of knowledge, skills, clinical competencies, and attitudes	
1. Availability of appropriate learning opportunities	
2.Nurses and clinical teachers collaborate with students in planning for clinical learning opportunities to meet students' learning goals	
3.Nurses and clinical teachers offer guidance to students when learning new skills and applying new knowledge	

4.Nurses and clinical teachers model to students the appropriate professional behaviours through their behaviour and practices	
5. Nurses demonstrate an interest in mentoring students and this is done in collaboration with the clinical teacher	
6.Students are encouraged to ask questions	
7.Students are involved in different problem-solving and decision-making activities	
8. Pre-post conferences are held regularly in the ward/unit and involve students, teachers and staff nurses	
9. During pre-post conference, students are encouraged to express their ideas and to reflect on the learning activities	
10. During the discussions, the interactions between students and their teachers/nurses convey a positive atmosphere of learning	
11.Reflection and critical thinking are encouraged during discussion	
12.Feedback is given in a constructive and non-judgemental way	

Adapted from: Chan, D. (2001). Development of an innovative tool to assess hospital

learning environments. *Nurse Education Today*, *21*(8), 624–631.

https://doi.org/10.1054/nedt.2001.0595

Appendix D: Demographic Questionnaire

1. Participant:
   - Student
   - Clinical instructor
   - Nurse
   - Administrator: academic setting/ clinical setting

2. Age:

3. Gender:

4. Year of study: students:

5. Level of education:
   - Clinical instructor:
   - Nurse:
   - Administrator:

6. Years of experience:
   - Clinical instructor:
   - Nurse:
   - Administrator:

7. Current ward/department:
   - Student:
   - Clinical instructor:
   - Nurse:
   - Administrator:

8. Previous wards allocated:
   - Student:
   - Clinical instructor:
   - Nurse:

9. List previous education about clinical mentorship/preceptorship:
   - Clinical instructor:
   - Nurse:
   - Administrator:

10. Other role/function in the school/ward:
    - Clinical instructor:
    - Nurse:
    - Administrator:

Appendix E: Semi-structured Interview Guides

Semi-Structured Interview Guide-Student Participants

1. What is it like to be a student in the medical/surgical ward/unit of the practice setting [name]?

   Prompts:
   – Which wards have you been allocated to?
   – How was your allocation to that ward/unit done?
   – How long did you stay in that ward/unit?
   – What did you like in being a student in that ward/unit?
   – What did you not like?

2. What do you think are important factors that a practice-based learning environment must have to be able to provide a supportive environment for students' learning?

   Prompts:
   – How does an ideal practice-based learning environment look like to you?
   – What do you value in a practice-based learning environment that supports students' professional development?
   – Are these values shared with nursing staff and your clinical teachers?
   – What facilitates the ACP environment from enacting these values?
   – What constrain the ACP environment from enacting these values?

3. What takes place in the ward/unit to support students achieving their clinical learning goals?

   Prompts:
   – How are students welcomed and oriented to the ward/unit?
   – How do students participate in the activities of the ward/unit?
   – Which activities do students participate in when in the ward/unit?
   – What do you think nurses in the ward/unit think of nursing students?
   – What do you think other health professionals in the ward/unit think of nursing students?
   – How do they behave towards students?
   – How do they interact with students?
   – To what extent do they take part in mentoring students?
   – Do you see any difference in how nursing students are treated by the care team as compared to other students (medical and allied health students)?
   – How do nurses in the ward/unit help students acquire knowledge, skills and clinical competencies when in clinical placement?
   – How do nurses in the ward/unit guide students in acquiring values and attitudes required of a nurse?
   – What procedures, policies or guidelines are available in the ward/unit to assist nurses in supporting students?
   – What facilities, resources, materials, and supplies are available in the ward/unit for students to use when in the clinical placement?

4. In what ways is your nursing program involved in helping to create a clinical environment that supports students' acquisition of knowledge, skills, and clinical competencies when they are in clinical placement?

Prompts:
  – How is clinical placement planned from the school?
  – How often do students receive clinical instructors in the ward/unit?
  – How do clinical instructors work with students in the ward/unit to support their acquisition of knowledge, skills and clinical competencies?
  – What resources (human, financial and material) are made available by the school for the acquisition of students' knowledge and clinical competencies when in clinical placement?
  – What procedures, policies, and guidelines are available from school that support students' clinical learning in the clinical placement?
  – How does the school collaborate with the clinical setting in planning and implementing clinical placement, and in mentoring students for acquisition of knowledge, skills and clinical competencies?

5. What do you see as facilitating your professional development during your practice placement and making the clinical environment more supportive to you?

Prompts:
  – In your acquisition of knowledge, skills and clinical competencies
  – In your acquisition of values and attitudes required of a nurse
  – What factors are from the medical/surgical unit of the clinical setting
  – What factors are from your school
  – Any other factor(s)

6. What do you see as hindering your acquisition of knowledge, and skills and clinical competencies during your practice placement?

Prompts:
  – Your acquisition of knowledge, skills and clinical competencies
  – In your acquisition of values and attitudes required of a nurse
  – What factors are from the medical/surgical unit of the clinical setting
  – What factors are from your school
  – Any other factor (s)

7. How can the current clinical environment of the medical/surgical ward/unit be changed to support you better in your clinical learning process?

Prompts:
  – In your knowledge, skills and clinical competencies acquisition
  – In your acquisition of values and attitudes required of a nurse
  – To whom would you address these recommendations?

8. Is there anything else you would like to share with me that you think is important for me to know about the current organizational culture of the medical/surgical

ward/unit of the clinical setting and how it influences your acquisition of knowledge, skills, clinical competencies, values and attitude, that we did not cover in this discussion?

Semi-Structured Interview Guide-Clinical Instructor Participants

4. Please share with me about your experiences of being a clinical instructor/teacher in the medical/surgical ward/unit of the clinical setting [name]?
   Prompts:
   – How are clinical settings and wards/units chosen as placement sites for students?
   – On which basis are clinical teachers assigned to a particular ward/unit or a clinical facility?
   – How many students does one clinical teacher have to teach?
   – How is clinical placement and teaching planned?
   – What do you like in being a clinical teacher in that ward?
   – What do you not like?

5. What do you think are important factors that a practice-based learning environment must have to be able to provide a supportive environment for students' learning?
   Prompts:
   – How does an ideal practice-based learning environment look like to you?
   – What do you value in a practice-based learning environment that supports students' professional development?
   – Are these values shared with nursing staff and the school/health facilities administrators?
   – What facilitate you from enacting these values?
   – What constrain you from enacting these values?

6. What takes place in the medical/surgical ward/unit to support students achieving their clinical learning goals?
   Prompts:
   – How students are welcomed and oriented to the ward/unit
   – How students and clinical teachers get to participate in the activities of the ward/unit
   – Which activities students and their clinical teachers participate in when in the ward/unit
   – The beliefs held by nurses towards students
   – How nurses behave towards students and towards clinical teachers
   – How nurse interact with students and with clinical teachers
   – The involvement of nurses in the mentoring of students
   – How nurses help students acquire knowledge, skills and clinical competencies when in clinical placement
   – How nurses inspire in students the values and attitudes required of a nurse?
   – How do you collaborate with the nurses in the ward/unit in planning learning activities for students?

- What procedures, policies or guidelines are available in the ward/unit to assist nurses and clinical teachers in supporting students? How are these procedures, policies and guidelines made known to you?
- What facilities, resources, materials, and supplies are available in the ward/unit for students and clinical teachers to use when in the clinical placement?

7. In what ways does your nursing program facilitate the creation of a clinical environment that supports students' acquisition of knowledge, skills, and clinical competencies when they are in clinical placement?

   Prompts:
   - How is clinical placement planned from the school?
   - How often do see your students?
   - How do you work with students in the ward/unit to support their acquisition of knowledge, skills and clinical competencies?
   - How do you inspire in your students the values and attitudes required of a nurse?
   - What resources (human, financial and material) are made available to you by the school for students' acquisition of knowledge and clinical competencies when in clinical placement?
   - What procedures, policies, and guidelines are available from your school that support students' clinical learning in the clinical placement?
   - Are these formally written or just informal?
   - How are these procedures, policies and guidelines communicated to the clinical settings?
   - What support do you get from your faculty/department held in creating a supportive environment for students' professional development?
   - How does the school collaborate with the clinical setting in planning and implementing clinical placement, and in mentoring students for knowledge, skills and clinical competencies' acquisition?

8. What do you see as facilitating you in creating an environment supportive of student professional development during clinical placement?

   Prompts:
   - In supporting their acquisition of knowledge, skills and clinical competencies
   - In inspiring in students the values and attitudes required of a nurse
   - What factors are from the medical/surgical unit of the clinical setting
   - What factors are from your school
   - Any other factor (s)

9. What do you see as hindering you in creating an environment supportive of student professional development during clinical placement?

   Prompts:

  – In supporting their acquisition of knowledge, skills and clinical competencies

  – In inspiring in students the values and attitudes required of a nurse

  – What factors are from the medical/surgical unit of the clinical setting

  – What factors are from your school

  – Any other factor (s)

  – How are these barriers overcome at clinical teacher/nurse level/the school level and the ward/unit level?

10. If you were given opportunity to make changes in how the ward/unit influences students' acquisition of knowledge, skills, attitudes and clinical competencies, what changes would you suggest?

Prompts:

  – What can be done at individual (student, clinical teacher and nurse) level?

  – What can be done at the medical/surgical ward/unit level

  – What can be done at the clinical setting level?

  – What can be done at the school level?

  – Any other recommendations?

11. Is there anything else can you share with me that you think is important for me to know about the current organizational culture of the ward/unit of the hospital and how it influences students' acquisition of knowledge, skills, attitudes and clinical competencies, that we did not cover in this discussion?

Semi-Structured Interview Guide-Nurse Participants

1. Please share with me your experiences of having students from the school [name] in your ward/unit?
   Prompts:
     − What types of students do you receive?
     − How many students are assigned to you? For how long?
     − How is this decided and by who?
     − How is this communicated to you?
     − How different is a day in the ward/unit when you have students compared to when you have no students?
     − What do you like the most in having students in your ward/unit?
     − What do you not like?
2. What do you think are the important factors that a practice-based learning environment must have to be able to provide a supportive environment for students' learning?
   Prompts:
     − How does an ideal practice-based learning environment look like to you?
     − What do you value in a practice-based learning environment that supports students' professional development?
     − Are these values shared with clinical instructors and the school/health facilities administrators?
     − What facilitate you from enacting these values?
     − What constrain you from enacting these values?
3. In what ways does the ward/unit support students achieving their clinical learning goals?
   Prompts:
     − How does your ward/unit get prepared to receive students?
     − How students are welcomed and oriented to the ward/unit
     − How students and clinical instructors get to participate in the activities of the ward/unit
     − Which activities students and their clinical teachers participate in when in the ward/unit
     − What do you think about students and their learning needs when they are in your ward/unit?
     − How do you interact with students and with clinical instructors?
     − How and who mentors students? How is this decided?
     − How do you help students acquire knowledge, skills and clinical competencies when in clinical placement?
     − How do you inspire in students the values and attitudes required of a nurse?

- How do you collaborate with the clinical instructors from school in planning learning activities for students?
- What procedures, policies or guidelines are available in the ward/unit to assist you in supporting students?
- How are these procedures, policies and guidelines made known to you?
- What facilities, resources, materials, and supplies are available in the ward/unit for students and clinical instructors to use when in the clinical placement?
- What support do you get from your ward/unit manager in creating a supportive environment for students' professional development?

4. What does the nursing program do to facilitate the creation of a clinical environment that supports students' acquisition of knowledge, skills, and clinical competencies when they are in clinical placement?

   Prompts:
   - How is clinical placement planned from the school?
   - How often do you get involved in the planning process?
   - How do you get to know when students are coming and their learning goals?
   - What resources (human, financial and material) are made available to you by the school for students' acquisition of knowledge and clinical competencies when in clinical placement?
   - What procedures, policies, and guidelines are available from the school that support students' clinical learning in the clinical placement?
   - Are these formally written or just informal?
   - How are these procedures, policies and guidelines communicated to your ward/unit and to you?
   - How does the school collaborate with your clinical setting and your ward/unit in planning and implementing clinical placement,
   - How does the school collaborate with your clinical setting and your ward/unit in mentoring students for their acquisition of knowledge, skills and clinical competencies'?

5. What do you see as facilitative to you in creating an environment supportive of student professional development during clinical placement?

   Prompts:
   - In supporting their acquisition of knowledge, skills and clinical competencies
   - In inspiring in students the values and attitudes required of a nurse
   - What factors are from the medical/surgical unit of the clinical setting
   - What factors are from your school
   - Any other factor (s)

6. What do you see as hindering you in creating an environment supportive of student professional development during clinical placement?

Prompts:
- In supporting their acquisition of knowledge, skills and clinical competencies
- In inspiring in students the values and attitudes required of a nurse
- What factors are from the medical/surgical unit of the clinical setting
- What factors are from your school
- Any other factor (s)
- How are these barriers overcome at clinical teacher/nurse level/the school level and the ward/unit level?

7. If you were given opportunity to make changes in how the ward/unit influences students' acquisition of knowledge, skills, attitudes and clinical competencies, what changes would you suggest?

Prompts:
- What can be done at individual (student, clinical instructor and nurse) level?
- What can be done at the medical/surgical ward/unit level
- What can be done at the clinical setting level?
- What can be done at the school level?
- Any other recommendations?

8. Is there anything else can you share with me that you think is important for me to know about the current organizational culture of the ward/unit of the hospital and how it influences students' acquisition of knowledge, skills, attitudes and clinical competencies, that we did not cover in this discussion?

Semi-Structured Interview Guide-Administrators

1. Please share with me how practice placements for students are organized at the school level (school administrator)? And at the medical/surgical ward/unit level (ACP setting administrator)?

   Prompts:
   - Who decide how many students must go to which ward/unit?
   - What procedures, policies and guidelines are followed from the school when sending students in the medical/surgical ward/unit of the clinical setting [name]?
   - What procedures, policies and guidelines are followed by the clinical setting in welcoming students in medical/surgical ward/unit and in mentoring them
   - Are these procedures and norms formally written? How are they designed?
   - How are they made known to those who are involved in students' teaching and mentoring?
   - How is clinical teaching/mentoring of students planned? Who plan for it?
   - How the school does communicate with the clinical setting and vice-versa with regards to students' clinical placement and their teaching/mentoring?

2. What do you think are important factors that a clinical learning environment must have to be able to provide a supportive environment for students' learning?

   Prompts:
   - How does an ideal practice-based learning environment look like to you?
   - What do you value in a practice-based learning environment that supports students' professional development?
   - Are these values shared with the school and the health facility?
   - What facilitate you from enacting these values?
   - What constrain you from enacting these values?

3. In what ways does the nursing program offer a supportive environment for students' acquisition of knowledge, skills and clinical competencies?

   Prompts:
   - In planning for clinical placement for students
   - In collaborating with school and clinical setting for student' mentoring and teaching
   - In availing the necessary resources: human, financial, equipment, supplies to support students in their acquisition of knowledge, skills and clinical competencies when in clinical placement
   - In designing procedures, policies, and guidelines to support students' clinical learning when in the clinical placement?
   - In giving the required support (time, knowledge, recognition) to clinical instructors and nurses to be able to mentor and teach students

4. In what ways does the ward/unit offer such a supportive environment for students' acquisition of knowledge, skills and clinical competencies?
   Prompts:
   - In planning for clinical placement for students
   - In collaborating with school and clinical setting for student' mentoring and teaching
   - In availing the necessary resources: human, financial, equipment, supplies to support students in their acquisition of knowledge, skills and clinical competencies when in clinical placement
   - In designing procedures, policies, and guidelines to support students' clinical learning when in the clinical placement?
   - In giving the required support (time, knowledge, recognition) to clinical instructors and nurses to be able to mentor and teach students

5. What do you see as facilitative to you in creating an environment supportive of student professional development during clinical placement?
   Prompts:
   - In supporting their acquisition of knowledge, skills and clinical competencies
   - In inspiring in students the values and attitudes required of a nurse
   - What factors are from the medical/surgical unit of the clinical setting
   - What factors are from the school
   - Any other factor (s)

6. What do you see as hindering you in creating an environment supportive of student professional development during clinical placement?
   Prompts:
   - In supporting their acquisition of knowledge, skills and clinical competencies
   - In inspiring in students the values and attitudes required of a nurse
   - What factors are from the medical/surgical unit of the clinical setting
   - What factors are from the school
   - Any other factor (s)
   - How are these barriers overcome at the school level and the ward/unit level?

7. If you were given opportunity to make changes in how the school/ward/unit influences students' acquisition of knowledge, skills, attitudes and clinical competencies, what changes would you suggest?
   Prompts:
   - What can be done at individual (student, clinical instructor and nurse) level?
   - What can be done at the medical/surgical ward/unit level
   - What can be done at the clinical setting level?
   - What can be done at the school level?
   - Any other recommendations?

8. Is there anything else can you share with me what you think is important for me to know about the current organizational culture of the ward/unit of the hospital and how it influences students' acquisition of knowledge, skills, attitudes and clinical competencies, that we did not cover in this discussion?

Appendix F: Confidentiality Agreement: Research Assistant

I understand confidential information will be made known to me as a research assistant during a study being conducted by Benoite Umubyeyi of the Arthur Labatt Family School of Nursing, Western University. I agree to keep all information collected during this study confidential, and will not reveal by speaking, communicating or transmitting this information in written, electronic (disks, tapes, transcripts, email) or any other manner to anyone outside the research team.

Name of Research Assistant: _____ (please print)

Signature of Research Assistant: _____

Date: _____

Name of Person Obtaining Consent: _____ (please print)

Signature of Person Obtaining Consent: _____

Date: _____

Appendix G: Letters of Information

Letter of Information -Student Participants

Values, Assumptions, Behaviours, and Practices Influencing the Professional Development of Nursing Students Within Acute Care Practice Environments in Rwanda: A Focused Ethnographic Study

Investigators: Umubyeyi Benoite, RN, (PhD Candidate), Dr. Yolanda Babenko-Mould, RN, PhD (Supervisor), Dr. Sandra Regan, RN, PhD (Committee member), Dr. Michaela Hynie, PhD (Committee member), Dr Beverly Leipert, RN, PhD (Committee member)

Invitation to Participate
As a student in one of the nursing academic programs in Rwanda, you are being invited to take part in a research study being conducted as a requirement for a graduate degree at Western University. By participating in this study, you will be sharing your experiences and contributing to understanding the current supportive or unsupportive practices of students' professional development within practice environments. This information may be used to strengthen the supportive practices and to design an enhanced acute care practice environment, which may have impact on how nursing students are taught within acute care practice environments.

Purpose of the Letter
The purpose of this letter is to provide you with detailed information that will allow you to make an informed decision about participating in this research.

Purpose of this Study
The purpose of this study is to explore how organizational culture of acute care practice environments influences nursing students' professional development when they are in practice placements.

Inclusion Criteria
Students enrolled in the senior levels (two last years) of the selected nursing program, and who have recently completed or are currently involved in a practice placement in a medical or surgical unit at one of the three selected clinical settings are eligible to participate in the study.

Exclusion Criteria
Students enrolled in the selected nursing program but in the first and second years, and third and fourth year students who did not complete their clinical placement in a medical or surgical unit of the selected clinical settings are not eligible to participate in the study.

Study Procedures
If you agree to participate in this study, you will be invited to share your experience in an individual interview, and to be observed during your practice placement. The interview will be planned at a convenient time and place of your choosing, and will last approximately 60-90 minutes. The interview will be audio-recorded with your permission, and later transcribed, but your name or any other identifying information will

not appear on the transcribed document. You may be requested to participate in a second follow-up interview to provide feedback about study findings. A pseudonym of your choice will be used instead of your actual name. Observation will involve observing the interactions between you and your clinical instructors/nurses during the pre or post-conference discussions. You will not be observed while providing direct care to patients. You have the right to refuse to participate, to stop your participation at any time, to refuse to respond to some questions, or even to refuse to be recorded or to be observed. If you decide to withdraw from the study, your data will be destroyed. This decision will not affect you in any way.

Possible Risks and Harms
There are no foreseeable risks in participating in this study.

Voluntary Participation
Participation in this study is voluntary. You have the right to refuse to participate, to refuse to answer any questions, or to withdraw from the study at any time. You also have the right to choose to be interviewed by me or by a research assistant. This decision will not affect you in any way.

Confidentiality
All the information that will be collected will be kept confidential. You will not be asked to state your name at any given time during the recorded portion of the interview, and your contact address will be kept separate from any data and will only be used by the researcher to contact you for the interview planning. No one else will be aware of your participation in this study. All information will be presented using a pseudonym of your choice. Transcribed notes will be kept confidential in a locked cabinet, and all the electronic data will be password protected.

Contact for Further Information
If you require further information regarding this research and your participation, please contact me at the following email address and phone: ………………….., cell phone: +……………………… If you have any other questions regarding your rights to participate in this study, please feel free to contact one of the following contacts: The Director, Office of Research Ethics, …………… or email ……………… or the ………….., email ……………

Publication
The findings from this study will be written in a report and will be presented at conferences and disseminated in professional journals, but with no identifying information. If you wish to receive a summary of the findings, please contact me by email with the request, and I will provide you with a summary document.

This letter is for you to keep.

Best regards,

Benoite Umubyeyi, RN, PhD Candidate
Arthur Labatt Family School of Nursing
Western University, London, Ontario, Canada
…………………………………………

Letter of Information-Clinical Instructor/Nurse Participants

Values, Assumptions, Behaviours, and Practices Influencing the Professional Development of Nursing Students Within Acute Care Practice Environments in Rwanda: A Focused Ethnographic Study

Investigators: Umubyeyi Benoite, RN, (PhD Candidate), Dr. Yolanda Babenko-Mould, RN, PhD (Supervisor), Dr. Sandra Regan, RN, PhD (Committee member), Dr. Michaela Hynie, PhD (Committee member), Dr Beverly Leipert, RN, PhD (Committee member)

Invitation to Participate
As a clinical instructor from one of the nursing academic programs in Rwanda, or a nurse from one of the three selected health settings, you are being invited to take part in a research study being conducted as a requirement for a graduate degree at Western University. By participating in this study, you will be sharing your experiences and contributing to understanding the current supportive or unsupportive practices of students' professional development within practice environments. This information may be used to strengthen the supportive practices and to design an enhanced acute care practice environment, which may have impact on how nursing students are taught within acute care practice environments.

Purpose of the Letter
The purpose of this letter is to provide you with detailed information that will allow you to make an informed decision about participating in this research.

Purpose of this Study
The purpose of this study is to explore how organizational culture of acute care practice environments influence nursing students professional development when they are in practice placements.

Inclusion Criteria
If you are a clinical instructor, you are eligible to participate in the study if you are: from the selected nursing academic program, and have at least one year of clinical teaching experience. If you are a nurse, you are eligible to participate in the study if you are: a nurse in the three selected clinical settings, have at least an advanced diploma in nursing, have at least one year of practice experience, and have been teaching students or have been involved in mentoring students in medical/surgical units of the selected clinical settings.

Exclusion Criteria
Clinical instructors or nurses with less than a year of clinical teaching and practice experience, nurses who do not hold at least an advanced diploma in nursing, and clinical instructors or nurses who do not mentor students in the medical or surgical units of the three selected clinical settings, are not eligible to participate.

Study Procedures
If you agree to participate in this study, you will be invited to share your experience in an individual interview, and to be observed during clinical placements in your interactions with your students during the pre or post-conference discussions. The interview will be

planned at a convenient time and place of your choosing, and will last approximately 60-90 minutes. You may be requested to participate in a second follow-up interview to provide feedback about study findings. The interviews will be audio-recorded with your permission, and later transcribed, but your name or any other identifying information will not appear on these notes. A pseudonym of your choice will be used instead. Observation will involve observing the interactions between you and your students during the pre or post-conference discussions. You will not be observed while providing direct care to patients. You have the right to refuse to participate, to stop your participation at any time, to refuse to respond to some questions, or even to refuse to be recorded or to be observed. If you decide to withdraw from the study, your data will be destroyed. This decision will not affect you in any way.

Possible Risks and Harms
There are no foreseeable risks in participating in this study.

Voluntary Participation
Participation in this study is voluntary. You have the right to refuse to participate, to refuse to answer any questions, or to withdraw from the study at any time. You also have the right to choose to be interviewed by me or by a research assistant. This decision will not affect you in any way

Confidentiality
All the information that will be collected will be kept confidential. You will not be asked to state your name at any given time, and your contact address will be kept separate from any data and will only be used by the researcher to contact you for the interview planning. No one else will be aware of your participation in this study. All information will be presented using a pseudonym of your choice. Transcribed notes will be kept confidential in a locked cabinet, and all the electronic data will be password protected.

Contact for Further Information
If you require further information regarding this research and your participation, please contact me at the following email address and phone: ….………………., cell phone: +…………………….... If you have any other questions regarding your rights to participate in this study, please feel free to contact one of the following contacts: The Director, Office of Research Ethics, …………… or email ……………… or the ………….., email ……………

Publication
The findings from this study will be written in a report and will be presented at conferences and disseminated in professional journals, but with no identifying information. If you wish to receive a summary of the findings, please contact me by email with the request, and I will provide you with a summary document.

This letter is for you to keep.

Best regards,

Benoite Umubyeyi, RN, PhD Candidate
Arthur Labatt Family School of Nursing
Western University, London, Ontario, Canada

Letter of Information- Academic and Clinical Setting' Administrator Participants

Values, Assumptions, Behaviours, and Practices Influencing the Professional Development of Nursing Students Within Acute Care Practice Environments in Rwanda: A Focused Ethnographic Study

Investigators: Umubyeyi Benoite, RN, (PhD Candidate), Dr. Yolanda Babenko-Mould, RN, PhD (Supervisor), Dr. Sandra Regan, RN, PhD (Committee member), Dr. Michaela Hynie, PhD (Committee member), Dr Beverly Leipert, RN, PhD (Committee member)

Invitation to Participate
As a key person in the development and implementation of policies and procedures related to clinical teaching and learning in the academic program and the practice setting, you are being invited to take part in a research study being conducted as a requirement for a graduate degree at Western University. By participating in this study, you will be sharing your experiences and contributing to understanding the current supportive or unsupportive practices of students' professional development within practice environments. This information may be used to strengthen the supportive practices and to design an enhanced acute care practice environment, which may have impact on how nursing students are taught within acute care practice environments.

Purpose of the Letter
The purpose of this letter is to provide you with detailed information that will allow you to make an informed decision about participating in this research.

Purpose of this Study
The purpose of this study is to explore how organizational culture of acute care practice environments influence nursing students acquisition of required knowledge, skills, attitudes and competencies when they are in practice placements

Inclusion Criteria
Academic program administrators at the faculty or department level, as well as practice setting administrators at the nursing division or unit level who have been in office for at least one year are eligible to participate in the study.

Exclusion Criteria
Academic program administrators and practice setting administrators who have less than a year of experience in office are not eligible to participate in the study.

Study Procedures
If you agree to participate in this study, you will be invited to share your experience in an individual interview with the researcher. The interview will be planned at a convenient time and place of your choosing, and will last approximately 60-90 minutes. You may be requested to participate in a second follow-up interview to provide feedback about study findings. Interviews will be audio-recorded with your permission, and later transcribed, but your name or any other identifying information will not appear on these notes. A pseudonym of your choice will be used instead. You have the right to refuse to

participate, to stop your participation at any time, to refuse to respond to some of the questions, or even to refuse to be recorded. If you decide to withdraw from the study, your data will be destroyed. This decision will not affect you in any way.

Possible Risks and Harms
There are no foreseeable risks in participating in this study.

Voluntary Participation
Participation in this study is voluntary. You have the right to refuse to participate, to refuse to answer any questions, or to withdraw from the study at any time. You also have the right to choose to be interviewed by me or by a research assistant. This decision will not affect you in any way.

Confidentiality
All the information that will be collected will be kept confidential. You will not be asked to state your name at any given time. No one else will be aware of your participation in this study. All information will be presented using pseudonyms of your choice. Transcribed notes will be kept confidential in a locked cabinet, and all the electronic data will be password protected.

Contact for Further Information
If you require further information regarding this research and your participation, please contact me at the following email address and phone: ………………….., cell phone: +…………………... If you have any other questions regarding your rights to participate in this study, please feel free to contact one of the following contacts: The Director, Office of Research Ethics, ……………or email ……………….. or the ………….., email ……………

Publication
The findings from this study will be written in a report and will be presented at conferences and disseminated in professional journals, but with no identifying information. If you wish to receive a summary of the findings, please contact me by email with the request, and I will provide you with a summary document.

This letter is for you to keep.

Best regards,

………………………………….., RN, PhD Candidate
Arthur Labatt Family School of Nursing
Western University, London, Ontario, Canada
………………………………….

Appendix H: Consents Forms

Consent Form-Individual Interview

Values, Assumptions, Behaviours, and Practices Influencing the Professional Development of Nursing Students Within Acute Care Practice Environments in Rwanda: A Focused Ethnographic Study

This form is part of the process of informed consent that you have to sign as a validation that you are voluntarily participating in this study. A copy will be left with you for your records and future reference. Please feel free to ask any question related to this study, should you like more details.

Please take time to read again the study letter of information, and feel free to ask for clarification of any words you do not understand clearly, and ensure that all your remaining questions have been answered with satisfaction before signing the consent form.

I have read and understood the study letter of information, and I have had the nature of this study explained to me. I agree to participate in this study. All questions have been answered to my satisfaction.

This copy is yours to keep for record and future reference.

Do you agree with the audio-recording of your discussion? (Please check the box that applies)

[ ] Yes
[ ] No

Name of research participant (Please print)

_____

Signature of research participant   Date

_____   _____

Name of person obtaining consent (Please Print)

_____

Signature of person obtaining consent   Date

_____   _____

Consent Form-Observation

Values, Assumptions, Behaviours, and Practices Influencing the Professional Development of Nursing Students Within Acute Care Practice Environments in Rwanda: A Focused Ethnographic Study

This form is part of the process of informed consent that you have to sign as a validation that you are voluntarily participating in this study. A copy will be left with you for your records and future reference. Please feel free to ask any question related to this study, should you like more details.

Please take time to read again the study letter of information, and feel free to ask for clarification of any words you do not understand clearly, and ensure that all your remaining questions have been answered with satisfaction before signing the consent form.

I have read and understood the study letter of information, and I have had the nature of this study explained to me. I agree to participate in this study. All questions have been answered to my satisfaction.

This copy is for you to keep.

Do you agree to be observed during your interactions with students (for clinical teachers/nurses), or with your clinical teachers/ nurses (for students) discussion? (Please check the box that applies)

     [ ] Yes
     [ ] No

Name of research participant (Please print)

_____

Signature of research participant   Date

_____   _____

Name of person obtaining consent (Please Print)

_____

Signature of person obtaining consent   Date

_____   _____

Curriculum Vitae

Name:	Umubyeyi Benoite

Post-secondary education and degrees:

1998-2000: Kigali Health Institute, Rwanda
Advanced Diploma (Mental Health Nursing)

2004-2006: University of KwaZulu-Natal, South Africa
Bachelor of Nursing Honours (Mental Health)

2009-2010: University of KwaZulu-Natal, South Africa
M.Sc.N. (Mental Health Nursing)

2013-2020: Western University, Canada
PhD (Nursing)

Awards: Canadian Trillium Scholarship for academic achievement
2013-2017

Africa Institute Graduate Student Research Fund
2020

Work experience: 2006-2009: Head of Department (Mental Health)
Kigali Health Institute

2012-present: Lecturer, School of Nursing and Midwifery
University of Rwanda

Selected Publications:

Umubyeyi, B. (2010). Depression among people living with HIV/AIDS in a Primary Health Centre in Kigali: *WHO bulletin* info in Rwanda, No 40 of September 2010.

Hynie, M., **Umubyeyi, B.,** Gasanganwa, M.C., Bohr, Y., McGrath, S. & Umuziga, P. (with B. Mukarusanga). (2015). Community resilience and community interventions for post-natal depression: Reflecting on maternal mental health in Rwanda. In Khanlou N. & Pilkington B. (Editors). Women's mental health: Resistance and resilience in community and society. (pp 343-356). Advances in Mental Health and Addiction (Series Editor: Masood Zangeneh). New York: Springer.

Binagwaho, A., Kyamanywa, P., Farmer, P.E., Nuthulaganti, T**., Umubyeyi, B.,**
Nyemazi, P.,…, Goosby, E. (2013). The human resources for health program in
Rwanda. A new partnership. The *New England Journal of Medicine, 369*(21),
2054–2059. https://doi.org/10.1056/nejmsr1302176.