ORIGINAL RESEARCH

# Clinical experiences of RN to BScN nursing students in Kenyan universities

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**Received:** September 7, 2023 **Accepted:** December 15, 2023 **Online Published:** March 13, 2024
**DOI:** 10.5430/jnep.v14n5p39 **URL:** https://doi.org/10.5430/jnep.v14n5p39

## ABSTRACT

**Introduction and objective:** Clinical learning environments play a great role in nursing training as they allow nursing students to develop their clinical skills by combining cognitive, psychomotor and affective skills. Consequently, clinical learning environments enable nursing students to bridge the theory-practice gap. Fewer studies have examined the clinical experiences of RN to BScN students in Kenya. This paper is part of analytical memo of a larger PhD study that sought to explore and describe the support needs of RN to BScN students in Kenyan universities. The paper focuses on clinical experiences of RN to BScN students.

**Methods:** Using a qualitative phenomenological approach, ten focus group discussions were conducted with 100 RN to BScN students, purposively sampled from four universities in Kenya. Data were analyzed using Tesch's data analysis protocol. The article has adhered to Consolidated criteria for reporting qualitative studies.

**Results:** The data on RN to BScN students' clinical experience revealed two themes: curriculum challenges and practice environment and six sub-themes: redundant learning outcomes, redundant clinical assessments, not acknowledging prior learning, lack of clinical supervision, lack of learning resources and "an extra pair of hands".

**Conclusions:** The study findings highlight the need for review of clinical learning outcomes for the RN to BScN students in Kenya. The findings emphasize the need for collaborative partnerships between universities, clinical learning environments, nurse educators, and policy makers, to design of clinical learning outcomes relevant to RN to BScN students in Kenya.

**Key Words:** Clinical learning environment, Clinical learning, Nursing education, Clinical placement, Part-time RN to BScN students, Collaborative practice

## 1. INTRODUCTION

Clinical learning environments play a great role in nursing training as they allow nursing students to develop their clinical skills by combining cognitive, psychomotor and affective skills.[1] Additionally, clinical learning environments enable nursing students to bridge the theory-practice gap by providing an opportunity for students to develop their psychomotor skills.[2] Clinical learning environments are interactive network of forces within the clinical settings that influence learning outcomes and have an impact on student behaviours.[3,4] These forces include staff, patients, preceptors, nurse educators and other health providers.[3,5] Flott and Linden (2015) analysed the concept of clinical learning environment and discovered four aspects of clinical learning experience that affect students' learning experiences. These aspects are physical space, psychosocial and interaction factors, organizational culture and the teaching and learning component.[6]

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**Background**

Studies conducted in developed countries have shown that a bachelor's level RN training is associated with positive patient outcomes.[7,8] Prompted by compelling evidence, the Institute of Medicine, in 2001, recommended that 80% of the RN workforce should be bachelor prepared, or should be higher by the year 2020.[8] Similarly, in 2001, the World Health Assembly (WHA) passed Resolution WHA54.12, validating WHO's commitment to the scaling-up of health professionals. This resolution specifically urged member states to give urgent attention to ways of improving nursing and midwifery in their respective countries.[9]

Nursing training in Kenya is offered at certificate level, diploma level, and bachelor's degree level. Bachelor's and diploma programs produce registered nurses, whereas certificate programs produce enrolled nurses.[10] Certificate level training takes two years, diploma level training takes three and a half years, and bachelor's level training takes four years. In 2010, the Nursing Council of Kenya, in partnership with Kenyan universities, developed a post RN Bachelor of Science in Nursing (BScN) programme to scale up nurses' and midwives' training to be in line with the implementation of Resolutions WHA54.12.[11] This programme is offered for two and a half years and on a part-time basis, thus allowing nurses to upgrade whilst still retaining employment and income. It focusses on nurses who hold a diploma in nursing or midwifery, and who have worked for at least two years in a clinical setting. The RN to BScN programme is designed with blocks of weeks for theoretical learning and blocks of weeks for clinical learning.

Evidence shows that clinical experience is vital in assisting nursing students to integrate theoretical components of the curriculum with the practical aspects of the nursing profession.[4] Effective clinical experience familiarizes nursing students with clinical judgement and decision making, stimulates critical thinking and challenges students to recognize the consequence of their mistakes.[2,12] However, not all clinical settings are conducive to students' learning outcomes or contribute to the development of their competencies.[4] Studies on clinical learning of nursing students have identified poor interpersonal relationships with clinical staff and preceptors as barriers to clinical learning within the clinical setting.[5,13] Furthermore, the quality of clinical learning is a reflection of the quality of the curriculum structure.[4]

Clinical nursing education is an essential and integral part of any nursing education programme.[14] This is no different in RN to BSN programmes. The clinical nursing education literature emphasises students' sense of belonging as a prerequisite for their learning in a clinical setting.[15] This assertion needs to be interrogated further in RN to BSN programmes where RN to BSN students are registered nurses with a wealth of clinical experience. Clinical experiences of RN to BSN students in Kenya have not been studied widely, with most local data focusing on pre-registration BScN students. Despite there being mechanisms for students to evaluate the clinical sites, it is evident that the feedback provided is not acted on, as consecutive students' cohorts complain of the same challenges in the clinical learning environments. Little is known about the suitability of most clinical environments in Kenya. These findings are part of a larger PhD study, whose purpose was to explore and describe the support needs of RN to BScN students in Kenya and to develop guidelines for enhanced student support strategies. One of the objectives of the PhD study was to describe the support needs for RN to BScN students in theoretical and clinical learning. This paper focuses on the findings that emerged as clinical experiences of RN to BScN students in Kenyan universities.

## 2. METHODS

### 2.1 Study design and setting

A qualitative phenomenological approach was used for the PhD study that was conducted in four Kenyan universities; two private and two public. Two of the universities are situated in an urban setting and the other two universities are situated in a rural setting.

### 2.2 Sampling technique and sample

Purposive sampling technique was utilised to sample the four universities. Convenient sampling was used to sample the participants. After permission to conduct the study was provided by the four universities, the researcher visited the institutions to recruit the RN to BScN students while they were in their theoretical class sessions. The purpose of the study was explained to the students, and they were provided with the researcher's telephone number for follow-up. Over four hundred RN to BScN students were invited to participate in the study. On follow up, 156 students indicated their willingness to participate in the focus group discussions. However, only a hundred students consented to participate in the study. The sample was drawn from first, second and third-year students. Their age ranged from 24 to 46 years, and their years of nursing practice ranged from three years to 20 years.

### 2.3 Data collection

Focus group discussions were held in the four universities using a semi-structured interview guide. Ten focus groups were held, each comprising 8-12 students. The focus group discussions lasted between 30 to 90 minutes. The discussions

were carried out until there was data saturation. All interviews were conducted in English and audio recorded. Data was collected by the first author. There was the presence of a notetaker who took notes during focus group discussions. The researcher spent at least a month in each university. Within the course of the month, permission to collect data was sought, participants recruitment was done and focus group discussions were carried out. This allowed the researcher to build trust with the participants and became conversant with the context.

### 2.4 Ethical considerations

Ethical approval was obtained from the four universities and the country research council. All participants provided written informed consent. Data was protected according to confidentiality and data protection policy of the concerned universities.

### 2.5 Data analysis

Data from focus group discussions was transcribed verbatim and checked for accuracy by the first author. The narratives were printed out and coded manually by two members of the team (first and third authors). Initial open codes were identified, and later copied into Nvivo version 9. Data were analyzed using Tesch's data analysis protocol[16] to develop themes and sub-themes.

### 2.6 Reflexivity

The first author is a nurse educator teaching RN to BScN students. In her role as a nurse educator, she is expected to provide academic support to RN to BScN students. She came across some of her previous students in the process of data collection. The researcher was cognizant of her role as an educator and the likelihood of power imbalance between her and RN to BScN students. The participants were assured that the researcher was carrying out the study as a doctoral student and not as their educator. They were urged to view the researcher as a student and not an educator. The researcher assured the participants of the confidentiality of the information provided. The presence of a note-taker during focus group discussions created a more relaxed environment as she was perceived as a neutral participant. The researcher recognized that as an educator, she could influence the way participants answered questions by providing unintentional verbal cues or asking leading questions. To counter this, the researcher started the focus group discussion with a broad grand tour question and used broad questions to probe. Participants were given the freedom to discuss among themselves and interject with each other conversations in a respectful way. The researcher interjected the discussion when posing a probing question or when clarifying a statement.

### 2.7 Rigor

The criteria of credibility, dependability and confirmability was used to ensure rigor throughout all stages of the research process. Credibility was maintained by collecting data among RN to BScN who were living the phenomenon of interest. All focus group discussions were audio recorded and checked for accuracy. Data was coded by two members of the research team and peer debriefing.[17] Field notes were used to provide a deeper understanding of the focus group discussions. Dependability was maintained by writing memos and an audit trail. Confirmability was maintained by having the data coded by two members of the research team, who later met to agree on the identified codes.[18] This process was carried out in all of the ten focus group discussions.

## 3. RESULTS

### 3.1 Participants demographics and characteristics

A hundred students consented to participate in the study, 28 from public universities and 72 from private universities. Their age ranged from 24 to 46 years, and their years of nursing practice ranged from three years to 20 years. All participants worked in hospital settings, which included government hospitals, private hospitals, and faith-based hospitals. Most of the participants worked in government hospitals, in rural settings and in acute care. They worked across all units in the hospitals; medical surgical units, peadiatric units, critical care units, oncology units, renal units, maternity units, neonatal units, outpatient units and theatre settings.

### 3.2 Themes and sub-themes

RN to BScN students' clinical experiences were related to curriculum and practice environment challenges. Data revealed two themes and six sub-themes (see Table 1).

**Table 1.** Themes

| Themes | Sub-themes |
|---|---|
| Curriculum challenges | Redundant learning outcomes |
| | Redundant clinical assessments |
| | Not acknowledging prior learning |
| Practice environment | Lack of clinical supervision |
| | Lack of learning resources |
| | "An extra pair of hands" |

#### 3.2.1 *Curriculum challenges*

Data revealed that the curriculum used to train part-time BScN students was redundant. The curriculum failed to acknowledge prior learning and there was repetition of content that was covered in the diploma training. This redundancy was evident in both theoretical content and clinical objectives. Clinical nursing assessments were similar to those carried

out in the diploma nursing training. This theme has three sub-themes: redundant learning outcomes, redundant clinical assessments, and not acknowledging prior learning.

**1) Redundant learning outcomes**

RN to BScN students stated that the clinical objectives that they were provided with at this level of training were similar to the ones they had received during their diploma training.

*These things we did them in Diploma, in Certificate level, but we are taken through the same, same things. So, if they can waive some things from the curriculum, I think it can be much, much better than this repetition we are doing. . .*

Therefore, some participants felt that there was no need to have clinical placements, yet this was a requirement for all BScN students.

*. . . for me what I can say everybody has a license, he or she passed through diploma college, they did the same things (clinical experiences), we are repeating the same thing, so we don't. . . I think there is no need for clinical placements.*

**2) Redundant clinical assessments**

RN to BScN students felt that clinical experience was important as they are likely to be out of touch with skills in certain areas that they do not practice in. They were expected to rotate in the same clinical experiences they had in diploma training. Therefore, clinical assessments that they were expected to undertake were also similar to the ones they had undertaken during their diploma training.

*I really support clinical placements. . . . some skills you have forgotten, so it would be nice to relearn those skills.*

The participants recommended that if there was need to retain similar clinical assessments as those being utilized at diploma training, it was necessary to use different assessment methods.

*So, if they are going to retain the same assessments, at least they should design it in a manner to show there is a difference between a Diploma and a BScN.*

**3) Not acknowledging prior learning**

The participants expressed concern that the RN to BScN programme had clinical learning outcomes that were similar to those of pre-registration students. It was clear that the curriculum failed to acknowledge the prior learning that RN to BScN students brought into the programme, since they were registered and practicing nurses.

*It's like you are very green in whatever you are doing. Let's say for example if it's a clinical assessment of a mother in labor, you know we did it in our Diploma course, so when we come to repeat it, they take as in we are green, it's like you know nothing.*

As a result of curriculum issues, RN to BScN students indicated that they did not benefit from clinical placements, and that they only went to the clinical settings to have their assessments done.

*Most of us we have experience and then when we go there in fact, we are not even interested in learning, you are interested to do assessment and go away so they should waive such kind of assessments.*

### 3.2.2 *Practice environment*

RN to BScN students are allowed to undertake clinical learning at their places of work or nearby health facilities. The clinical learning is supposed to be supervised by preceptors in the clinical settings and their nursing faculty. The majority of participants worked in public health facilities, and therefore, undertook their clinical practice in those facilities. Government health facilities in Kenya experience shortage of workforce and medical supplies. This theme has three sub-themes: lack of clinical supervision, lack of learning resources and "an extra pair of hands".

**1) Lack of clinical supervision**

Clinical learning facilities where part-time BScN students were allocated for clinical assessments were greatly understaffed. Therefore, RN to BScN students were seen as part of the workforce to cover the nursing shortage instead of being seen as students who needed to acquire specific skills. Clinical learning settings failed to provide clinical supervision to RN to BScN students as there were no preceptors available to supervise students' learning. Therefore, RN to BScN students felt that learning did not take place.

*In terms of quality that we should get when we go to the governmental facilities, they don't have the right manpower, they don't have the right clinical instructors. Instead of us learning from the clinical instructors, they find us to be more resourceful to them. In other words, we are not learning anything from them.*

Lack of clinical supervision in clinical settings was compounded by the RNs' negative attitude towards the BScN programme. The participants stated they were mocked by their fellow colleagues and other registered nurses as wasting their time in pursuing a bachelor's programme.

*. . . to us it's actually a challenge, repeating the same things that you do on daily basis. . . . at the end of the day there's no need of you coming back to school and you go back with no difference. They need to see a difference in us such that it will empower other nurses to come back to school.*

**2) Lack of learning resources**

The universities utilized both private and public health institutions as clinical placement settings for RN to BScN students. Government hospitals lacked essential supplies to facilitate students' learning, despite the fact that part-time BScN students had to pay for clinical learning facilities in order to utilize them for learning. The participants reported that the lack of resources to facilitate learning in government clinical settings, made clinical learning difficult.

*The only problem with clinical placement is the resources they are allocating us when we are in those clinical areas. We are going to a government hospital where the resources are limited.*

Hospitals in Kenya demand payment for providing clinical learning for nursing students. Universities pass this cost to students who are required to pay for clinical placements even though they had already paid tuition fees. They wondered why the money they had paid to the hospitals for clinical placements was not used to buy resources in government hospitals that were being utilized for clinical placements.

*We are paying a lot of money reason being most of that money should even be put on those clinical areas so that if there isn't some resources they could just buy for our sake so that we can practice with them and we come out as better students.*

**3) "An extra pair of hands"**

Registered nurses in clinical settings considered RN to BScN students as an "extra pair of hands" to cover nursing staff shortages. In some instances, RN to BScN students were left alone in the wards to continue providing nursing care, whilst registered nurses went out of the wards to attend to personal issues.

*But now the staffs whom we were interacting with kind of are not friendly, they saw us as manpower but not students, yes and that was the conflict.*

*When these people see you working, they see an extra pair of hands. In fact they can even leave you there to manage the ward for them.*

## 4. DISCUSSION

Clinical learning in nursing takes place in complex healthcare settings.[19] Nursing students' experiences within the clinical settings is of great importance to how students learn and what they learn.[19] This article aims to discuss clinical experiences of RN to BScN students. The clinical experiences of RN to BScN students' Kenyan universities were characterized by curriculum challenges and practice environment challenges. The curricula failed to acknowledge prior learning, which resulted in redundant clinical learning outcomes and redundant clinical assessments. These findings are consistent with the findings of other studies that have shown that curriculum inadequacies have contributed to the gap between theory and practice in nursing education.[15,20,21] Jayasekara et al. (2018) stated that for effective clinical learning to be achieved, there is a need for collaboration between academic and health care organizations in order to successfully deliver the intended learning outcomes. Similarly, there is a need for curriculum change.[22] Salifu et al. (2019) found that challenges with curriculum implementation too contributed to poor clinical learning.

Curriculum redesign is vital since mature and working students need to see that their education realities reflect their working realities.[23–25] They need to be able to translate knowledge acquired in their studies to their work environment.[24,25] Most participants acknowledged that they were undertaking the RN to BScN programme to acquire a degree certificate, but they did not feel they have learnt new concepts. Regular review of the RN to BScN curriculum is essential to level learning with rapidly evolving nursing practice.[26] A review of nursing education in Sub-Saharan Africa indicated the need for curricula reforms to produce graduates that can meet the needs of the population.[1]

The findings of this study revealed challenges experienced by RN to BScN students while in clinical learning sites. RN to BScN students lacked clinical supervision and resources for clinical learning. They were also viewed as workforce to make up for nursing shortages in clinical learning environments. Consequently, RN to BScN students received minimal clinical support from nurse educators and clinical preceptors. These findings are similar to the findings of a study undertaken at a university in The University of the Western Cape, South Africa involving full-time BScN students[27] Similar findings were observed in Finland where students reported a lack of clinical instruction and a feeling of being abandoned in clinical learning settings.[28] Furthermore, participants reported a negative attitude towards RNs who were upgrading to a baccalaureate degree. This was in line with the findings of Asiimwe et al. (2019) who reported that nurses experienced a lack of support from other colleagues who perceived BSN learning as not applicable to the RN clinical role. The way activities are planned in the clinical learning environment has been shown to affect clinical learning.[29] Salifu et al. (2018) found that where clinical activities were routine, ritualistic and monotonous, students became uninterested and apathetic in clinical learning.

Similar findings were demonstrated in a Kenyan study that evaluated the clinical learning of pre-registration BScN stu-

dents.[30] In the Kenyan study, pre-registration BScN students expressed dissatisfaction with their training with respect to the unavailability of faculty members during clinical practice and the inadequacy of clinical supervision.[30] On the other hand, a study that assessed the level of satisfaction with the clinical learning environment among nursing and midwifery students at the University of Rwanda[31] revealed that the majority of nursing students (94%) were satisfied with the clinical supervision in the clinical learning environment. Similar findings were found in a Ghanaian study that examined the clinical placement experiences of undergraduate students in select teaching hospitals.[32] The findings of the Ghanaian study revealed that undergraduate nursing students were not being supervised and were learning wrong nursing practices from registered nurses.[32] Lack of clinical supervision has been identified in other countries beyond Africa, also in disciplines other than nursing.[21,29,33] An Australian study investigating clinical supervision in the disciplines of medicine, physiotherapy, nutrition and dietetics, science and occupational therapy from two large health districts in New South Wales, revealed that a lack of clinical supervision was common among all the disciplines.[34] A study conducted in Spain which examined nursing students' satisfaction with their clinical learning environment and supervision found that the students were least satisfied with the supervisory role of the nurse educators.[35] However, in the USA nursing students who were attached to magnet hospitals were generally satisfied with the learning environment in those hospitals.[35]

## 5. Conclusions

These findings highlight the need to review curriculum for RN to BScN program to acknowledge prior learning. Consequently, there will be review of clinical learning outcomes and clinical assessments for RN to BScN students in Kenyan universities. There is also a need for universities to audit clinical learning environments for their suitability to support clinical learning of RN to BScN students.

### Relevance to clinical practice

The study findings provide an important evidence base for transforming clinical teaching through involving relevant partners from practice, nursing regulators and policy makers to ensure students achieve their competencies and to also ensure excellence in nursing.

## Acknowledgements

The researchers would like to acknowledge all study participants who willingly participated in the study.

## Authors contributions

Dr. Gladys Mbuthia and Prof. Gisela Van Rensburg were responsible for study design and revising. Dr. Gladys Mbuthia was responsible for data collection. Prof. Sheila Shaibu and Dr. Gladys Mbuthia analysed the data and drafted the manuscript and Prof. Gisela Van Rensburg revised it. All authors read and approved the final manuscript.

## Funding

The study was fuded by Aga Khan University Research Council.

## Conflicts of Interest Disclosure

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## Informed consent

Obtained.

## Ethics approval

The Publication Ethics Committee of the Sciedu Press. The journal's policies adhere to the Core Practices established by the Committee on Publication Ethics (COPE).

## Provenance and peer review

Not commissioned; externally double-blind peer reviewed.

## Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

## Data sharing statement

No additional data are available.

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