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**Developing Effective Strategies
for Nursing Care:
The learning process of Thai undergraduate
nursing students**

**A thesis presented in fulfilment of the requirements for the degree of
Doctor of Philosophy
in
Nursing**

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ABSTRACT

Developing Effective Strategies for Nursing Care: The learning process of Thai undergraduate nursing students

The low average pass percentages in the Thai licence test of newly graduating nurses from the nursing college programmes has been recognised as a critical problem in Thailand for a significant period of time. There are many studies about conditions and strategies to improve the student nurses' competence. However, which teaching and learning strategies should be used, and when they should be applied in the process of learning had not been fully investigated. In this study, a grounded theory approach was used to explore the learning process of nursing students developing their nursing skills to become professional nurses. Thirty-two nursing students were interviewed individually about their learning in clinical situations. The main early emerging category in the study was **continuing practical studies**, which was based on two sub-categories: namely *attending to procedure training*, and *seeking case problems and how to provide nursing care*. The second main category, **learning how to provide nursing care**, emerged later, and supplied another two sub-categories: *modifying strategies for case learning*, and *discovering how to understand case conditions*. The main findings were that having enough learning opportunities and *willing supervision* develops the nursing students' self-confidence in practising and their learning motivation. Feelings of worry and fear, a sense of professional responsibility and *supervisors' expectations* are important influences that motivate nursing skill development of the participants. The ability of some students to transition from learning in order to meet *supervisors' expectations* to an internal *desire to learn* marked those students as successful adult learners who demonstrated critical thinking skills and the ability to integrate theoretical knowledge into the care planning for their patients. These students were able to transfer their knowledge to other nursing care situations, to develop effective strategies for nursing care and to pass the external registration exams. The findings from this study could be used to guide nursing instructors about how to enable the students to successfully integrate theory into clinical practice.

Keywords: undergraduate nursing students, learning process, learning motivation, Thai nursing education, grounded theory, teaching and learning strategies, learning environment, clinical supervision

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GLOSSARY: THE THAI COLLEGE PROGRAMMES

‘Adult’ is the previous paper name of the practical papers, Nursing care of Persons with Health Problems.

‘BCPN’: Basic Concepts and Principles in Nursing (the previous paper name of Principles and Techniques in Nursing)

B.E. means Buddhist Era. Some time periods are recorded in this thesis as ‘Buddhist Era’; in Thailand, the use of the Buddhist calendar remains a common practice.

Case learning means the understandings of the students about their assigned patients’ problems and how to care for them.

Content conferences are undertaken, normally once a month, by nursing care teams in each setting for nursing care activities of selected clients and their families. While placed in particular settings, the students have to join this conference. However, this frequency does not meet the requirement of the colleges. Therefore, students in two sub-groups of three to four are required to discuss one interesting case in every setting in the presence of an instructor, other students in the same group, and the participation of staff nurses, especially their preceptor if possible.

GPA: Grade point average is an internationally recognised calculation used to find the average result of all grades achieved for a given course. The GPA is usually calculated by dividing the total amount of grade points earned by the total amount of credit hours attempted. The grade point average may range from 0.0 to a 4.0.

‘Persons with Health Problems’ is the name of a group of practical papers that include Nursing Care of Persons with Health Problems Practicum I, II, and III.

Praboromarajchanok Institute for Health Workforce Development (PBRI) is administered under the Permanent Secretary's office at the Ministry of Public Health, Thailand.

Supervisors are instructors, preceptors, and qualified nurses or public health providers who supervised the students during their practical studies.

The 11 patterns of Gordon means Gordon's Functional Health Patterns. It is a method developed by Marjorie Gordon in 1987 to be used as a guide for nurses to establish a comprehensive nursing assessment of patients (Somantri, 2011).

The nurses are nursing staff who might or might not be qualified; they worked on the same shifts as the students, but often did not like to work with or teach students or were too busy to do this.

GLOSSARY: MEDICAL TERMS

A **Bird respirator** is a respiratory device using oxygen that was developed for breathing assistance.

Ammonia is a toxic substance that can form in the body when protein is broken down by bacteria in the intestines. Normally, the liver converts ammonia into urea, which is then eliminated in urine (Alchemistlab, 2012; WebMD: Digestive Disorders Health Center, 2011)

Crepitation is a soft fine crackling lung sound like that made by rubbing hair between the fingers close to the ear. It is caused by a build-up of fluid that associated with different medical conditions.

DM: Diabetes Mellitus

Extern is a medical student who is studying in the final year of study (6th year). An extern can treat patients under supervision of experienced physicians or medical instructors.

IICP: Increased Intra Cranial Pressure

Intern is a graduate medical student who is registered as licence physician and is working in the first year of internship, a period of time for working as physician in order to learn particular skills needed in medical field.

I/O: Intake/Output

“O” means objective data

PCU: Primary Care Unit

Radivac drain is one type of surgical closed drain. It is attached to an evacuated glass bottle providing suction used to drain blood beneath the skin or from deep spaces.

“S” means subjective data

SGOT: Serum Glutamic Oxaloacetic Transaminase means an enzyme that is normally present in liver and heart cells. SGOT is released into blood when the liver or heart is damaged. This means that if the blood SGOT levels are elevated, these organs are damaged (MedicineNet.com, 2013).

V/S: Vital Signs

WBC: White Blood Cells

GLOSSARY: THAI WORDS

Jubpid means to find faults.

Kamlang jai means will or willpower.

Khang means to be left unfinished or to remain stuck.

Krengjai means to be considerate.

Ku means I, me (personal pronouns).

Prachot means to be sarcastic.

Tea means to put on airs.

Thiphung means a supporter.

Ti means to hit.

Tumjai means to restrain one's mind.

Wai means paying respect by bringing the hands together to the face.

Xunci means to feel encouraged, to feel relieved.

INTRODUCTION AND BACKGROUND TO THE STUDY

INTRODUCTION

In this study, a Straussian grounded theory methodology was used to explore the learning process of Thai undergraduate nursing students in developing nursing skills to become professional nurses. At the outset of this study, most of the Thai nursing colleges affiliated to the Praboromarajchanok Institute for Health Workforce Development (PBRI)¹ were not succeeding in teaching and learning management as measured by the low pass rates in the first licence tests of students graduating from the Colleges. This situation was recognised as a critical problem as the pass rates had been low for nearly a decade. During the period 2002-2010, none of the Colleges met the Thailand Nursing and Midwifery Council accreditation criterion of a 70% pass rate averaged retrospectively over three years, and 16 of the 29 Colleges had obtained no more than a 50% pass rate. In the setting, throughout the period, the average pass rate ranged from 31 to 59% (Thailand Nursing and Midwifery Council, 2010a). This situation raised a critical question as to why the students could not integrate theoretical knowledge into clinical nursing care, on which the majority of licence test items were focused (Thailand Nursing and Midwifery Council, 2010b).

Previous Thai studies identified differing strategies that PBRI instructors have used to facilitate successful student learning (Krikgulthorn, Prasertpol, Jungthanajarenlud, & Pongsukchat, 2003; Lounekaew, Siripan, & Kongsuwan, 2004; Paenkaew, Sungkachat, Nontaphut, & Wanvilai, 2002). Other studies explored techniques students used to solve their own learning problems (Ariyanon, Krongrawa, & Leesuwan, 2008; Bintaprasit, 2003; Thepworachai, Saratawanpad, & Meeboon, 2008). Most of these studies, however, used quantitative research methods, and none investigated the students'

¹ Praboromarajchanok Institute for Health Workforce Development (PBRI) is administered under the Permanent Secretary's office at the Ministry of Public Health, Thailand.

perspectives on learning in the clinical context. That is, how the students develop their learning experience in the process of caring for patients in the wards and community settings.

It could be argued that addressing this broad research topic may contribute to an understanding of what underpins the low pass rates in the external registration exams. This gap can best be addressed by an inductive research approach to obtain an in-depth understanding for new knowledge generation. A grounded theory design, therefore, fits this study (Strauss & Corbin, 1998).

To understand how the students learn to develop their nursing knowledge and skills in clinical practice, it is necessary to understand the broader context within which the nursing programmes and this study take place. In the following sections, information that provides the background to the study is presented, the research question is determined and the significance of the study is also identified. The chapter ends with an outline of the structure of the thesis and a brief summary of each chapter.

BACKGROUND TO THE STUDY

This section includes the history of the nursing shortage in Thailand, an overview of nursing education in Thailand, especially within the Thai college programmes, and information about *The Professional Nurse Graduate Increment Project for Southern Border Problem Solution* initiated by the Ministry of Public Health to address the nursing shortage in provinces near the southern border with Malaysia. In addition, information about Thai traditional culture that affects nursing student learning is provided. All of these factors impact on the learning experiences of student nurses in the context of this study.

THE NURSING SHORTAGE IN THAILAND

In Thailand, a nursing shortage over the past 40 years has been a chronic problem for the health system (Boontong, 2008, September; Sawaengdee, 2008). Although this serious situation was addressed through an urgent policy of increasing the nursing workforce for nearly two decades (1977-1996), this intervention has still been insufficient for the needs of the country (Sawaengdee, 2008). For a significant time

period, limited attention has been paid to nursing workforce planning (Boontong, 2008, September), and this has had consequences. For instance, in the last decade, despite the increasing demand, Thai government policy led to a decrease in the number of trained nurses by more than 40% over a five year period, from 1999 to 2005 (Sawaengdee, 2008). Furthermore, because of the economic crisis that developed in Thailand in 1997, scholarships for nursing students, which provided financial support for their study and eligibility to be government officers when graduating students successfully passed the licence tests, were discontinued (National Health Commission Office, 2011). New graduate nurses working in government hospitals are thus employees with less security of employment than government officers (National Health Commission Office, 2011; Sawaengdee, 2011). In addition, nursing is perceived as hard work with relatively low income, when compared to its responsibilities and vulnerability to diseases and other illnesses. These two factors mitigate against young people with high academic achievement choosing nursing as a profession in Thailand (Sawaengdee, 2009).

Moreover, political unrest in the southern border provinces since 2004 has led to a sizeable increase in patients with conflict injuries and a corresponding rise in the nursing workload. Many nurses have tried to leave the border provinces due to the difficult situation (Hasuwanakitt, 2005). Simultaneously, the entire Thai health system has been facing an increasing number of challenging factors. Increased needs for nursing care have arisen from socio-demographic changes, such as increased numbers of elderly people, the changing patterns of illness into crisis and complex status, and chronic diseases. In addition, health assurance policies arising from health system reform, health care service export policies resulting in increasing numbers of private health care units, and an increasing nursing loss rate have all impacted on the availability of nurses for the public health sector (Jindawatthana, 2007; Sawaengdee, 2008). This has been compounded by an imbalanced distribution of human health resources, and lack of linkage between health workforce planning and production of qualified nurses.

All of the influences outlined above have led to a chronic and complex problem of nursing shortage (Jindawatthana, 2007; Sawaengdee, 2008, 2009). In 2010, the country had a nursing shortage of approximately 43,250 nurses. Of this number, the identified shortage for the Ministry of Public Health was 31,250 nurses (Srisupun & Sawaengdee,

2012). The ratio of nurses to the population in 2011 was 1:498 (Ministry of Public Health, 2013), in comparison with the ratio in Asian countries such as Singapore and Malaysia (1:250 and 1:300, respectively), and in developed countries of 1:200 (Witayasuporn, 2013). Moreover, the Mutual Recognition Arrangement (MRA) on nursing services of the ASEAN Economic Community (AEC) that will be enacted in 2015 allows nurses to work in any member country if they are qualified. This may increase the nursing shortage in Thailand as Thai nurses, especially experienced nurses from both nursing services and nursing education, take up opportunities to work in other countries; although some nurses from the neighbour countries will enter Thailand nursing services (Saenprasan, 2012; Witayasuporn, 2013). With an unknown number of nurses leaving before retirement, and retirement of more than 2,000 nurses per year in the next 10 years (Srisupun & Sawaengdee, 2012), Thailand is likely to encounter a serious nursing shortage in the near future.

The Ministry of Public Health has implemented a number of strategies over time to address the workforce shortage. These include increasing nursing workforce production, balancing the distribution of nurses (which is based on the principle of rural recruitment, local training, and hometown placement), and increasing undergraduate nursing staff and developing their competencies for caring for rural people. The Ministry also developed a broader public health infrastructure with increased numbers of community hospitals and primary health care units with equipment and vehicles and enacted the policy of signing a reimbursement contract² for nurses graduating from the government institutes to work in those units, as well as motivating them by raising fringe benefits and compensations (Jindawatthana, 2007).

As human health resource issues have become more difficult and complicated, the Thai government has again paid more attention to the nursing shortage. To work out integrated and sustainable solutions for the problem, the Ministry of Public Health appointed a committee to prepare the strategic plan of human health resources for the decade 2007 to 2016. A major strategy within this plan, which has dramatically affected the quality of nursing teaching and learning management, was the re-engineering of

² The contract that supports scholarships for nursing students during their course and bonds students to work in government health service units for two times the period of study.

health workforce production and development systems in order to balance the workforce distribution (Jindawatthana, 2007; Sawaengdee, 2008). A concrete example was the mega project: *Professional Nurse Graduate Increment Project for Southern Border Problem Solution* that was initiated in 2007. In this *Project*, 3,000 students from the southern border provinces were recruited in one drive and allocated to 26 of the 29 nursing colleges across Thailand. However this strategy led to new problems in the college nursing education system, management difficulties (Intongpan, Methanawin, & Jiamarmonrat, 2008), and low learning competency of students (Ariyanon et al., 2008) (this *Project* is discussed in more depth later in this chapter).

It remains necessary to offer a more complete overview of nursing education in Thailand, with particular attention to the Boromarajonani College of Nursing with its 29 colleges, because one of these colleges is the setting for this study.

NURSING EDUCATION IN THAILAND

By virtue of the Nursing and Midwifery Professional Acts, 2528 B.E.³ and amendments in 2540 B.E., persons who are entitled to be registered and licensed as a professional nurse (first class) under section 29 of the Act in Thailand will have received a bachelor degree or an equivalent certificate to the degree in nursing, midwifery, or nursing and midwifery from an institute authorised by the Thailand Nursing and Midwifery Council, both in Thailand and other countries. As well, they have to pass the licence test and other attributes as approved by the Council. The candidate who has been registered can gain the benefits of a professional nurse as stated in the Act (Thailand Nursing and Midwifery Council, 2007).

In accordance with the regulation of Thailand Nursing and Midwifery Council 2543 B.E., the licence test is held three times a year. The candidate who wishes to be licensed as a nursing and midwifery professional nurse has to pass eight subjects; to become a registered nurse, the regulations require seven related nursing subjects. To be registered as a midwifery professional, only three subjects are required (Thailand Nursing and Midwifery Council, 2008). Following the plan of human health resources, however, new graduates are normally asked to qualify as a nursing and midwifery professional

³ B.E. means Buddhist Era. Some time periods are recorded in this thesis as 'Buddhist Era'; in Thailand, the use of the Buddhist calendar remains a common practice.

nurse to meet the needs of the country's health system contexts which require generalists more than specialists (Jindawatthana, 2007). The passing score is 60% in every subject. Students failed a range of subjects, but those most commonly failed were Adult and Elderly Nursing, Community Health Nursing, and the group subject of Obstetrics, especially Midwifery Nursing (Thailand Nursing and Midwifery Council, 2014). The majority of licence test items are focused on clinical scenarios and require students to be able to integrate theoretical knowledge into clinical nursing care. According to the Thailand Nursing and Midwifery Council (2010b), it is those assessments that are commonly failed. If the candidates fail any subject they can re-sit the exam anytime the test is held (three times a year). Passes in subject(s) are valid for three years. After this period, applicants who have not passed all of the subjects will have to re-sit all exams (Thailand Nursing and Midwifery Council, 2008). Because of the nursing shortage, graduates who have not yet passed all subjects of the licence test are allowed to work as second class nurses, namely "technician nurses", under the control of professional nurses (first class) (Thailand Nursing and Midwifery Council, 2007).

Schools of nursing in Thailand are located within six institute groups. These are: the institutes under the higher education commission under the Ministry of Education; the nursing colleges affiliated to PBRI under the Ministry of Public Health; the institute under the Ministry of Defence; Royal Thai Police; Bangkok; and private nursing educational institutes. Presently, 79 nursing institutes have been approved by Thailand Nursing and Midwifery Council (Thailand Nursing and Midwifery Council, 2012a) to offer undergraduate degrees in Nursing. However, the major organisation that produces nurses for the country's health system is PBRI. Its missions have been operated by the affiliated nursing colleges over the country named "Boromarajonani College of Nursing" (Praboromarajchanok Institute, 2010b).

AN OVERVIEW OF NURSING EDUCATION IN THE THAI COLLEGE PROGRAMMES

PBRI has 37 affiliated colleges distributed over the country, which are altogether responsible for producing and developing the nursing and public health workforce according to the needs of the Ministry of Public Health. This organisation has authority to develop plans corresponding with the policies and human health resource needs of

the Ministry. As such, all of the programmes, both bachelor and lower degrees, emphasise building a community-oriented health workforce to support high standards of health services (Praboromarajchanok Institute, 2010b). The nursing college programmes operated by 29 nursing colleges, have approval to offer five courses: Bachelor of Nursing Science, Bachelor of Nursing Science (continuous), Bachelor of Nursing Science (equivalency transfer programme for public health officers), Diploma of Nursing (continuous), and Bachelor of Nursing Science (continuous special programme) (Thailand Nursing and Midwifery Council, 2012a). The missions of the PBRI also include producing and developing the health workforce, researching and developing knowledge, providing academic services to societies, and preserving cultures (Praboromarajchanok Institute, 2010b). As a result, the staff members of each affiliated college have to serve multiple roles according to those missions (Boromarajonani College of Nursing, 2012). This is not the only factor that influences nursing education administration in college programmes; the administration for the programmes has other related influences which together make their graduates with a unique character. The influences are summarised in the following five main areas.

Recruitment and students

The principle of recruitment of students for study in PBRI includes the distribution of educational opportunities for regional persons and ‘hometown’ placement to facilitate sustainable work. For instance, in the Bachelor of Nursing Science programme, which is a four-year course, prospective students are recruited from the candidates who have settled in the areas that have quotas for admission. Prospective students are eligible if they are 16-35 years old, no less than 150 cm tall, and have appropriate health attributes, (i.e. they do not have diseases or disabilities that do not fit with the job description), and they are studying or have graduated high school in a programme focusing on mathematics and sciences. Prospective students who need to enter by direct entry system (the quotas allowing for some number of them) have to gain a Grade Point Average (GPA)⁴ of no less than 2.00. Particularly, they have to gain a GPA in mathematics and sciences subjects of no less than 2.00. Those who enter by an admission system have to present the results of standardised occupational descriptor (O-

⁴ GPA: Grade point average is an internationally recognised calculation used to find the average result of all grades achieved for a given course. The GPA is usually calculated by dividing the total amount of grade points earned by the total amount of credit hours attempted. The grade point average may range from 0.0 to a 4.0.

NET) test, professional and academic aptitude (PAT2) test, and general aptitude (GAT) test with a GPA from a high school programme. In another programme, the two-year continuous courses, the students are recruited from candidates graduating in lower degrees. These courses have been developed for personnel who have been working in the health service units, who seek to progress in their professional development (Praboromarajchanok Institute, 2007, 2010a). However, recruitment is undertaken centrally and the size of the student intake each year is a significant element that individual colleges cannot control; this impacts on planning for course management. The intake size depends on the Ministry of Public Health policies which might feature new projects during that time (Glynara et al., 2008).

Curriculum and management

During their course, the nursing students who study in the Thai college programmes have to learn under an *integrated programme* and a particular *teaching and learning management*. The following information informs the readers about these.

Integrated programme

Because the five year National Economic and Social Development Plan of Thailand, especially volume seven (1992-1996) to nine (2002-2006), focused continuously on human resource development to meet the goal of sustainable development relevant to globalisation, as well as the health insurance policy that was initiated, public health personnel were required to meet these missions, both in the short and long period (Jiamboonsri, 2006). Moreover, in 1997, the Constitution of the Kingdom of Thailand proclaimed that the government had to improve the education system to meet the economic and social changes. This led the government to enact the National Education Act, 2542 B.E. for re-engineering the Thailand education system. Because of this Act, all educational institutes had to develop their teaching and learning management systems to achieve the goal of transforming learning. It meant that the management had to “centre on the learners” (Watanachai, 2002). For these reasons, as the main institute for the production and development of a health workforce who can respond to the health system needs of the country, PBRI had to be responsible for producing excellent health graduates and maintaining their quality throughout their work period, to be in accordance with the health care and educational systems. In 2002, therefore, PBRI

initiated an integrated programme to balance the content and teaching and learning process of its courses. The goal of this programme was to achieve the desirable characteristics that were required for newly graduated nurses. That is, they had to be knowledgeable and skilful in nursing, virtue, ethics, and lifelong learning, leading to an integration of nursing and other sciences for the advancement of their work. They were also to develop skills that would enable their clients to live self-reliant and competent lives with a high degree of well-being (Praboromarajchanok Institute, 2002).

After the integrated programme was initiated in 2002, it was continuously developed (Glynara et al., 2008; Sottipolanun, Chitthathairatt, & Chaisup, 2007; Thepworachai et al., 2008). Course evaluations have since identified a number of issues with the implementation of the integrated programme. For instance, while its contents are broad-based, some themes the students have to know are missing, others are redundant, and it has too many issues that have to be taught in the limited time. Moreover, instructor and student preparation for the programme has been limited. Most instructors have participated in teaching and learning plans (Sottipolanun et al., 2007), and have been supported to implement the programme at a moderate level; however, they still need more help to develop skills for integrated course teaching, especially the skills related to analysing and presentation of key points (Sirivedsunthorn & Methanawin, 2007).

Adoption of the integrated programme has led to restructuring of the working management of many colleges, such as breaking down the departments into subject integration groups to correspond with the teaching and learning of the programme. However, according to Glynara et al. (2008), some instructors continued their teaching as they have always done, teaching their students only that content within their area of expertise, resulting in lack of connection to other issues. Also, team teaching management which leads to integration among the subjects has rarely operated. The main reason for this situation is the lack of both the quality and quantity of instructors. Importantly, some content in the course does not correspond with the test blueprints of the licence tests. All of these problems have affected the integration of students' knowledge in the related content areas (Glynara et al., 2008). Most of the students could not adequately make use of the theoretical knowledge they had learned to diagnose their clients' problems and design the corresponding nursing care for them as indicated by the low pass rates in the first licence tests over nearly a decade for more than half of the

colleges affiliated to PBRI (Thailand Nursing and Midwifery Council, 2010a).

Overall, the course is viewed as appropriate to continue, but the implementation process needs to be improved (Glynara et al., 2008). It should also be noted that the integrated curriculum is difficult to implement where nursing colleges have large student numbers with lower learning competencies (Glynara et al., 2008; Sottipolanun et al., 2007). Normally, the courses of college nursing programmes have been modified every five years to ensure a responsive health care system of the country (Boromarajonani College of Nursing, 2011a). According to the national qualification framework for higher education B.E. 2552, available courses had to be modified to correspond to the framework by the 2012 academic year. Thus, the teaching and learning management of the new programme followed Rudkronkran's (2010) guidelines to achieve the required compliance.

Teaching and learning management

The Bachelor of Nursing Science (BNS) programme offers a four-year course. During the first three years, the students study three semesters per year (semesters one, two and a summer semester). In their fourth year, they end with semester two. The programme consists of 144 credits—31 from general education, 107 from pre-clinical nursing and the professional course, and six from an elective course. For the professional course, the students have to complete 51 theoretical credits and 28 practical credits. Clinical training starts in the second semester of the students' second year and this runs concurrently with theoretical sessions until the end of the course. In their third year, however, they are consecutively placed for a period of around seven months, for a half of their practical credits (14 credits); whereas the rest of their credits come from practice in the second and fourth years of their course. The students learn in the clinical environment under the direct guidance and supervision of instructors or nurse preceptors. In their final year, they have to practise in an elective field under the guidance of preceptors. Throughout the course, they are placed both in the regional hospital and outside settings—community hospitals and primary care units. While placed in outside settings, normally the students work with preceptors and/or staff nurses, and are sometimes visited by their instructors who liaise with those staff (Boromarajonani College of Nursing, 2009). However, because of limited clinical

settings, sometimes two groups of students are placed in the same settings, and some are placed in settings that do not match the order of the theoretical content of the subjects taught (Boromarajonani College of Nursing, 2010a).

For practical study placement in the bachelor degree, 60 hours of clinical practice equates to one credit (Praboromarajchanok Institute, 2009). Normally, students practise seven hours a day, and five days per week. This means students have to be placed for two weeks to complete one subject that holds one credit. Practical papers range from one to four credits, but students are placed into each setting depending on the related theoretical content integrated into the subject. This means they are rotated into several settings within a limited time period, with most placements being two weeks per setting. Before each placement, the students are provided with practical guidelines and orientation about how to complete the requirements. The co-ordinators of the papers also introduce them and what they have to experience to most of the head preceptors of the settings. Before starting practising each morning shift, the students have to observe their assigned cases in the evening of the day before that shift. The college allows them to complete this activity over two hours, from 3pm to 5pm. During practising, the students have to meet all requirements of the paper. Generally, they have to participate in pre and post conferences every shift as well as complete nursing care plans and content conferences⁵. How to complete all of these requirements is guided in the paper manual (Boromarajonani College of Nursing, 2010a).

Instructors

In the Bachelor of Nursing Science programme, the students mostly study theoretical sessions with their instructors, but there are also some invited lecturers, especially in those basic pre-clinical subjects such as mathematics, Thai and English languages, pharmacology, and microbiology (Boromarajonani College of Nursing, 2010a). Most instructors of the nursing colleges have graduated with a Master degree, but a proportion of qualified teachers do not meet Thailand Nursing and Midwifery Council

⁵ Content conferences are undertaken, normally once a month, by nursing care teams in each setting for nursing care activities of selected clients and their families. While placed in particular settings, the students have to join this conference. However, this frequency does not meet the requirement of the colleges. Therefore, students in two sub-groups of three to four are required to discuss one interesting case in every setting in the presence of an instructor, other students in the same group, and the participation of staff nurses, especially their preceptor if possible.

criteria; that is, the number with doctoral degrees is limited compared to those with master's degrees (Glynara et al., 2008). As a result of the impact of the government system (i.e. where control rests with government officials rather than each college), nursing colleges have had few opportunities for instructor selection. Sometimes, eligible persons want to work in the colleges, but they cannot move in because there are no vacant positions. Moreover, the incentives are rather low compared to the workload because the colleges are restricted to the disbursement expenditure of the Ministry of Finance. This means that instructors are only paid their usual salary, even if they are required to work overtime. As a consequence, people who are qualified may not choose to become instructors (Glynara et al., 2008). These conditions have led to a shortage of instructors. For instance, the ratio of instructors per students is less than the approved criteria at 1:10-1:11 whereas the limit is set at 1:6-1:8, especially during clinical placement (Khunratanasiri, Chaiyasamut, Tepaneeyakorn, & Petchprapi, 2007).

There may be other problems involving the instructors of nursing students. According to the National Education Act, 2542 B.E., section 22, teaching and learning management must be based on the principle that every learner has the ability to learn and develop themselves. The focus on students is considered as the most important cause for concern. The processes of education management must facilitate learners to naturally develop their competencies and full potential (Office of the Council of State, 2003). For this reason, PBRI has a guideline for instructors to help students with learning problems or those who could not pass a particular subject. This means that instructors and course co-ordinator(s) have to be ready to assist their weak students by re-teaching them any time they find their quiz results might lead to failing a particular subject. If the students do not pass, course co-ordinator(s) have to make the first re-test available within a reasonable period. If students again fail, course co-ordinator(s) are expected to provide failing students with a revision programme before letting them to take the second re-test. The students are only graded with "F" and have to re-enrol in a particular subject(s) if they fail the second re-test (Boromarajonani College of Nursing, 2011b). This system of teaching and learning management results in additional workload for instructors while they also carry out many other functions to meet the missions of the institute (Glynara et al., 2008).

Preceptors

All of the nursing programmes have preceptors who are involved in the student nurses' practical studies, especially during the late hours, official holiday shifts, and in outside settings (as previously mentioned) (Arkal & Chutchavarat, 2004; Sivadamrongpong, Chunpetch, & Pitakbhut, 2003). Facilitators are selected based on the criteria defined by Thailand Nursing and Midwifery Council (2009). That is, they must hold registration as a professional nurse; a masters or doctoral degree in nursing or public health, and no less than one year of clinical nursing experience. If they hold a masters or doctoral degree in another field, then they require two years of nursing experience. Nurses who hold a bachelor degree or diploma can also be facilitators if they have three or more years nursing experience, work in clinical settings, have relevant experience to the subject(s) they supervise, and are not responsible for nursing tasks during the shift(s) working as preceptors. They must also have undertaken a relevant teaching course such as a clinical preceptor programme, a nursing teaching development programme as approved by Thailand Nursing Council, a diploma in nursing education, the five day preceptor programme of Thailand Nursing Council, and continue their nursing teaching competencies by attending nursing teaching and learning workshop(s) or conference(s). They are also expected to have experience in practical teaching no less than 120 hours or two credits. In some settings, however, it is difficult to provide the students with fully qualified preceptors and most of the students have to learn with preceptors who are concurrently responsible for nursing tasks during shift(s) (Boromarajonani College of Nursing, 2011b).

Learning environment of the setting

The setting of this study is one Boromarajonani College of Nursing located in the southern region of Thailand where there has been political unrest for nearly a decade. The College has two main buildings on a small area—around one acre—of one municipality. In the academic year 2007, 386 students enrolled in two available programmes. This intake included 182 students of the *Project* (for Southern border problem solution) and 60-80 students of the normal programme for each class. At that time, the college had 35 instructors with a ratio of Doctor of Philosophy, master and bachelor degrees of 0.29:8.0:1.71. The teaching and learning management of the college focused on being student-centred (Boromarajonani College of Nursing, 2008b). In 2010,

it had one library with a computer Internet network that could be accessed by a Union Library Management (ULIBM) retrieval system. The Internet connection and signal distribution were available for the students and instructors over a full 24 hours period. At this time, the college also provided the students with one computer laboratory that had 62 computers and one nursing laboratory. On a five-point scale, the students rated their overall satisfaction on the quality of teaching and learning management and learning supports in this academic year at 3.51. Moreover, the college had one dining hall, both indoor and outdoor stadiums, and a strict security system, i.e. every unit of the buildings had a CCTV system. At the front-gate, the college had a bomb check using mirrors under cars. The students thought that the physical environment of the college facilitated their learning; they rated their satisfaction at 3.60 (on a five-point scale) (Praboromarajchanok Institute, 2010c).

Furthermore, the college provided the students with three dormitories—two for female students and another one for the males. This means junior and senior students had to live in the same dorms, but in different units. While living on campus, the students had to follow many accommodation rules. During the week, they could not stay out overnight; however, this was permitted on the weekend. They had to return to the dorms by 6pm of the day before their next class. During practical placement, they could go out or stay out overnight if they were off duty, but they had to return to the college for no less than three hours before their next evening shifts, and by 4pm of the day they worked on night shifts. Beyond these arrangements, the students had to ask for formal permission from the Director of the College. Every day at 8pm, all of the students who were staying in the dorms had to join the evening meeting to receive college information, attend Buddhist and Muslim prayers and make a pledge to their patients and profession. This activity took around 30-40 minutes. In addition, when living on campus, the students had to clean their units by themselves, including always maintaining the residential and college environment in good condition (Boromarajonani College of Nursing, 2007, 2010b). It should be remembered that all these students were not only living and studying in an area of unrest and were affected by the situation, but they also faced several difficulties due to the *Project's* implementation to address the serious nursing shortage of the area. The next section summarises the *Project* details and the problems resulting from it.

THE PROFESSIONAL NURSE GRADUATE INCREMENT PROJECT FOR SOUTHERN BORDER PROBLEM SOLUTION

The Professional Nurse Graduate Increment Project for Southern Border Problem Solution, as specified by The Secretariat of the Cabinet (SOC) (2007), was proposed by Ministry of the Interior. After being approved by the Cabinet on April 24, 2007, the *Project* was implemented during 2007-2011 under the shared responsibility of the Ministry of Public Health and the Ministry of the Interior. Because the main objectives of the *Project* were to address the serious nursing shortage of the area and strengthen the stabilisation of the country, 3,000 students from the five southern border provinces were recruited in one intake in 2007. The Thai government hoped that graduates from this programme who came from the local area would hold good attitudes towards serving the regional people based on their good understanding of their life-styles, culture, and languages, leading to an enhancement of public health services for the region. Scholarships for *Project* students (which provided financial support for their study and eligibility to be government officers when graduating students successfully passed the licence tests and took up work in their hometowns) motivated students to apply for the programme. The government expected that this policy could motivate the graduating nurses to continue to work in the local area instead of moving out due to the unrest. Moreover, it was thought that the *Project* could encourage higher education and quality of life for the youth of the southern border provinces, which would contribute to the sustainable development of the area (Secretariat of the Cabinet, 2007).

However, this large scale recruitment of nursing students from the southern region led to many problems. A study that evaluated the implementation of the *Project* during the beginning period found lower admission standards into the nursing education college programme (Intongpan et al., 2008). Sixty-seven percent of the candidates had low GPAs, i.e. 2.00-2.90, and only 1.77% of them had achieved an examination score of 50% or more. Only 49% of the students had recently completed their high school programmes, whereas many of the other students transferred from other programmes of study. Twenty-four percent were studying for a bachelor degree, 23% had completed a bachelor degree, 3%, had completed a diploma, and one was studying for a master degree. Most of the *Project* students had completed their high school education in a Muslim seminary school and nearly half of them were skilful in Yawi language (a dialect of the Muslim language spoken in southern Thailand) but had a poor basic

education, especially of English. This resulted in learning problems when entering their nursing course, i.e. when they had to learn technical terms. They perceived that they were weak students, would communicate only within their groups, and did not dare to speak Thai because they were concerned they might say something wrong. As a result, they sometimes could not understand what their instructors explained in Thai, but they were not confident to ask for more explanation (Intongpan et al., 2008).

Furthermore, according to Intongpan et al. (2008), although the *Project* had enough financial support, the students and instructors encountered many difficulties, especially during the beginning period. They had to attend lectures in an overcrowded classroom with distracting noise and some students were seated too far from the media being used by instructors. They also had insufficient learning supports such as textbooks, computers, and audio-visual equipment, due to inadequate lead-in time for their purchase. In the dormitories, they had to live in cramped rooms in hot weather and with poor ventilation and not enough storage cabinets and desks, so they could not concentrate on their studies. In addition, the large number of *Project* students, especially when combined with the students in normal programme, led to difficulties in teaching management. In some colleges that had 200-370 students per class, the students were divided into two to four groups, which meant the instructors had to teach the same topics up to four times. When the students could not understand their lessons and/or could not pass examinations, instructors had to help them by repeating teaching sessions again and again in extra time. Finally, 2,848 students graduated and started work in the five border provinces on April 1, 2012; 116 students were still studying. (Some of these *Project* students had to change their studies to a public health course; 104 students were expected to graduate in 2012, and 12 in 2013 (Lucksanavisit, 2011)). At the time of data collection for this study, these *Project* students were in the fourth year of their BNS programme.

As previously mentioned, the students in the *Project* could be eligible to become government officers if they successfully passed the licence tests and took up work in their home towns. This reason should motivate them to continue to work, as being a government officer can bring several compensations, as explained in the following section.

Compensation of a Thai Government Officer

Apart from salary/wages, wage incentives, honour and family pride, Thai government officers and their families (parents, spouses, and children) can earn several fringe benefits, both monetary and non-monetary, to motivate and sustain them to continue their practice. The monetary benefits include medical expenditure, children's education expenditure, remuneration for working during late hours, rents and funds for accommodations, the costs for outside practice, and pensions for retirements. For non-monetary benefits, not only weekends and special holidays, the government officers also have rights to leave on full salary for sick leave, maternity leave, personal leave, extra holiday leave (10 days/year), religious leave, and education/training/research/study tour leave (Office of the Civil Service Commission, 2013).

It remains to note that although all *Project* students had this future to look forward to, they also had to endure a number of difficulties that were caused by the disruptions described above, and they faced the requirements of Thai culture itself. In the following section, aspects of Thai culture that may impact on the way nursing students develop their nursing knowledge and skills in clinical practice are outlined.

ASPECTS OF THAI TRADITIONAL CULTURE THAT AFFECT NURSING STUDENT LEARNING

As Thai persons live in a long established social hierarchy, interpersonal relationships are very important, and perhaps especially so within the health care system. Understanding Thai culture therefore leads to an understanding of why Thais exhibit particular behaviours and actions, and why Thai nursing students are not only affected by external constraints, but also 'internal' ones that are culturally driven. The three following issues guide these behaviour patterns.

Thai interpersonal relationships: the social hierarchy

Thais have structured patterns of interpersonal relations such as symbiotic relationships of patron-client, teacher-student, elder-younger, superior-subordinate, and master-servant (Klausner, 2000; Mulder, 2000). A person on the lower rung of the hierarchy ladder must show awe, deference, diffidence and respect to those above. Moreover, to make the relationships meaningful and complete, the superiors have reciprocal duties to

fulfil the needs of inferiors in the form of moral support, and sometimes, by supporting materials, giving advice, protection, and maybe helping them for their career advancement. For this reason, the subordinates look to their superiors for praise and attention. Often the mere presence of them will give “kamlang jai⁶” or strength of heart to the inferiors. The patrons may well be viewed as possessing higher merit levels because of their accumulated merit, which led them to enjoy their prerogative power and high rank positions. When the patrons, however, fall from power and grace, the subordinates do not give them respect. New relationships are quickly formed. That is, they instead “grasp the neck” of their new patrons and give them their loyalty and allegiance (Klausner, 2000).

Avoidance of confrontation: the preserving of social relationships

Thais are culturally expected to preserve social harmony. They are expected to hide their feelings, especially emotions such as anger, hatred, and annoyance that destroy interpersonal relationships. When encountering the situations that make them feel such negative emotions, Thais try to present a friendly smile to hide their dislike, disagreement, distrust, rather than frankly responding to avoid offence. In some situations, they decide to postpone the responses instead of an abrupt refusal of an invitation. Even though Thais feel annoyed, offended and infuriated with some persons, they can greet them with a friendly smile and a gracious and respectful “wai⁷” because they know those persons would expect that response (Klausner, 2000). Moreover, according to Klausner (2000), Thais try to avoid emotional extremes, commitment, and confrontation because they are also Buddhist who are taught to value emotions expressed through love and friendship. Thus, confrontation is socially unacceptable for the Thais, though they might have a penchant for gossip to release such emotions. Sometimes, Thais use techniques to deflect negative social expression, that is, they refer to the word “prachot⁸”. It means if they are annoyed or angered, they not only do not express such feelings directly, but also reflect them towards another object, either animate or inanimate as to how the injured party feels. For example, many dogs have

⁶ Kamlang jai means will or willpower.

⁷ Wai means paying respect by bringing the hands together to the face.

⁸ Prachot means to be sarcastic.

been kicked to signal annoyance with the boss or even some guests. This is probably one response they apply to preserve an outward semblance of friendly social relationships.

Krengjai⁹: the feelings of deference and consideration

“Krengjai” is another word that Thais use when being reluctant to impose on others, or to have consideration for others, especially those who are in higher rank, social status or age scale, than them. This word merges diffidence, deference and consideration with respect (Klausner, 2000). The awareness and anticipation of the feelings of others manifest themselves in kindness, self-restraint, tolerance, and avoidance of interpersonal irritation (Mulder, 2000). For example, a person may hesitate to invite some elders or superiors to a social function because they do not want to force these persons to deal with the situations they might not be happy to join. Furthermore, “krengjai” is explained in the situation that someone avoids seeking help or asking for something desired from superiors unless it is definitely necessary. They might also display that reticence toward friends or those who are in the same status as them, particularly, when they know that these persons have already been generous or helpful (Klausner, 2000).

The cultural understandings outlined above are likely to influence nursing student behaviours as they interact with superiors, patients, their relatives and fellow students in the clinical settings. Subsequently, it is quite important to bear this and the other material in this chapter in mind when considering the research question and significance of the study.

RESEARCH QUESTION

The low pass rates in the first licence tests of students graduating from the Colleges affiliated to PBRI has raised the question as to why many students did not seem to be able to integrate theoretical knowledge into clinical nursing care. In this study, I therefore sought to investigate how Thai nursing students develop their nursing skills in the process of caring for clients during their practical studies.

⁹ Krengjai means to be considerate.

SIGNIFICANCE OF THE STUDY

The average percentage of newly graduating nurses from most of the nursing colleges affiliated to the institute who are successful in the first licence test has been low for nearly 10 years (Thailand Nursing and Midwifery Council, 2010a). None of the studies of the institute, however, has investigated the students' perspectives on how nursing students learn to develop their nursing skills. They failed to take into consideration an exploration of the phenomena concerning how these students learn to handle their clients' problems. Discovering the learning processes for developing the nursing skills of these students by applying Straussian grounded theory will be an original contribution to knowledge about how students learn in clinical settings to enable successful integration of theory and practice. This could lead to guidelines for further implementations in the nursing education of the institute, assisting students to reach their academic goals.

STRUCTURE OUTLINE OF THE THESIS

The thesis consists of eight chapters. **Chapter 1** introduces the readers to this study and informs them about the background to the study that describes the contexts of the setting in which the programmes take place. **Chapter 2** provides a literature review that is both relevant to the Thai college nursing programmes and to international nursing programmes. **Chapter 3** outlines the philosophy underpinning the study and informs the readers about the study design and methods. **Chapter 4** introduces the overall framework, the core category, the process of **Developing Effective Strategies for Nursing Care**. **Chapter 5** reports how the novice students start caring for their patients, especially developing their basic nursing skills during the first stage (sub-category) of their learning process—*attending to procedure training*. **Chapter 6** emphasises reporting the details of the stage (sub-category) of *seeking case problems and how to provide nursing care*. It explains how these students start to handle the problems of their patients after having improved their skills in dealing with nursing procedures for a period of time. The chapter also provides the reasons relating to why they only developed some understanding of how to provide nursing care for particular problems of their cases, and rarely learned about their patients when encountering inhibiting/interrupting conditions. **Chapter 7** focuses on explaining why and how the

students advanced their case learning¹⁰ skill to understand their patients' conditions during the next two stages (sub-categories), *modifying the strategies for case learning*, and *discovering how to understand case conditions*. **Chapter 8**, the final chapter, summarises the ways the students developed their learning strategies and discusses the reasons underlining the findings presented in the study, leading to nursing recommendations.

CONCLUSION

In this introductory chapter, I have outlined material that guides the research, which is concerned with the low pass rate in the licence exams of newly graduating nurses from the Thai college programmes over a significant period of time. Some of the main influences and possible problems of teaching and learning that might affect nursing education at the institute have also been indicated, as has a range of possible background material that included governmental, educational and socio-cultural considerations. Subsequently, in this thesis, I will explore how the nursing students integrate theoretical knowledge into patients' nursing care through their learning experiences from their own perspectives. In the next chapter, a review of the possible literature that is relevant to the aim of the study will be examined.

¹⁰ Case learning means the understandings of the students about their assigned patients' problems and how to care for them.

LITERATURE REVIEW

INTRODUCTION

As stated in the previous chapter, it is necessary to clarify the learning process of the nursing students in order to assist them to successfully integrate theory into their clinical practice. An important part of this clarification for the purposes of this thesis involves an examination and use of available literature; to which end this chapter is now presented. Some grounded theorists e.g. Glaser (Glaser, 1978; Glaser & Strauss, 1967) argue that a literature review on the topic should not be undertaken before data collection, in case theoretical concepts identified in the literature shape subsequent data collection and analysis. However, Corbin and Strauss (2008; 1998) argue that when properly applied, the literature review is one source that facilitates a researcher in accomplishing his/her objective(s). Following their guidelines, I reviewed literature throughout the study, but the review was differently focused at each stage. In this instance, the literature review was firstly employed to identify the gaps in existing knowledge and certify the new approach that has the potential to make a significant contribution of new understanding. During this stage, the literature was used only to stimulate my curiosities about the research question and where the focus of my project should be, but was not applied to frame my study.

This review is presented in this chapter and reflects my understanding prior to undertaking data collection. When planning the project, I used the literature review to provide me with questions for initial interviews and observations. I then occasionally applied it to enhance my sensitivity for asking questions and making comparisons during the parallel processes of data collection and analysis. For theoretical sampling, I also made use of the review(s) to suggest where I might go to investigate certain relevant concepts, especially during the early stage of my study. Finally, after the categories had emerged, I conducted a more in-depth literature review to fully understand the phenomenon, so I could more comprehensively make recommendations based on my research findings. The latter review is used to corroborate the connections

among the phenomena of the core category shown in Chapter Eight.

SEARCHING PROCEDURES FOR LITERATURE REVIEW

In this study, the search procedures for the Thai literature and the international literature were different. These two literature review processes are now briefly described.

THAI LITERATURE REVIEW

Most of the relevant Thai literature in this study was located by using manual library indexes because very few PBRI research reports have been published via websites. Most research reports are written in Thai and only available as hard copies held in the library or other network colleges (Praboromarajchanok Institute, 2010c). As a researcher who is interested in investigation of the crucial problems of the students studying in the Thai college programmes, I made an effort to search for previous studies and documents related to my study in the local setting and any other nursing colleges I could access, anytime I returned to Thailand—after entering my PhD programme, during my data collection, and preliminary finding verification. I searched in the manual indexes of the library first by highlighting the areas of learning conditions, teaching and learning strategies, and predictors of academic outcome that were reported during 2000-2012. Then I looked for the hard-copies that I needed at the book-shelves. After that, I made copies of the relevant parts and translated them into an English version. Thai literature used in this study is referenced in APA style as “book”. Much of this literature has not been published in an internationally available format.

INTERNATIONAL LITERATURE REVIEW

To access relevant international literature to inform this study, I made use of three main databases: Scopus, Google Scholar, and CINAHL. The search keywords I focused on were “nursing students” with the dimensions of learning conditions, teaching and learning strategies, and predictors of academic outcome reported during 1995-2014. These terms varied but the ones which shed light on the three dimensions frequently employed were “learning conditions”, “learning factors”, “clinical studies”, “clinical practice”, “clinical placement”, “learning experience”, “clinical supervision”, “theory-practice gap”, “preceptorship”, “teaching and learning strategies”, “critical thinking”,

“problem-based learning”, “clinical simulation¹¹”, “predictors of success”, “outcome”, “nurse licensure”, and “nursing education”. Particularly, when moving to the discussion and recommendations in Chapter Eight, I also tried to look for other keywords to explain the phenomena presented. In this phase, the main keywords applied included “learning theory”, “adult learners”, “self-directed learning”, and “learning motivation”.

As my reviews emphasised searching for the dimensions of learning conditions, teaching and learning strategies, and predictors of academic outcome, throughout this chapter the literature presented in relation to each dimension is separated into that applying to Thai college nursing programmes and to international nursing programmes. In this study, international literature refers to that of any country other than Thailand.

LEARNING CONDITIONS IN THE THAI COLLEGE NURSING PROGRAMMES

Research studies exploring learning conditions in the Thai college nursing programmes suggest that a number of factors can affect nursing skill development of students. These factors include the instructor readiness, the clinical teaching and practical environment, student competencies, and learning facilities and management. The reviewed literature is grouped under each of these sub-headings.

INSTRUCTOR READINESS

A critical shortage of nursing instructors has been reported (Sawaengdee, 2009); in addition, a number of studies have indicated that many instructors have insufficient teaching competencies for the integrated programme (Glynara et al., 2008; Khunratanasiri et al., 2007; Sottipolanun et al., 2007; Thepworachai et al., 2008). To exemplify, a research study that aimed to develop the teaching competence of 35 new nursing instructors to meet the desirable characteristic model of a PBRI instructor (Khunratanasiri et al., 2007) showed that it was not achieving its goals. Although PBRI instructors recognised that a teaching role was their most significant responsibility, they thought they had under-performed in this role, especially in relation to analysis of the

¹¹ Clinical simulation is “a dynamic process involving the creation of a hypothetical opportunity that incorporates an authentic representation of reality, facilitates active student engagement and integrates the complexities of practical and theoretical learning with opportunity for repetition, feedback, evaluation and reflection” (Bland, Topping, & Wood, 2011, p. 668)

curriculum and making teaching plans based on student-centred learning. Instructor development put more emphasis on other competencies than teaching or learning management. The teaching development of instructors also lacked continuity due to no systematic and continuous coordination of the departments responsible (Khunratanasiri et al., 2007; Khunratanasiri, Kerdchuen, & Khongkoontot, 2005). The training activities were implemented to meet the goals of teaching and learning in the nursing programme of the study. Interestingly, even though the trainees were satisfied with the programme and rated the overview of their teaching competence at a high level, they still rated the lowest score on three competencies. These were curriculum analysis and integration into teaching plans, identifying teaching methods that were relevant to learning objectives, and providing the variety of teaching techniques which corresponded with learning objectives and content (Khunratanasiri et al., 2007).

Moreover, a mixed methods study that aimed to evaluate an integrated programme (Khunratanasiri et al., 2005) through the view of two specialists in nursing education, seven curriculum administrators, 84 nursing instructors and guest lecturers, 88 mentors, 273 clients, and 894 nursing students found that although overall, the students rated the curriculum administration and teaching-learning processes at a high level of appropriateness, many instructors thought they were still not clear about the key concepts of integration, especially the reasons and objectives of the course. They did not understand how to manage the teaching and learning of an integrated programme, and still had rather poor attitudes towards its implementation.

Another study evaluated the outcomes of this integrated programme management (Sottipolanun et al., 2007) through the perspective of 37 instructors, including deputy directors, and 363 of the first to fourth year undergraduate nursing students. It revealed that even though the instructors and students rated satisfaction in relation to curriculum management at a relatively high level and instructors tried to apply a variety of teaching and learning methods, only 59.5% of the teachers thought they were ready for a student-centred teaching and learning programme. Seventy-three point five percent of instructors reported they required competence development in teaching techniques that corresponded to the programme, whereas support for the development was quite impracticable.

In addition, a study that explored the factors relating to and affecting academic achievement (Thepworachai et al., 2008) through the perspective of 1,307 senior nursing students of PBRI showed a significant factor about instructors. Although overall, the students thought that their instructors were interested in student learning and intended to teach with a variety of methods, some students revealed that their instructors did not provide them with a method of analysing nursing problems. Some instructors mostly employed lectures, which many students found boring in the lessons. Others described lots of content with high speed teaching that they could not follow, resulting in their being unable to integrate the content into practice.

These studies showed college nursing instructors were not sufficiently prepared to modify their teaching techniques to correspond with the changing curriculum in an integrated programme as they did not clearly understand how to integrate concepts into their teaching tasks. Their teaching methods were not appropriate for what their students had to learn. Although some studies reported that many instructors tried to improve their teaching ability, they were competent only to a certain degree. This implies that they could not maximise their students' learning.

CLINICAL TEACHING AND PRACTICAL ENVIRONMENT

To further illustrate the factors that influence nursing students' development, a survey of 299 undergraduate nursing students who had experienced practical studies (Arkal & Chutchavarat, 2004) found only 52% thought clinical study management was effective. Even though they gave the highest rating, 93%, to their instructors as persons who were very important for their placement, the effectiveness of their instructors was rated the lowest effectiveness score of the programme, 56.5%. The researchers believed that this was because nursing instructors did not prepare students enough before going to settings. As the supervisors of practical preceptors, they also did not prepare them enough either, and so planning for supervision was inadequate.

Furthermore, PBRI nursing students reflected that some teaching methods they received during their practical placement were not relevant to the techniques they needed. This finding is echoed in a study by Naosuwan, Pasaprates, and Chaichana (2006) that examined the perceptions of 77 first year undergraduate nursing students in a Bachelor of Nursing Science programme (continued) who were studying Adult and Elderly

Nursing Care 2. They revealed that the students were frequently taught by case study, followed by demonstration, and the last method applied was analysis of incident situations; however, the students agreed that the teaching methods that were effective for them were demonstration, followed by a nursing conference, case study, and the nursing round—where student nurses and a nursing team go around the ward sharing information about each patient. A study by Arkal and Chutchavarat (2004) showed that practical facilitators were not clear about aspects of practical supervision. Moreover, some facilitators were also worried about this role because they had multiple responsibilities, in addition to learning how to teach effectively. The teaching techniques they provided sometimes did not correspond with what students have to understand. Therefore, only 82% of the nursing students thought that practical facilitators could make practical teaching and learning effective (Arkal & Chutchavarat, 2004).

In another study, by Kamdee, Arkal, and Thathan (2007), the perception of preceptors' caring behaviours by surveying 257 nursing students, from second year to fourth year was investigated. Although the students rated nurse preceptors' caring behaviours overall at a high level, students from all years rated preceptors' acceptance of students' positive and negative feelings the lowest. Moreover, a survey of 39 clinical nurses about job satisfaction in practical teaching showed the nurses had a high level of satisfaction, especially those who had been working for many years (Binchai & Neadsiri, 2003).

These studies identify differing contexts of practical teaching and learning that impact on students' development of their nursing skills. In particular, the studies emphasised how instructors' lack of teaching competency impacted on the preparation of students for practical placements, contributing to an unsuitable clinical environment for students and less effective practical nursing education. Lack of acceptance by preceptors of students' feelings, whether negative or positive, may restrain students from expressing their thoughts, asking for help, and/or refusing to do the activities that divert their learning, thus leading to limitations in student learning opportunities.

STUDENT COMPETENCIES

In trying to understand the learning conditions of nursing students in Thailand, students' competencies also need to be taken into account. Many studies (Ariyanon et al., 2008;

Glynara et al., 2008; Janjaroen, Sukwong, Leksomsun, Naka, & Kaowkong, 2006; Sottipolanun et al., 2007; Thepworachai et al., 2008; Treesaranuwatana, Sirinapadol, Sothipoolmas, & Wongsalar, 2007) indicated that nursing students studying in the Thai college programmes had rather low learning competencies, particularly, the students studying in the *Professional Nurse Graduate Increment Project for southern Border Problem Solution*. For example, a study by Ariyanon et al. (2008) surveyed the learning problems, their related factors, and methods of problem solving of 810 nursing students who were studying in this project. They revealed that most of the students had only low to moderate preadmission GPA, i.e. 2.50-2.99 on a four point scale. The GPAs of the *Project* students in the first year of the course ranged from 1.75 to 3.92. The students rated their learning problems at a moderate level. However, most nursing students who studied in the normal college programme also had GPAs within the range 2.50-2.99 during their course (Thepworachai et al., 2008), suggesting that the academic ability of the *Project* students was no different to that of the normal intake of nursing students.

Treesaranuwatana et al. (2007) examined critical thinking ability and the relationship between this competence and GPA of 70 undergraduate nursing students who were studying in the fourth year. The findings showed they had only a moderate level of critical thinking ability and it did not relate to their academic achievement. Likewise, a study by Janjaroen et al. (2006) that investigated critical thinking ability of 205 nursing students showed important findings. Sixty-one percent of them demonstrated a low level of critical thinking, 38% a medium level, and 1% a high level. Those who were in the higher years of study had higher critical skills than those in lower ones. However, again there were no significant differences for critical thinking ability between the students who had higher and lower grade achievement. A third study by Glynara, et al. (2008) demonstrated similar results. They found that applicants who entered into the Bachelor of Nursing Science programme had critical thinking and problem solving skills lower than other skills.

Learning readiness is another competency investigated for nursing students. Again, results have varied. In one study, 90% of students thought that they had only a moderate level of self-directed learning readiness for the integrated programme (Sottipolanun et al., 2007). Conversely, a descriptive study that examined self-directed learning readiness through the views of 325 undergraduate nursing students, 95% of whom had

GPA's in the 2.50 to 2.99 range, found that they thought their self-directed learning readiness was high (Bintaprasit, 2003). They rated high levels for the elements of learning responsibility and openness to learning opportunities. However, they rated the elements of their ability to employ basic learning skills, problem solving skills, love of learning, including creativity, initiative and independence in learning as moderate. The study also found that students who were younger than 25 years had higher scores in self-directed learning readiness than the older students. Those who were studying in Bachelor of Nursing Science programme had higher level scores than the others. Nevertheless, there were no differences in self-directed learning readiness in relation to differences in academic achievement or reasons for studying nursing in this cohort (Bintaprasit, 2003).

Thus, a number of studies that were reviewed identified low learning competencies, especially critical thinking and problem solving abilities in nursing students studying in the college programmes that may affect their nursing skill development.

LEARNING FACILITIES AND MANAGEMENT

Another condition that can influence nursing students who study in the Thai college programmes is the learning facilities and management. Many previous studies reported that nursing students have to learn in quite poor conditions with insufficient and inappropriate learning materials and environments; for example, inadequate nursing books, journals, texts, group learning classrooms (Sivadamrongpong et al., 2003; Sottipolanun et al., 2007), computers (Glynara et al., 2008; Sottipolanun et al., 2007), and data bases (Sottipolanun et al., 2007). Some students thought that the textbooks were rather obsolete and did not meet subject requirements, and that their classrooms did not match the large number of the students and their practical settings were also quite limited. Only 56.8% of students rated the learning materials and resources as sufficient (Sottipolanun et al., 2007). Moreover, students sometimes have had to learn with inappropriate schedules—self-learning hours are tight; they are frequently given up for compensatory learning, resulting from doing some complementary activities such as health promotion activities. In some semesters, difficult subjects were scheduled together, which meant that students had to work too hard (Sottipolanun et al., 2007). One study (Glynara et al., 2008) reported that Thai journals were rated at the highest level of quality, sufficiency, and accessibility, and that the quality and convenience of

libraries were evaluated at a very high level. However, classrooms were sufficient but microbiological laboratories were slightly inadequate, and the quality of dormitory accommodation was rated at the lowest level.

Learning facilities and management that do not provide enough support make it more difficult for students to learn. Learning where there is material shortage and/or inappropriate contexts could not only limit their learning opportunities, but also needs students to make more effort to improve their skills. This might be another important factor that influences their nursing skill development.

LEARNING CONDITIONS IN INTERNATIONAL NURSING PROGRAMMES

Teaching and learning in international nursing programmes are also not always as effective in facilitating the nursing skill development of students as they could be. This is reflected in a qualitative study by Corlett (2000) that investigated the theory-practice gap in nursing education through the shared perspectives of 69 British participants that consisted of nurse teachers, student nurses across three years, and clinical preceptors. The results of 23 group interviews showed all groups of participants felt this gap does exist. It was not always seen as a lack of knowledge, but was perceived as a difficulty that was experienced by students when attempting to apply principles to practical situations. It was argued that what the teacher had taught was seen as an idealised knowledge version, which often did not fit with the reality of practical situations. Preceptors and students in this study also described the difficulty in trying to manage effective teaching and learning, based on the shortness of practical placements and the workloads of preceptors. These factors were perceived as compounding conditions that deterred students and preceptors from working together. Similarly, an Iranian study (Sharif & Masoumi, 2005) that investigated the clinical experience of 90 nursing students from the second to fourth year, using focus groups, reported that students were unable to integrate what they learned in theory into real clinical situations. This was most reflected in the literature derived from clinical teaching and learning situations, both related to nursing instructors/preceptors/ward nurses and to the nursing students who had to learn in those clinical environments. The reviewed literature is, therefore, grouped in two sections addressing the clinical teaching and practical environment, and

student competencies.

CLINICAL TEACHING AND PRACTICAL ENVIRONMENT

Although nursing skills are mainly developed by clinical experiential learning (Naphthine, 1996; Nolan, 1998), a number of international studies (Brammer, 2006; Hsu, 2006; Pearcey & Draper, 2008; Sharif & Masoumi, 2005) reported that clinical teaching, and practical environments are unsupportive of student learning. Sharif and Masoumi (2005) found that the ward staff were not concerned about what the students had to learn; they were busy with their duties and unable to act in both educational and service roles concurrently. Some staff were not aware of the skills and strategies which are necessary in clinical teaching and were not prepared to act as clinical instructors.

The issue of not paying attention to the teaching of nursing students was apparently confirmed by Brammer (2006) who explored the understanding of 30 registered nurses (RNs) about their role as facilitators of student learning in Australia. She revealed some registered nurses (RNs) perceived that students were not their responsibility, so they tried to avoid teaching students and were not interested in the students' learning. However, Brammer also identified a range of beliefs of RNs about how students learn that influence student learning opportunities. Some RNs believed that students would learn by being controlled and they needed to manage the learning opportunities of students, resulting in students having to learn under the RNs' expectations. Other RNs thought that students learn by completion of an allocated workload as time permits and liked to control student experiences with close supervision, without allowing any independence. They were also likely to allocate lower acuity patients to students as they felt students were capable of coping with these. The RNs who considered that students are future peers believed they have to assist students to learn the reality of nursing in order to prepare them as RNs. As a result, some students might have extended learning experiences while others will have limited learning opportunities. Nevertheless, by learning with different RNs, nursing students have to adapt themselves to the variety of characteristics shown by their facilitators at different times.

Research indicates that clinical nurses are not always good role models for students in relation to patient care. For example, Pearcey and Draper (2008) in a grounded theory study, identified core concepts of the clinical nursing environment through the views of

12 British first year nursing students, representing 21 wards and five hospitals. Based on four weeks clinical placement experience, the students reflected on nursing, viewing it overall as paperwork completing, rather than reflecting personal values such as communicating, listening to patients. They explained that the nursing care that nurses provided for patients was implied in written documents instead of being implemented in practice, e.g. that several nursing care activities were done without verbal interaction. Nurses focused on tasks and routine work, but left caring for patients to auxiliary nurses. They were very concerned that they had to finish their tasks or routine work in-time, and that every activity was to be completed as quickly as possible. The participants thought that nurses focused on tasks, rather trying to find out what patients wanted. However, they made use of negative experience they had seen at settings to remind themselves that they did not want to become uncaring nurses. That staff nurses were not always good role models was also found in Sharif and Masoumi's (2005) research. It revealed that the students thought that some nurse work was "not really professional nursing". They were confused by what they had learned in the faculty and what actual clinical practice was expected from them. The students also noted that they should have opportunities to provide nursing care as the professionals should do, and not just do the auxiliary nursing tasks that anyone can do.

Regarding training nursing students, it has been argued that not only clinical nurses, but their instructors also contributed to the unsuitable learning contexts. This is reflected in a Taiwanese study (Hsu, 2006) where the behaviours of 10 teachers were observed during regular clinical teaching time. All of the teachers had Master's degrees and the ratio of teacher per students was 1:10. The observations took place in the second or third week of four practical weeks in medical-surgical units. They included watching activities, recording, and listening to conversations; each teacher was observed for two days (16 hours). Preliminary findings were also validated by participants. The observations supported the notion that the educators were more focused on task completion than an awareness of the necessary nursing skills their students had to develop. They primarily emphasised routine work and took only a few opportunities to stimulate and develop students' critical thinking skills. Most teachers frequently focused their questions on treatment and pathophysiology, rarely touching on nursing care questions. Some of them had gaps in theoretical knowledge; i.e. they did not know exactly how to provide nursing care for some patients. A few clinical teachers focused

only on supervising their students on how to perform procedures, but ignored patient concerns. Even in arranging enough learning experiences, seven teachers did not assist their students. However, some educators did give feedback after students completed tasks for patients; two of them provided opportunities for students to reflect on their clinical learning experiences. Others led theory discussion in relation to nursing care that students provided. They sometimes also asked students about the independent nursing care they should provide for their patients. Two teachers demonstrated emotional support when their students encountered stressful situations during clinical practice. Furthermore, in a related study by Sharif and Masoumi (2005) also found most students perceived that their instructors played a more evaluative role than a teaching role.

The clinical teaching and practical environments reported in these studies were not optimal for facilitating the nursing students' learning. Although students were in a variety of nursing care situations, when the clinical nurses and nurse instructors were not aware of skill training or not good role models of caring, learning opportunities were limited. Clinical skills not only relate to task implementation, but also the understanding of patients' problems and making appropriate decisions to respond their nursing care needs. If students spend most of their time assisting nurses with tasks, then little time is allocated to the development of other essential clinical skills such as problem solving abilities, and decision-making skills that are the heart of professional nurse work. Practical placements based in unsuitable clinical teaching environments cannot maximise the nursing skill development of the students.

STUDENT COMPETENCIES

Another point that must be taken into consideration when trying to understand learning conditions in international contexts is student competencies. For instance, several studies identified that international nursing students may have low skills in critical thinking (Shin, Ha, Shin, & Davis, 2006; Suliman & Halabi, 2007; Zhang & Lambert, 2008) and assertiveness (Begley & Glacken, 2004; Çelebioğlu, Akpınar, Küçükoğlu, & Engin, 2010), but also noted that these are required for nursing studies and nursing work. Regarding critical thinking skills, a descriptive study in Korea that assessed this ability of 301 senior students in three undergraduate nursing programmes—Associate Degree in Nursing (AND), Bachelor of Science in Nursing (BSN), and Registered

Nurse-Bachelor of Science in Nursing (EN-to-BSN)—showed average scores of 41.59 on the Watson Glaser Critical Thinking Appraisal (WGCTA) tool, in comparison with nursing studies published in western countries that reported scores ranging from 50 to 61.1 out of a maximum of 80 points (Shin et al., 2006). The researchers explained that the lower scores occurred because of two reasons. Firstly, the educational objectives of nursing programmes in Korea did not fully focus on improving students' critical thinking skills during either the theoretical sessions or the clinical course. Secondly, they are also not clearly reflected in the overall nursing education system. There was no set standard for the level of critical thinking that the students should achieve, or any measures of the ability. Korean nursing education, however, has since promoted new efforts to enhance critical thinking skill for decision-making in nursing community care (Shin et al., 2006).

Another study (Zhang & Lambert, 2008) investigated the learning styles and critical thinking dispositions of 100 Chinese baccalaureate nursing students. It revealed the most common dimensions of four learning styles the students preferred. These were a) being reflective or learning by thinking things through and preferring working alone, b) sensing or using a concrete and practical orientation toward facts and procedures, c) preferring visual representations of presented material (such as pictures, diagrams, and flow charts), and d) having a global style which is the use of a holistic thinking process and learning in large leaps. The overall critical thinking ability of the students was reported as a weakness in that the average total score of California Critical Thinking Disposition Inventory (CCTDI) was 272.82, which was lower than the established mean score of 280 as measured by the same instrument. This result was also lower than the scores of nursing students reported in previous studies conducted in western countries. The researchers considered this was because the students' learning styles, which were much influenced by the Chinese educational system from elementary school through to higher education, were unlikely to encourage them to think critically within a traditional nursing education programme. Chinese nursing students have tended to learn by focusing on memorising facts related to diseases, rather than engage in any form of clinical practice until the final year. They are also not likely to take part in debates or discussions related to nursing, ask questions during class, and synthesise information through writing scholarly papers or verbal presentations (Zhang & Lambert, 2008).

To further exemplify this issue, another research project by Suliman and Halabi (2007) applied a cross-sectional design to explore the existing predominant critical thinking disposition(s) of 105 first year and 60 fourth year nursing students in Jordan using the same instrument as Zhang and Lambert (2008). They found that both groups held marginal overall CCTDI mean score of 284.93 for critical thinking. The graduating students showed higher scores than beginners. They anticipated that the critical thinking of these students would significantly increase from the beginning to the end of the programme, but the findings were not significant, even though the nursing education in Jordan used problem-solving as one method of instruction. However, it may still not have emphasised the affective/attitudinal dimension of critical thinking in the teaching of nurses.

In relation to the assertiveness that is necessary for nurses in effective communication, many recent studies e.g. Begley and Glacken (2004); Çelebioğlu et al. (2010) have pointed out that international nursing students are rather low on this competence as it was not well developed as they progressed through their course. This issue is supported in a study by Begley and Glacken (2004) who surveyed the assertiveness level of 59 Irish nursing students by asking them to complete a questionnaire in the first week they entered a nursing course and again when they were near to graduating from their three-year programme. They found that the mean score on the pre-course questionnaire was 69.87, whereas the post-course questionnaire score was 73.73 from a maximum 112 points.

Low assertiveness means persons do not have enough skill and capacity of interpersonal communication to refuse, request and express their thoughts without causing upset to others they valued (Alberti & Emmons, 2001). It is a compounding problem if students are subjected to 'violence' as asserted in a descriptive study by Çelebioğlu et al. (2010). The study reported that 50.3% of 380 Turkish nursing students were subjected to violence during their clinical practice, and 91.6% of them were subjected to verbal violence. The most violence (53.4%) was caused by patients and their relatives due to anxiety, fears, and lack of confidence in students' competence. This was followed by nurses, doctors, and other clinical staff, also mainly due to lack of trust in their ability. After confronting violence, the students most frequently experienced anger, fury, and enmity (84.3%), followed by anxiety (81.2%). However, most of them (66.0%) did not

react to patients and continued to provide them with nursing care.

Learning with a lack of critical thinking and assertiveness skills means the nursing students have limited opportunities to learn. Not being able to refuse what they do not want to do, ask for help, and/or express their thoughts, reduces learning. As well, nursing education that cannot support them to develop these skills makes their learning less effective. Poor assertiveness skills also create negative feeling experiences, which could lead to students not being confident or reassured in their learning. These can be powerful factors that prevent nursing students in developing their nursing skills as they should be.

Although learning conditions in the Thai college nursing programmes and international nursing programmes are somewhat different, they both tend to cause limited learning opportunities and unsupportive learning environments for students. A number of factors together mean the students have to develop their nursing skills in difficult learning situations, especially when they are at clinical settings. The issue about how they can learn in such conditions needs more investigation, particularly, more needs to be clarified about how the students who seem not to be ready to improve their skills (due to having rather low learning competencies) develop their nursing skills when they encounter conditions that do not facilitate them to learn.

TEACHING AND LEARNING STRATEGIES IN THE THAI COLLEGE NURSING PROGRAMMES

When considering the effort required by students to be successful in the Thai college nursing programmes, there is evidence from a number of studies that students and their instructors and/or preceptors tried to improve students' learning skills to reach academic goals. The two following sections present literature reviewed in relation to the strategies of each group.

NURSING STUDENTS' ATTEMPTS

In case of students, most studies have explored how they attempt to achieve their nursing skills or solve their own learning problems. They revealed that students apply differing techniques. They include using self-directed learning methods (Bintaprasit,

2003); attending their classes regularly, trying to complete their assignments, asking for more explanations from or consulting their teachers, discussing with or asking for more explanations from friends, reviewing their lessons (Ariyanon et al., 2008; Thepworachai et al., 2008); note taking, more researching of the issues they did not clearly understand or needed to learn more about (Thepworachai et al., 2008). Moreover, when getting close to tests, especially the licence test, they concentrated more on their studies. They applied different strategies to prepare for examinations such as, cooperative learning, reviewing lessons based on previous tests, concentrating on the content they did not clearly understand, reviewing lessons everyday as planned in their schedules for three months before the licence test (Thepworachai et al., 2008). Unfortunately, the students' use of these techniques did not always result in success as their use correlated with learning problems at a low level ($r=0.08$) (Ariyanon et al., 2008), and its correlation with academic achievement was also at a somewhat low level ($r=0.378$) (Thepworachai et al., 2008). However, as these strategies were relevant to nursing students' learning needs, they might be guidelines for their instructors/preceptors to further find out the appropriate ways to assist the students.

INSTRUCTORS/PRECEPTORS' INVESTIGATIONS

On the part of their teachers, several reports investigated a variety of implementations of methods which could assist the students to accomplish their nursing skill development or work out their learning problems. To exemplify, a quasi-experimental, 2×2 factorial research design tested the effects of cooperative learning with positive reinforcement in the subject of Basic Concepts and Principles of Nursing on nursing problem-solving and social skills, including self-esteem. Forty-eight first year nursing students were recruited and randomly assigned into two experimental groups and two control groups equally by GPA ranging from high to low (Paenkaew et al., 2002). The results revealed that before involvement in the programme, the students had low to moderate levels of achievement on all nursing skills, but they increased after taking part in the programme. The highest increase was found in the heterogeneous group with positive reinforcement, followed by the homogeneous group with positive reinforcement and the heterogeneous group without reinforcement. The homogeneous group without reinforcement showed the lowest increase in score. Therefore, a cooperative learning method and positive reinforcement seem to be strategies that support the achievement of nursing skills of nursing students.

In an alternative study, a one-group pre-test post-test designed by Lounekaew, Siripan, and Kongsuwan (2004), the effect of a Problem Based Learning (PBL) method on critical thinking competence of 33 second year nursing students who were studying Obstetric Nursing 1 was investigated. The researchers found that there was no difference in mean scores of critical thinking competence before and after learning with a PBL method at $p < .05$. The percentage of the students who had a high level score increased from 26.40% to 30.73%. After learning in this programme, however, the students rated each element of the problem solving process at a higher level of competence than before the intervention. The authors concluded that PBL method did encourage the critical thinking of the students, but not as much as expected.

Another study aimed to test the effects of Problem Based Learning on knowledge, problem solving ability and self-directed learning readiness of 66 second year nursing students who enrolled in a six-week practicum to study three nursing subjects (Kirkgulthorn et al., 2003). It revealed that the mean scores of knowledge and problem solving ability in the experimental group significantly increased and were higher than the control group at the post-test phase, though there were no statistical differences between the mean self-directed learning readiness scores of the two groups. Also, in the experimental group, the mean scores of self-directed learning readiness did not show a statistically significant increase in the post-test phase. The findings acknowledged that integrating Problem Based Learning in practical subjects can increase the knowledge and problem solving skills of the nursing students. Integrating Problem Based Learning into practical studies might be also one strategy instructors should apply to assist their students.

TEACHING AND LEARNING STRATEGIES IN INTERNATIONAL NURSING PROGRAMMES

Having conducted studies with several designs in many international countries, researchers have shown that various strategies can improve the skills of student nurses. The strategies the students and their instructors/preceptors applied are outlined in the two following sections.

NURSING STUDENTS' ATTEMPTS

One study in Australia implemented the Dedicated Education Unit (DEU) model to explore how first year undergraduate nursing students learn in clinical settings (Grealish & Ranse, 2009). Through 49 written learning experience narratives, students reported three triggers that had helped them to learn. These were: 1) taking part in or making observations of tasks/procedures led them to learn about nursing work (that they perceived as much more complex than the task intimates), establish relationships in order to deal with patients' emotions, and talk to patients to know their needs. The students found they could develop self-awareness about nursing care and new insights from the simple situations they engaged in; 2) confronting personal or emotional challenging situations, both positive and negative, during practising also gave them significant opportunities to learn what they did not know and extend their nursing care experiences; and 3) meeting a variety of nurses led the students to see the way they manage their duties to meet their clients' needs with effective time management and the techniques they used to approach and support the students. This made the students feel confident and happy to try tasks, as well as constructing an image of what they wanted to be as nurses. Although when encountering the situations where they did not feel supported or guided, the students were aware of their assertiveness; they learned how to deal with the situations and align their personal identity with images of nurses unlike that observed. The triggers the students developed reflect their effort to learn, even when they were in the early stage of their clinical studies, and it is to be noted that although these were quite simple strategies, they helped the students to begin their learning. Therefore, they might be appropriate methods to include to facilitate nursing students' learning in clinical settings, especially during their early placements.

Another study based among Norwegian nursing students also showed the value of a range of participation experiences. Participating in the situations nursing students want to know about is confirmed as a fitting strategy for learning how to provide nursing care for clients (Solvoll & Heggen, 2010). The researchers applied a qualitative design to investigate how six nursing students knew how to provide nursing care. Through observations, interviews and students' documented reflections during nursing home and hospital placements over a period of two and a half years, they revealed that being involved in close patient situations gave the students opportunity to learn. A good relationship, clear concern about patients' suffering and expressing their will and ability

to understand and respond to patients' despair led the students to provide corresponding nursing care. Therefore, the students' personal experience of nursing care showed that their psychomotor, communicative, and understanding case problem skills were simultaneously developed.

Apart from trying to be involved in the situations they want to learn about, some studies showed that nursing students discover that their friends are significant resources for developing their nursing skills. This is evident in the work of Roberts (2009) who employed an ethnographic study to enquire whether 15 British pre-registration nursing students learned from each other and if so, how this took place. Through direct observation in clinical settings in conjunction with interviewing, she revealed that the students valued the help of friends over the placement course. Based on seeing each other as a knowledge resource, they developed the "ask anything" culture in their own community. The students reported that they did not feel stupid about asking their friends as they have done or will do the same thing to them. This bound them together as a community of students; they felt belonging as they were "in the same boat", i.e. trying to complete their qualification as a group of allies. They used the student community as a resource for learning together. Thus, it is to be noted that friends who were in the same situation and wanted to meet the same goals were the important support persons who could help nursing students to develop their nursing skills.

Even though the learning strategies reported in these studies were discovered by the students and might not reflect systematic research by educational scholars, they helped the students develop their nursing skills. As such, these might be important strategies that together with strategies their instructors/preceptors implement, facilitate skill development of nursing students.

INSTRUCTORS/PRECEPTORS' INVESTIGATIONS

Because most strategies that most instructors/preceptors applied to assist international nursing students to improve their skills were peer learning, integrated learning and clinical simulation, this section is presented under these three sub-headings.

Peer learning

With regards to instructors and/or preceptors, a study by Goldsmith, Stewart, and Ferguson (2006) implemented a peer learning strategy by matching first and third year Australian nursing students from two campuses in a clinical practice unit for one semester. The third year students who took on the leadership roles in the peer learning process studied a therapeutic subject. They were prepared by a programmed tutorial session with the lecturers prior to assisting their first year learners for the first two weeks of semester. Those in the first year were studying basic techniques in nursing care. Instructors demonstrated skills during a one hour tutorial session for a few weeks before their practical placements and they were linked with the senior students by week three. The research revealed that both groups (75% of the first year and 95% of the third year students) agreed that the experience enhanced their learning or that of their peer learners, but they had limited practice time to maximise peer learning opportunities. The senior students' responses were more likely to be positive than the junior ones. In particular, they thought that the peer learning experience enhanced their understanding of the relevance of Australian Nursing Council Inc (ANCI) competency standards to practice, as well as improving their nursing skills and self-confidence by being involved in the first year students' learning. The first year students valued the experience of their friendly senior partners, and both groups gained satisfaction from the process.

To further illustrate the positive effect of peer learning, in Hong Kong, Loke and Chow (2007) implemented cooperative learning among undergraduate nursing students through a peer-tutoring scheme. Sixteen of the second year students who were taking a Maternal and Child Care subject were invited to participate as tutees. Fourteen of the third year students in the same programme who had satisfied the requirements of the subject and had relevant clinical competence in their previous year of study were invited to join the project as tutors. The tutors were prepared through a two hour training workshop and a guidebook of peer-tutoring activities. A set of course materials that included the syllabus, learning objectives, and content covered, was also provided. Peer tutoring was offered for one hour as an adjunct to the regular lectures, laboratory, and clinical placement of the tutees, on a one-to-one weekly basis throughout the semester. The meetings were to provide a forum for the tutors or tutees to share their experience and any difficulties during the fourth, seventh, and tenth week of the semester. Group

and individual interviews showed the students' peer-tutoring experience brought more benefits than negative comments. Benefits were, the tutoring programme could enhance students' learning skills—critical thinking and problem-solving abilities, and communication skills. It also enabled students to gain a stronger motivation to learn and to be more active in their learning. Some negative experiences of the students mostly occurred from frustrations in dealing with incompatible tutor and tutee learning styles, and the required time commitment.

Although the two studies were applied over limited time spans, they showed peer learning can enhance the professional skills of both the senior and junior nursing students. This might facilitate them to be patient educators, as well as preparing them for the role of preceptor that is necessary for today's nursing workforce. This means instructors and/or preceptors should consider promoting more opportunities their peer support in their nursing programmes.

Integrated learning

Another way to help students develop self-learning techniques is facilitating their learning of how to integrate their knowledge. In Canada, Hicks-Moore (2005) reported that, although it took time to assist baccalaureate nursing students in understanding and development of useful concept maps in the early stage of their clinical training, applying this strategy could facilitate their effective data gathering and critical thinking. It is a strategy that encourages students' application and synthesis. The maps enabled them to see clear connections for patients' problems and how one concern could affect another. Employing this strategy led the students to a deeper understanding about how diagnostic information, medications, and signs and symptoms of their patients were related. They could understand why they had to do the care they were doing for their patients. The concept map strategy challenged the students to identify and question data to support their hypotheses, as well as allowing nursing instructors to assist them by asking questions, sharing expertise and providing additional information they might not have realised was important. This could make the students search for ways to assimilate new knowledge with their existing understanding and to integrate what they had learned in theoretical sessions to address their clients' problems.

In trying to improve students' ability to integrate their learning and the clinical learning environment in Sweden, Ehrenberg and Häggblom (2007) applied Problem Based Learning (PBL) and implemented a new model for supervision during 11 weeks of acute care clinical training for second year nursing students. On evaluating the experience of the 45 students and 30 preceptors, the findings showed both groups considered the supervised reflections very positive. The students stated that their opportunities to gain an overall picture of patient care were enhanced. They also appreciated being respected and trusted for their responsibilities in the care activities, which increased their self-esteem and self-confidence. The findings of this study indicate the value of PBL and reflection strategies for enhancing nursing students' learning, preparing them for their working life, as well as improving the clinical learning environment.

In another study testing a strategy for integrating learning, Nielsen (2009) applied a concept-based learning method, using the clinical judgment model as a foundation for pediatric clinical learning in third year American baccalaureate nursing students. Concept-based learning activities had been designed to guide students' study of specific concepts that were viewed as essential for children and family care. The activities based on this model required students to gather information about specific clinical problems, interpret findings, deliver relevant nursing care, and then reflect on the experience, both individually and as a group to consider how the concept presented in different patients. She found that the method added significantly to students' clinical learning as it could encourage deep understanding in clinical phenomena for them. The findings of this study echo the learning process of nursing students in new clinical situations by integrating theoretical knowledge and their critical thinking. The method could facilitate the development of students' nursing skills by connecting concepts to other new patient care situations that they might face in the future. It can promote nursing student progression to higher levels of thinking, which can drive them to move on a continuum from novice to professional.

Using an ethnographic approach, another Swedish study aimed to describe strategies and techniques that 16 preceptors applied in the training of Swedish undergraduate nursing students. Carlon, Wann-Hansson, and Pilhammar (2009) found several different methods that supported integration. The observational field notes and focus group

interviews illustrated preceptor teaching as an actual continuing process: adjusting the level of precepting, performing precepting strategies, and evaluating precepting. Preceptors started with trying to get to know the students to get a picture of how and what they had to learn and then planned to meet the learning objectives that emerged. In this step, based on their preconceived ideas and previous experience, however, preceptors had preconceived expectations as to what students should know and be able to do in their particular year of study. When coming to the step of performing supervision, preceptors stated that first it was essential that they made a trusting relationship with students, so students felt safe to make decisions and know when and to what extent they should ask for help. They thought that this was a fundamental factor for quality precepting. They then were aware of encouraging a free thinking climate for students. In order to understand, preceptors believed that students should be able to ask anything they want to know. This approving climate was very important. For them, there were no stupid questions. If the answers they gave students were different then that was seen as a starting point for discussion.

Moreover, the same study revealed that preceptors wanted to be close to students, but not to hover over them. They had to create safe learning environment for their students. To train nursing students, they thought they had to apply several techniques such as demonstration in combination with students' observation before encouraging them to try, especially for teaching psychomotor skills. For cognitive training, these preceptors revealed their effort to use different techniques to promote reflection, critical thinking, and problem solving skills of their students. For example, low-level or factual questioning for knowledge recall, giving cues for being extra attentive before probing with reflective questions, and encouraging students to verbalise their thinking; they found were effective for clinical teaching. Furthermore, giving situational feedback to create a feeling of security for students, and sometimes reinforcing was needed to confirm what students were performing were also main methods they used. The preceptors took a moment each day to reflect on their students' nursing actions. When passing the half time point, the evaluation about what students had achieved and what they still had to learn was done to guide the remaining part of their clinical practice. The final assessment was also usually held in the form of a conclusion and recommendations. Both the students and preceptors benefited from knowing what they needed to focus on during their coming clinical practice or preceptorship.

Beyond the strategies mentioned, to facilitate nursing students to effectively develop their nursing skills, many international nursing instructors also introduce clinical simulation into nursing programmes.

Clinical simulation

Nowadays rapid change in health care situations calls for nurses who are competent in multiple skills. Clinical simulation is another strategy that has been recommended to promote nursing student learning. Based on limited clinical placements/settings and maybe other potential barriers to learning in the clinical settings that nursing education institutes have to face, this advanced technology provides inexperienced students with opportunities to apply theoretical principles of nursing care through experiential learning and rehearsal practice in a safe clinical environment that mimics a real care setting (Bambini, Washburn, & Perkins, 2009).

Bambini et al. (2009) evaluated the effectiveness of simulated clinical experiences during the initial clinical course, preparation for maternal infant rotation, of 112 American baccalaureate nursing students through an integrated, quasi-experimental, repeated measure design. They revealed that the students valued this learning experience. The quantitative data showed increased self-efficacy to perform clinical skills whereas the qualitative data indicated that the students felt confident in psychomotor skills and patient interactions. They could also develop their clinical judgment; they know when and how to deal with, and how to better identify abnormal physical assessments they found.

However, Cason et al. (2010) applied a comparison group design to evaluate the usefulness of MicroSim in learning the principles and concepts of airway management during the pediatric nursing course of 78 American undergraduate nursing students who were equivalent in GPA. They found that after allowing the lecture group (students who started learning the concepts with the usual classroom lecture) to engage in the scenario as many times they desired, their exam scores were similar to the MicroSim group (students who started learning the concepts with microsimulation and were allowed to engage and participate in the microsimulation as the lecture group did). Nevertheless, the lecture group spent significantly more time to complete the required microsimulation than the MicroSim group. Also, the MicroSim group had better scores

in the first attempt on performance of the required scenario. Therefore, microsimulation was as effective a teaching and learning strategy as lecture plus microsimulation practice, but it could facilitate the students to better transfer their knowledge to perform nursing care (the required scenario) and more quickly than lecture method.

Moreover, Lapkin, Levett-Jones, Bellchambers, and Fernandez (2010) employed a systemic review to identify the evidence for the effectiveness of human patient simulation manikins (HPSMs) in the teaching of clinical reasoning skills (reflective thinking to address new care situations) to undergraduate nursing students. The review included eight English-language studies from 1999 to 2009, seven were from USA and one was from UK, which assessed the effectiveness of high-fidelity HPSMs in facilitating undergraduate nursing students to develop their nursing skills. They discovered that although the use of HPSMs significantly improves three outcomes integral to clinical reasoning: knowledge acquisition, critical thinking, and the ability to identify deteriorating patients, and enhances students' satisfaction with the learning, the results of review were inconclusive about the effectiveness of using high-fidelity HPSMs in the teaching of clinical reasoning skills to undergraduate nursing students; further research was required.

These studies indicated that clinical simulation could support the clinical learning of nursing students and provides another option for nursing education. Nevertheless, it needs to be coupled with other existing strategies and followed up by further research.

Even though the teaching and learning strategies in the Thai college nursing programmes are somewhat different from those in the international context, all of the previous approaches applied focused on facilitating nursing students to develop their critical thinking skills. This leads them to discover the strategies for understanding the essential concepts of nursing care provision. They could be helpful for developing nursing skills of nursing students. Importantly, nursing students should be trained to continuously experience clinical situations where they are challenged to take appropriate decisions and act in a professional way as they will be nurses in the near future. For this reason, any strategy they apply or experience should develop their learning ability to integrate theoretical knowledge into nursing care, especially new patient care situations. These review findings will be the basic data for more

investigation into how the nursing students studying in the Thai college programmes in this study learn to be professional nurses.

PREDICTORS OF ACADEMIC OUTCOME IN THE THAI COLLEGE NURSING PROGRAMMES

A few studies attempted to search for predictors of nursing academic outcomes in the Thai college nursing programmes. The studies used quantitative research and examined graduates, rather than focusing on those who were studying in the course. To exemplify, a study by Thepworachai et al. (2008) reported factors significantly correlated with academic achievement of the nursing students were academic behaviours ($r=0.378$), preparation for examination ($r=0.351$), friend relationships ($r=0.250$), and preadmission GPA ($r=0.182$). The factors that significantly predicted academic achievement of these students were academic behaviours ($\beta=0.842$), preparation for examination ($\beta=0.566$), and friend relationships ($\beta=0.566$). These accounted for 61.90% of variance in academic achievement of nursing students, $F(1,1076)$, $p < 0.05$. Therefore, academic behaviours seem to be a significant factor for developing skills in nursing students.

Regarding the results of licence tests of graduates from the Thai college nursing programmes, a study by Maneechote and Kanyuk (2006) examined the factors related to success in the first licence test attempt in 107 new graduating nurses in Bachelor of Nursing Science programme and Bachelor of Nursing Science programme (continuous). One interesting finding showed that only students' GPA had positive significant correlation with this result. This issue was also found by Warahut, Kaiprasit, and Namjarern (2007) who investigated factors influencing the results of this test with 120 new graduating nurses in similar programmes. The correlation between the result of the first test attempt and a students' GPA, however, was only statistically significant at a low level, $r=0.282$, $p < 0.05$. The researchers tried to explain that it makes sense conceptually that a good GPA means new nurses could develop a strong understanding of nursing concepts, and the critical thinking skills underlying professional nursing practice. Such nurses will be more likely to succeed in nursing situations and the corresponding nursing care analyses that form the main contents of the licence test.

According to these studies, although academic behaviours seem to be important to student academic achievement, they do not clearly show what educational administrators should contribute to assist their students. These studies are only one mirror that indicates teaching and learning administration in the Thai college nursing programmes was not paid enough attention. Being assessed when the students are seniors or graduates is not providing educational administrators with the details of their learning which might lead to their failure. It is also a superficial measure of their progress. These results do not support suitable way(s) to help them before they fail.

PREDICTORS OF ACADEMIC OUTCOME IN INTERNATIONAL NURSING PROGRAMMES

Many factors can illustrate academic achievement in international nursing programmes. In USA, Newton, Smith, Moore, and Magnan (2007) applied an exploratory descriptive design to examine the factors that could predict early academic achievement of 164 sophomore nursing students in a baccalaureate nursing programme. They revealed that a preadmission GPA is a more important predictor of the first-semester GPA of the students than their results of a nursing aptitude test—consisting of four components: math, reading, science, and English. They also discovered that scholastic aptitude—a pre-nursing course GPA calculated from biology, anatomy, physiology, chemistry, biochemistry, psychology, and composition I and II—and a nursing aptitude are both significant predictors of early academic achievement in this programme.

Moreover, a retrospective study by Jeffreys (2007) assessed the progress and success of 112 international nursing students studying in USA through their profile characteristics—academic outcomes, type of retention or attrition, programme completion length, and licensure. She found that the students whose average pre-nursing course GPA (Anatomy and Physiology I, English writing, introduction to Psychology, and Philosophy) was 3.07 on a four-point scale were likely to succeed in nursing, as approximately 83 percent of them earned B grades or better in a nursing fundamentals and medical-surgical nursing course. The course provides the foundation for future nursing courses, clinical decision-making and nursing practice. Students' grades on this course also significantly influenced their retention, attrition, graduation, and licensure. Interestingly, 80 percent of graduating nurses from the study and 100 percent of them

who achieved a B or higher as their nursing course grade average passed the first nursing license examination.

Other studies in USA have also explored what influences could predict students' success on their nursing course and licensure. Concerned about high attrition rates in most nursing programmes of the USA, Ellis (2006) initiated a programme evaluation project using the Nurse Entrance Test (NET) score for the sections of this examination that predict higher critical thinking ability to determine the role of this skill in student success and retention at the end of level I. Of 137 admitted students into the nursing programme, 82 of those entered before the requirement of higher NET scores on the critical thinking analysis portion of the exam (group 1), and 55 of those entered after the implementation of the higher NET scores for admission (group 2). The findings showed 89.1% of the students in group 2 were still retained at the end of level I nursing programme, compared with 70.7% of those in group 1. Therefore, students with higher critical thinking ability had higher percentage of success on their nursing course.

In addition, Romeo (2010) applied an integrative review to analyse 12 recent quantitative research studies focusing on the measurement of critical thinking abilities and skills in undergraduate nursing students as a predictor of National Council Licensure Examination-Registered Nurse (NCLEX-RN) performance. She found half of the studies using the California Critical Thinking Skills Test showed positive relationships between critical thinking skills and NCLEX-RN success. Two also revealed that higher WGCTA total scores were a significant predictor of NCLEX-RN success. Meanwhile, one study reported statistically significant findings that the graduates who pass NCLEX-RN the first-time had higher total mean CCTDI scores than the failure group. According to Romeo, these researchers summarised that adequate critical thinking abilities and skills could lead to students succeeding on this examination.

Rogers' (2010) qualitative study explored what conditions contributed to student success in an associate degree nursing programme and on the NCLEX-RN. Through the interviews of both American students and instructors, the findings showed they strongly believed that no one factor guarantees success. They thought that a combination of factors play a different role among different students. These significant factors might

either relate to student qualities and skill sets, collaboration with others, or the framework and implementation of the nursing curriculum. Student qualities and skill sets included motivation, academic abilities (such as critical thinking, test taking, study skills), prioritisation of roles and responsibilities, the abilities to deal with life situations and extreme stress. Collaboration with others might be a support system from family and friends. Meanwhile, the framework and implementation of nursing curriculum related to innovative teaching methods, and carefully constructed course examinations.

All of these mainly quantitative studies clearly indicate that academic abilities, especially critical thinking competence, are significant predictors of academic achievement and licensure success of the students. Nevertheless, the qualitative study provides other useful information that educational administrators have to take into account before planning appropriate teaching and learning strategies for their students.

CONCLUSION

This literature review shows that both Thai and international nursing students had to develop their nursing skills in often difficult learning situations. Particularly, a great deal of Thai literature revealed that the Thai college nursing programmes have been arranged within an unsupportive learning environment as instructors were not ready for the integrated curriculum, insufficient and inappropriate learning materials and environment, especially in practical contexts. All of these together worsen limited learning opportunities of the students who had rather low learning competencies. Although both previous Thai and international nursing teaching and learning strategies were focused on facilitating nursing students' critical thinking skills to discover how to understand the essential nursing care, they cannot provide the in-depth information for educational administrators to use to assist their students with what and when specific learning strategies could be implemented. The significant issue about how Thai nursing students studying in the college programmes learn in such conditions needs more investigation. The initial literature review, as presented in this chapter, provided the basis for this study. Additional literature is presented in Chapter Eight. The following chapter presents the study design and methods.

METHODOLOGY AND METHODS

INTRODUCTION

In the previous chapter, I reviewed literature that showed nursing students studying in the Thai college programmes had to frequently develop their nursing skills within a range of difficult learning situations. In this study, information is gathered using grounded theory methodology in order to interpret the learning strategies that the students applied in such conditions. Grounded theory methodology was used because it is maintained that persons' behaviours in particular situations are guided by the meanings they give to what others are doing or are concerned to do, and it is necessary to understand how they interpret these meanings in a trustworthy fashion.

To provide the readers with an overview of the methodology and methods that support this thesis, and to eventually support the findings regarding insights into why and how the students behaved in the ways reported within this study, I start the chapter by outlining the philosophy, theoretical and conceptual ideas and main arguments that underpin the study; then detail how the study was conducted. The chapter comprises the sections of grounded theory methodology, methodological rationale, study design and methods. Finally, material covering ethical considerations and establishing research trustworthiness is also included.

GROUNDED THEORY METHODOLOGY

Grounded theory methodology has been a major qualitative method in social science since the three decades of its development (Morse, 2001), the second most popular qualitative research method published in nursing during the last decade (Schreiber & Stern, 2001), and the most accepted method choice (43%) for recent social work qualitative dissertations (Gringeri, Barusch, & Cambron, 2013). It was developed from symbolic interactionism, which has pragmatist ideas as its origin (Charmaz, 2006). Its perspective implies that people construct their own actions from the situations they encounter by interpreting them through interaction both within themselves and others;

and then they behave and interact based on how they interpret the meanings to the things that have for them (Carpenter, 2003; Charmaz, 2006). For this reason, this methodology could be a way to reveal how people manage the situations they need to deal with. This section focuses on reviewing the philosophical underpinnings of grounded theory and the emergence and evolution of this methodology.

PHILOSOPHICAL UNDERPINNINGS OF GROUNDED THEORY

Grounded theory methodology is rooted in two mainstream ideas—the thrust of American *pragmatism* (Strauss, 1987) and the *symbolic interactionism* tradition of social psychology and sociology (Glaser & Strauss, 1967). These are presented in the two following outlines.

Pragmatism

Pragmatism is a humanistic movement in philosophy that supports the central notion that knowledge may be gained about the world through the investigation of things mainly through the valuing of objective and realistic human experiences (Shalin, 1991). Overall, pragmatists maintained that the search for wisdom and knowledge about the world was best approached from an examination of human actions in response to the content of any given situation (Reck, 1964). They focused on understanding the dynamic processes of social life by explaining people's conduct and the meanings underlying that conduct in all of its dynamic and social complexity (Elkjaer & Simpson, 2011), and in ways that help them proceed with the situations that they need to deal with (Wickman, 2012). This is because existing scientific approaches, which relied on discovering meaning in a largely theoretical fashion under frequently artificially prepared circumstances, only created new knowledge within hypothetical constructions. This produced an empirical epistemology of sorts, but not a necessarily realistic or practically useful one, and certainly not useful explanations of phenomena that are available to any person at any time (Peirce & Turrisi, 1998). Subsequently, it was argued, pragmatist 'truth' was to be found by examining the meanings humans gave to the world around them, and whether or not these meanings had any real value to them (James, 1907). Later pragmatists argued that the scientific and representative form of inquiry would therefore not fully serve the unification of knowledge and action because it did not pay enough attention to actual human experiences and interpretations (Smith,

Brightman, & Freeman, 1930). Raising the value of human experience to such levels was a relatively new way to identify solutions to a variety of problems, and certainly to the problems associated with human activities, which may themselves be examined through human interaction and the communication of ideas. This is why pragmatic thought is said to underpin symbolic interactionism (Mead, 1934, as presented by Morris, 1934; Reynolds, Herman-Kinney, & Musolf, 2003), which itself underpins the later sociologically focussed development of grounded theory as a major method of social inquiry.

This original philosophy was established in Anglo-European traditions that were also deeply influenced by the scientific development of the modern era. It was then developed by four influential American Pragmatists, Charles Sanders Peirce (1839-1914), William James (1842-1910), John Dewey (1859-1952), and George Herbert Mead (1863-1931). In the evolution of pragmatism, four key themes—experience, inquiry, transaction, and habit —were identified as ways to find practical knowledge (Elkjaer & Simpson, 2011) and a brief discussion on each of these now follows.

Experience

All of the four pragmatists agreed that persons could learn based on their experience. For example, James (1912) believed that the process of understanding future actions needed previous experiences; persons made use of these experiences to give the meanings to things, not the belief about them as antecedent causes. In particular, Dewey (1941, as cited in Webb, 1941 [1976]) make use of experience as a function to advance their present lives to reach future expectations. They could direct all of their intelligent activities based on the experience they had, so a person's experience could inform and give meaning to social actions in their present lives (Elkjaer & Simpson, 2011; Webb, 1941 [1976]).

Inquiry

Both Peirce (1878, as cited in Anderson, 1995) and Dewey thought that inquiry was at the heart of their respective versions of pragmatism. Peirce thought that inquiry raised uncertainties in order to find out the appropriateness of specific actions. Dewey then elaborated this idea as a response to a specific type of experience. He believed that

persons think about inquiry in terms of analysis and diagnosis of what the nature of the barriers to continuing actions is and what influences they have to overcome, including what possible approaches they should apply. For this reason, inquiry is a method that can be used to modify persons' experiences to creative potential actions all the time, leading to their new understandings. During the inquiry process, however, persons can also implement their preferred hypotheses which then inform another cycle of inquiry. This explains how persons learn about their world (Elkjaer & Simpson, 2011).

Transaction

Both Dewey and Mead (1934, as presented by Morris, 1934) thought that by interaction, persons became socialised to any particular society. It meant they formed mutual expectations of conduct, and in turn they came to understand both self and situation. The idea about transaction leads persons to understand social practices that happen by the continuous weaving together of selves and social situations (Elkjaer & Simpson, 2011).

Habit

Habit was another concern of all four of the original pragmatists. They explained that in a particular situation, habits allow persons to predict their own and others' actions, contributing to the construction of their sociality. Thus, habits can guide persons about what behaviours are acceptable by a particular society. They are symbolic forms of actions that persons conduct to culturally communicate within their society (Elkjaer & Simpson, 2011).

As pragmatic philosophy informed ways of gaining practical knowledge to elucidate the human experiences, many insights came from understanding people's socialisation and the meanings they gave to their interpretations of the world. Mead (1934, as presented by Morris, 1934) emphasised the concept of human self and the social interaction through which the self developed. He clarified these through his perspectives of symbolic interactionism.

Symbolic interactionism

Symbolic interactionism is a theoretical perspective used by several scholars, especially the notable American figure George Herbert Mead, for an approach to study the nature of human group life and conduct. Because none of his books were published before his death due to the unsystematic character of his work, Mead's thoughts were assembled from the lecture notes on his courses and other unpublished manuscripts left to his students and/or colleagues (Morris, 1934; Reck, 1964), e.g. Charles W. Morris and Herbert Blumer. By relying chiefly on the thoughts of Mead, Blumer explained this perspective assumes that persons can give the meanings to everything in their world through a process of their interpretation or communication with themselves and from interactions with others. He maintained that the interpreted meaning guides action to cope with the given situation. This approach was in contrast to the more 'scientific' arguments of the day, i.e. the notion that human behaviours were the products of various 'natural' factors that stimulated and guided their actions. Mead's approach emphasises that persons can initiate actions as they are thinking and acting organisms who can take the world they confront into account in ways that go beyond mere animal responsiveness. Also, human groups are seen as consisting of human beings engaging in action, so the human groups or society exist *in action*; the interlinking of their ongoing actions constitutes society. For symbolic interactionists, the picture of human society as beings in action is the starting point to analyse human society (Blumer, 1969).

In particular, as Mead's perspective saw human beings as thinking and acting organisms, Mead thought that an organism had a *self* and he specifically concentrated on analysing the self and its development in the process of socialisation. *Self* leads the human being to meet the world by the process of self-interaction and social interaction which forms and guides conduct (Blumer, 1969). Mead analysed the *self* into two distinct phases, an "*I*" and a "*me*". He explained that the *I* is the self-in-action/function, whereas the *me* is self-conscious. When the *I* acts, the *me*, as the phase of being conscious, reflects on how these actions appears to others. For Mead, the *me* is also perceivable as an organised set of attitudes of others. Constituting the organised *me* involves responding to the attitudes of others, and an individual then reacts toward that as an *I*. Conventionality and innovation in our social life, therefore, are together explained by the *me* and the *I*. The ability of the *I* to introduce novel experiences to

society causes different responses in the attitudes of others, leading to the *me* of all those involved undergoing change, so that society was constantly changing. Most importantly, according to Mead, persons' selves, especially the *me*, developed relationally in interaction with others rather than individually. This means selves are determined by one's social environment, not one's given nature. By this interpretation, selves can be changed through socialisation. In other words, society can form multiple selves. This line of reasoning became a significant contribution to sociological theory that developed from Mead's social behaviourism as it was gradually transformed into symbolic interactionism which has been of great importance to the development of sociology and sociological thought (Morris, 1934; Schneider, 2006).

Hence, the symbolic interactionist perspective focuses on social interaction, an interaction between persons or a process that forms human conduct. In this process, human beings have to take an account of what others are doing or are concerned to do to direct what they themselves should do in particular situations. In relation to this, Mead identified it into two levels—"the conversation of gestures" (or non-symbolic interaction) and "the use of significant symbols" (or symbolic interaction). He explained that people act with non-symbolic interaction when they respond directly to the actions of another without interpreting that action. If they tried to understand the meaning of others' actions before reacting to them, it means they use symbols in their interactions. Thus, the interaction of "being" considered what others were doing, or were concerned to do, and it is this symbolic interaction that is necessary for a human society (Blumer, 1969).

According to Blumer (1969), meaning occurs as a product of symbolic interaction, and it is called an "object" or anything that can be referred to. Objects are classified in three categories—physical objects such as trees, social objects such as friends, and abstract objects such as ideas. As the meaning of objects arises out of the way persons interact with others, objects may have different meanings for different persons. This leads different persons to have their own environments or their own world viewpoint. Subsequently, human beings conduct themselves according to their own perceptions of objects in the world. If their world of objects changes, it is frequently necessary for persons to change their actions. Therefore, to understand about a person's actions or social behaviours about how they handle the succession of situations confronting them,

it is necessary to explore their world of objects or get inside the process of their interpretation of objects by direct examination of their interpretation of what they perceive. This can be readily tested and validated by observing what is taking place in actual human group life by *four central conceptions* in symbolic interactionism (Blumer, 1969), and an outline of each now follows.

Firstly, as human beings act based on the meaning of objects that comprise their world, to understand their actions, it is necessary to see their objects as they see them. The scholars have to get inside their world of meanings and ‘identify their objects’ by placing themselves as far as possible in the position of individuals. Also, they must have a body of relevant observations about how human beings or actors see objects, how they have acted toward them in diverse situations, and how they refer to the objects in their social interactions. Secondly, as persons interpret each other’s behaviours and their social interactions happens in the form of a process, there is a need to adjust to the lines of action of each other—the ways or given sphere in which persons are defining and interpreting each other’s actions. Therefore, in a study about human group life and social interaction, it is important to seriously examine all forms of social interaction in a given setting. That is, it is necessary to view how the members of the society fit their ‘lines of actions’ (that frequently move back and forth from one to another figure) to serve their harmonious social system. Thirdly, because social interaction forms the ongoing human group life, it is crucial to understand an accurate picture of social action (that consists of the individual and collective activities of the group who are engaged in the interaction) by observing how the process is actually constructed. Finally, social organisation is seen as a huge organism and a complexly organised phenomenon, yet it may reveal the independent arrangements of members who are interlinked in their actions beneath the norms and rules of the society at any given point. For this reason, social organisation should be investigated in terms of the process of interaction. That is, how the members who have to be responsible for sustaining organisation interpret and handle the situations at their positions in the organisation (Blumer, 1969). The guides of pragmatic philosophy and symbolic interaction perspective led to the development of grounded theory.

THE EMERGENCE AND EVOLUTION OF GROUNDED THEORY

Grounded theory is a qualitative research design first developed by two American sociologists, Barney Glaser and Anselm Strauss, in the early 1960s during their field observational study of how hospital staff handled their dying patients (Charmaz, 2006). By developing and utilising a major strategy, a *general method of comparative analysis*, to find *what is going on* in regard to the chosen phenomena, they developed a theory that was grounded in the data and was usable in practical applications. In this method, most hypotheses and concepts not only come from the data, but also are systematically interpreted in relation to the data during the course of the research. This inductive method of theory development was different from the method of generating theory by logical deduction from a priori assumptions used by most sociologists in that era (Glaser & Strauss, 1967). Glaser and Strauss (1967) presented this idea in the book *The discovery of grounded theory: Strategies for qualitative research*, hoping to encourage other sociologists to try to generate theory in this manner, as well as to stimulate them to codify and publish their own methods for generating theory.

However, Glaser and Strauss were from different philosophical and research backgrounds. That is, Glaser was a Columbia university positivist who was influenced by two proficient descriptive statisticians, namely Paul Lazarsfeld and Robert K. Merton. Meanwhile, Strauss was a Chicago school pragmatist and a field researcher being trained by Herbert Blumer, a symbolic interactionist who believed in the pragmatic philosophy of George Herbert Mead (Charmaz, 2006; Stern, 2009b). Thus, the techniques for qualitative data analysis they developed reflected their backgrounds. As descriptive statistics made it natural for him, Glaser proposed to systematise qualitative research methods in a similar way to Lazarsfeld's codified quantitative studies. As a result, Glaser defined "grounded theory as a method of discovery" (Charmaz, 2006, p. 8), and he advocated rigorous codified methods, constant comparisons of the data, but with somewhat ambiguous specialised language which echoed quantitative methods, and for some time both Glaser and Strauss generally supported this overall approach. Nevertheless, in later years, Strauss moved the grounded theory method toward verification to emphasis his experiences in theory generation (Charmaz, 2006; Stern, 2009b). He and his co-author, Juliet M. Corbin, further developed their new techniques and procedures for a growing number of researchers who favoured the development of grounded theory away from the earliest

version (Charmaz, 2006). For these reasons, by the early 1990s, grounded theory developed into two distinct versions, *Straussian grounded theory* and *Glaserian grounded theory* (Morse, 2009).

Straussian grounded theory

To accomplish the four criteria of a well-constructed grounded theory, i.e. fit, understanding, generality, and control (Glaser & Strauss, 1967), Strauss made some changes in terminology and in specific procedures of the earliest version in the late 1980s. He then elaborated these changes in the book he authored with Corbin in 1990, namely *Basics of Qualitative Research: Grounded theory Procedures and Techniques*. In this version, some new procedures and concepts were also introduced as the changes came from additional reflections and different research experiences both on teaching and specific projects of many qualitative researchers (Strauss & Corbin, 1990). Moreover, based on thinking from pragmatist and interactionist perspectives, Strauss (1987) emphasised that both the philosophical and the sociological tradition presumed that social life was in constant change, but its specific directions were based on how people constructed, approved, and changed meanings and actions. He also re-emphasised Chicago sociologists tradition that argued to understand a person's interaction, process, and social change, one needs to 'grasp' the person's viewpoints (Strauss, 1987).

From this point of view, Strauss and Corbin (1990; 1998) contributed their part in the development of a revised grounded theory methodology. These contributions remained in congruence with the belief that if one wants to understand what is actually going on in the given phenomena of interest, he or she needs to get out into the field to comprehend the complexity and variability of human actions and of the phenomena. However, they maintained that developing theory and discipline grounded in data can lead one to understand social actions, and that people perform actions based on the meanings they interpret to respond to problematic situations; that is, their meanings are defined and redefined through their interactions. Hence, to understand the given phenomena, one must be aware of the change and process of human life, including the interrelationships among conditions, actions or strategies applied and consequences (Strauss & Corbin, 1990; Strauss & Corbin, 1998). These refinements to their original

paradigm model (Strauss & Corbin, 1990) led to the main aspects of the Straussian grounded theory version being developed in 1990. They include development in theoretical sensitivity, coding procedures, and theoretical sampling.

Theoretical sensitivity

Strauss and Corbin (1990) re-emphasised that theoretical sensitivity is a capability that is necessary for grounded theorists to develop theory that is grounded in data. It sensitises the researchers to be aware of what is going on with the phenomena they are exploring. Their conceptual senses also help them to identify the conceptual similarities and differences. This leads them to be able to analyse the variation, which in turn can assist them when analysing and verifying data as well as evolving theory. For Strauss and Corbin, researchers could develop this ability both by being familiar with literature and by using their professional and personal experiences. For this reason, the researchers could constitute the essence of specific discovery by connecting what they already known to what had previously been unknown.

Furthermore, Strauss and Corbin offered techniques for enhancing theoretical sensitivity. These are techniques to ‘open up the data’—such as asking basic questions (who, when, where, what, how, how much, and why), analysing a word, phrase, sentence (to raise further questions on what the researchers need to think about deeply). When researchers are stuck or nothing seems to strike them, Strauss and Corbin also suggested that researchers should make use of some comparison techniques to further enhance their sensitivity. For instance, the ‘flip-flop procedure’, which is the technique that helps researchers to think comparatively about the concepts in completely opposite ways, both ‘close-in’ and ‘far-out’—inside and outside the area being studied—in order to discover another issue (that might relate to the concept) to examine. However, concerned about how the researchers can keep a balance between the creativity and the reality, Strauss and Corbin offered further techniques to follow, such as *periodically stepping back and asking*, *maintaining an attitude of skepticism*, and *following the researcher procedures*. These terms indicate coming back to the data, questioning, and asking about particular statements as well as thinking that any theoretical explanations or categories should be considered provisional until they could have enough support data and are useful in reflecting ‘the reality’. Also, they maintained that following the

research procedures and designs can help the researchers to break through the biases that might otherwise affect the reality of the data. All of these techniques can enable the researchers to think about data in new ways and then get all of the relevant information. They not only allow concepts to emerge, but also further verify the hypotheses (Strauss & Corbin, 1990).

Coding procedures

Coding is the name of the procedure most associated with data analysis of a grounded theory. In the Straussian version, coding procedures mean “the data are broken down, conceptualised, and put back together in new ways” (Strauss & Corbin, 1990, p. 57). Strauss and Corbin (1990) described three levels of data analysis—open coding, axial coding and selective coding. Open coding refers to the processes of concept labelling, forming categories, and developing categories in terms of their properties and dimensions. In axial coding, Strauss and Corbin used the paradigm model concluding conditions, actions/interactions or strategies, and consequences to construct categories under the control of a specific framework. This technique can facilitate the researchers to discover the relationships among categories and their sub-categories to form more precise and complete explanations about what is going on in the phenomena they are studying. When moving on to selective coding, the researchers select the core category by grouping categories in accordance with their specific properties. They then validate the category relationships, and maybe fill in some poor categories that require additional refinement and development. These processes lead the researchers to be able to explain how major categories are integrated. However, Strauss and Corbin (1990; 1998) asserted that researchers should verify their data throughout the research process, and not confine themselves to formulating theory, but also include looking for evidence in the data to verify hypotheses and relationships among categories.

Theoretical sampling

In Straussian grounded theory, theoretical sampling involves sampling events, incidents, and related observations, that are indicative of categories based on particular concepts to prove theoretical relevance to the emerging theory. This sampling allows grounded theorists to gather data about the range of conditions that lead to actions/interactions and their variations, as well as the consequences of either taking or not taking certain

actions/interactions. It is guided by asking questions and making constant comparisons during data analysis. As well, literature can give the researchers ideas about where they might go to discover the reality of the phenomena they are studying; which probably involve those situations that they might not normally consider in the first instance. Then the researchers will know the next sources to get the data. This means they can use theoretical sensitivity both to decide what concepts to look at deeply and direct them to where they might find the evidence (Strauss & Corbin, 1990). Therefore, theoretical sampling helps grounded theorists to find as many differences as possible.

Although all main techniques and procedures of the Straussian grounded theory were carefully developed based on research experiences of grounded theorists, they seemed to be not necessary in Glaser's view. This led Glaser to insist in his earliest version and further develop the particular grounded theory methodology known as Glaserian grounded theory.

Glaserian grounded theory

Glaser (1992) strongly disagreed with the processes initiated by Strauss (1987) and elaborated by Strauss and Corbin (1990). He thought that those distorted and misconceived original conceptions of grounded theory to a great degree or even destroyed his creativity of this methodology. Glaser reflected that Strauss wrote a totally different method as if he had never grasped what they had done together. For Glaser, Strauss's work was fractured and scattered rules as it could not generate a grounded theory. Rather, "it produces a forced, preconceived, full conceptual description" (Glaser, 1992, p. 3). He disagreed with the use of theoretical sensitivity as a way of establishing solid connections between the previous known and the unknown, and then making verification. Glaser only used a few neutral questions to enhance theoretical sensitivity and enable literature to be integrated with the emerging theory to show similarities. In relation to coding procedures, Glaser started open coding without any preconceived concepts. He only broke down the data into incidents, to be closely scrutinised and then compared for the similarities and differences by asking, "What category or property of a category does this incident indicate?" (Glaser, 1992, p. 39). Then he moved to theoretical coding to look for the conceptual relationships between categories and their properties to be integrated into a theory. For selective coding,

Glaser used it to selectively code for a core category and to cease open coding. He believed that categories emerged using the constant comparison method and trusted that the core category simply emerges from sorting with theoretical code. It then became a guide to further theoretical sampling. Grounded theorists should use deduction method minimally and closely based on the emergent conceptual guides to guide them where to go next. Theoretical sampling is only an action to round out some areas in order to extend the emerging theory (Glaser, 1992).

However, later grounded theorists have argued that both Straussian and Glaserian grounded theory are still close to a positivist methodology, i.e. discovering social reality based on the research process rather than looking to the changing world (Charmaz, 2009). While they applied systematically gathered and analysed processes to generate theory that emerged from the data, they have not included knowledge that researchers constructed through their own past and present involvements. This recognition by recent grounded theory researchers leads to constructivist grounded theory—the approach that includes integrating the subjective experience of researchers as they believe that reality or knowledge can be constructed through the own past and present involvements of observers/researchers because they are a part of the world—and feminist grounded theory—the approach that pays attention to respect for participants by avoiding gender oppression (Charmaz, 2008). Nevertheless, all of grounded theory methodologies reviewed are alternative methods for grounded theorists to generate potential substantive theory, depending on which approach suits their selected phenomena.

METHODOLOGICAL RATIONALE

From the methodological assumptions outlined above, I was confident that a Straussian grounded theory approach that preserves the pragmatist and interactionist underpinnings would enable me to explore and gain the deep information I required about the ways nursing students learn to develop their knowledge and skills in the clinical context. However, I had four more reasons for selecting this methodology.

Firstly, Strauss and Corbin (1998) suggested a set of techniques, including the paradigm model based on their research experiences that can guide novice researchers to collect and analyse their data systematically, especially in the early stages of the study.

Although some commentators (Glaser, 1992; Stern, 1994; Wilson & Hutchinson, 1996) argued that Straussian grounded theory is prescriptive and procedure-focused with a step by step approach that may prevent researchers from developing the creativity and flexibility that is essential in discovering theory, Strauss and Corbin (1998) stated that researchers should not employ these techniques rigidly. Consequently, researchers are able to apply the techniques or strategies which correspond with their studies. Secondly, this methodology allows researchers to apply theoretical sensitivity from not only the researchers' experience but also the literature review throughout the processes of data collection and analysis. This idea implicitly reflected the assumptions of constructivist grounded theory I agree as the researcher is a part of society (Charmaz, 2008). Strauss and Corbin (1990) agreed that it is necessary to employ researchers' backgrounds to establish solid connections between the previously known and the unknown that constitute the essence of specific discovery. They acknowledged that the more the researchers' experience, the richer the knowledge base and insight available to draw upon in the research. Thirdly, this methodology also reminded the researchers to be concerned more about theoretical sampling which is congruent with feminist perspective that makes recognition of multiple explanations of social reality as they are more responsive to the participants' differences in gender, culture, ability, and so on. This leads the researchers to grasp the variations in concept emerging, leading to the theory that reflects diverse social structures (Burns & Chantler, 2011; Wuest & Merritt-Gray, 2001). Finally, Strauss and Corbin (1990) strongly believed in the role of data verification through the techniques so that interpretations become sufficiently free of biases and unrecognised assumptions that it is possible to produce a valid and reliable theory. All of these reasons made me confident that I was able to collect the data that reflected what is going on with the phenomenon I was studying and then develop theory grounded in the data.

STUDY DESIGN AND METHODS

For Strauss and Corbin (1990), grounded theory was derived from the study of the phenomenon which is discovered, developed, and provisionally verified through systematic data collection and analysis in which "data collection, analysis, and theory stand in reciprocal relationship with each other" (Strauss & Corbin, 1990, p. 23). In this study, therefore, the processes of data collection and data analysis were undertaken in

parallel (as illustrated in Figure 3.1). This included asking questions, theoretical sampling, making comparisons, generating theoretical sensitivity and hypotheses, making theoretical memos and diagrams, moving back and forth until theoretical saturation was achieved. This meant no new or significant data were emerging and all categories were well developed in terms of their properties and dimensions (Corbin & Strauss, 2008).

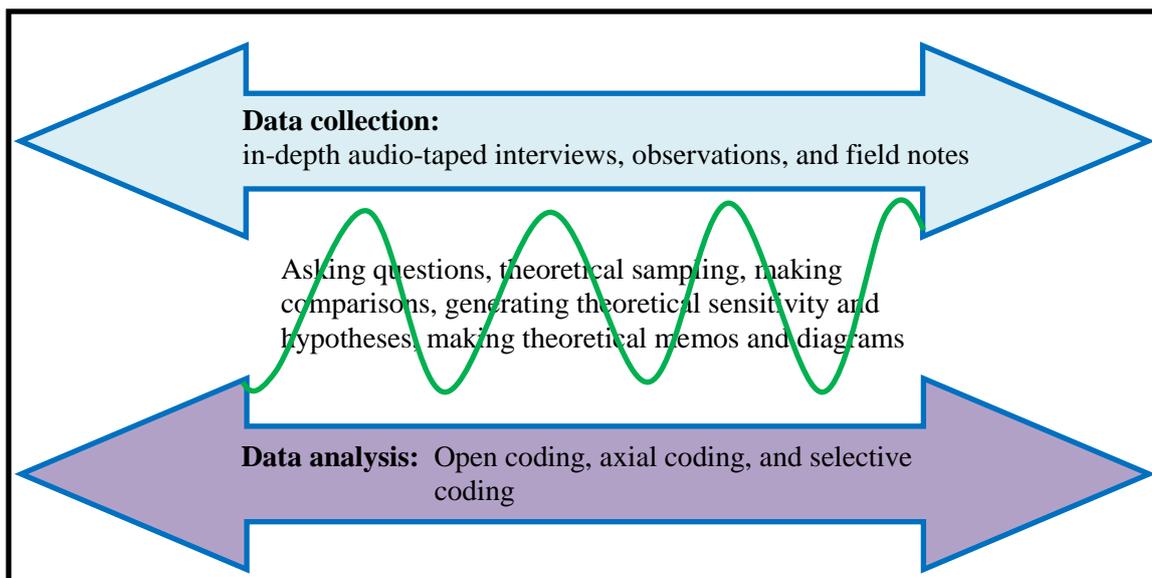


Figure 3.1 Data collection and analysis parallel processes

PARTICIPANTS AND SETTING

As grounded theorists believe that persons can construct their actions from the situations they encounter (Strauss & Corbin, 1998), they look for participants who have had experience with the social process under investigation. In order to comprehensively understand the learning process of the nursing students using a grounded theory design, participants were selected who were over the age of 19 and had experienced practical studies—the second, third, and fourth year bachelor of nursing students. The setting for the study was one Boromarajonani College of Nursing, in Southern Thailand, where the learning environment for students has been affected by the southern border situation.

Thirty-two participants were recruited into the study—15 from the fourth year, 10 from the third year, and seven from the second year. Four of the 32 participants were male (two from the fourth year and another two from the second year) and two of the fourth

year informants were married. The participants' ages ranged from 20-31 years (mean = 22.81 years). Nearly all of the fourth year participants were part of the *Project* intake and most of them were Muslim, reflecting the local population where 82% are Muslim (Public Relations Office Region 4, 2012). In contrast, half of the third year and nearly all of the second year participants were Buddhist, reflecting their recruitment from outside the local region. Twenty-one of the participants passed the licence test in their first attempt. This information related to their GPAs, i.e. those with high and moderate GPAs gained 100% and around 64% pass rate respectively; whereas only 30% of the low GPA students passed. Further details of all participants are reported in Table 3.1.

SAMPLING TECHNIQUES

In grounded theory methods, the researcher recruits participants for theory construction, not for population representativeness (Glaser & Strauss, 1967). Moreover, being concerned more with concepts, he or she is looking for variation of conditions to maximise opportunities for determining how a category varies in terms of its properties and dimensions (Corbin & Strauss, 2008; Strauss & Corbin, 1998). In the initial stage of data collection, the researcher is interested in generating as many categories as possible; he or she will gather data on a variety of relevant areas. As a result, the sampling during this phase is opened to those persons, places, situations that will provide the greatest opportunity to gather the most pertinent data regarding the phenomenon under investigation (Strauss & Corbin, 1990). I began my sampling, therefore, with a purposive method targeting participants who were willing to participate in my study—two groups of five from the fourth and third years—in order to generate as many categories as possible.

After that I continued more specific sampling from the target group by employing a snowball technique based on theoretical sampling to search for further participants by asking previous participants and/or instructor advisors of classes. I started this sampling after the hypotheses were generated by comparing concepts along with their properties for similarities and differences. They led me to more data collection to discover how concepts vary under different conditions. In this stage, therefore, I tried to look for different data that could increase the broadness of concepts and scope of the theory I developed. As such, I went to the participants who would be the best sources that might provide information about the concepts I needed to learn more. I recruited participants

who were different in grade point average scores (GPAs), year of study, reasons for studying nursing, marital status, religion, ages, and gender. For GPAs, I divided the participants into three groups—high, moderate, and low GPA. Although I tried to search for students who had the same GPA levels for each year group, my participants did not have the same scores because their GPA levels corresponded to the range of GPAs of their class. The different colour bands detailed in Table 3.1—blue, yellow, and orange—represent high, moderate, and low GPAs, respectively. Finally, in this phase, I recruited 22 participants—10 from the fourth year, five from the third year, and seven from the second year. To further clarify some hypotheses, I also looked for relevant documents as well as returning back to interview some participants from the initial phase. Only two prospective participants refused my invitation to take part in the study, both worried about their abilities to effectively express themselves in interviews.

DATA COLLECTION INSTRUMENTS

In this study, a significant instrument was me, the researcher. I tried to seek knowledge and train myself to be a grounded theorist who went to a great deal of effort to collect and analyse the data of participants' learning processes. Moreover, I used a socio-demographic record, an academic record and a brief interview guide with two main questions: 1) What is going on in your practical studies? and 2) During your practical placement, how do you learn about and deal with your clients' problems? Also, probing questions were used for more in-depth information based on data brought up by the participants. For example, how do you feel about your practical experiences? How do you develop your nursing skills? What helps you to improve your nursing skills? During your practical placement, do you have to learn in the unsatisfactory conditions? What are the factors that can cause you to learn in such conditions? Why? What is your expectation of practical experiences? How do you achieve them?

Table 3.1 Characteristics of the participants

Pseudonyms	Year of study	Reason(s) for studying nursing	GPA (before being recruited)	Graduated GPA	1st licence test attempt
Arun	4	Interested in health work	3.34	3.33	Pass
Suvadee	4	Permanent job & self-care	3.66	3.65	Pass
Noree	4	Interested & permanent job	3.54	3.53	Pass
Areeda	4	Really like & permanent job	3.32	3.31	Pass
Kanda	4	Individual's wish & permanent job	3.41	3.39	Pass
Yarat	4	Like & permanent job	3.08	3.07	Fail (2 of 8)
Laina	4	Permanent job & family's wish	3.18	3.16	Pass
Inee	4	Family's wish	3.21	3.22	Fail (1 of 8)
Needa	4	Permanent job & self-care	3.14	3.15	Pass
Alfa	4	Permanent job & family's wish	3.02	3.03	Fail (1 of 8)
Siripat	4	Family's wish	2.53	2.52	Fail (5 of 8)
Chuntira	4	Family's wish & permanent job	2.49	2.49	Fail (2 of 8)
Nutsaree	4	Family's wish	2.60	2.59	Fail (7 of 8)
Meena	4	Permanent job & family's wish	2.58	2.58	Fail (2 of 8)
Jeena	4	Family's wish	2.56	2.57	No attempt

Table 3.1 Characteristics of the participants (continued)

Pseudonyms	Year of study	Reason(s) for studying nursing	GPA (before being recruited)	Graduated GPA	1st licence test attempt
Hana	3	Permanent job & family's wish	3.57	3.57	Pass
Leeya	3	Really want to be a community nurse	3.33	3.32	Pass
Sorphee	3	Individual like	3.31	3.29	Pass
Nirin	3	Permanent job & socially acceptable	3.13	3.16	Pass
Fatou	3	Family's wish	3.15	3.11	Pass
Kasaree	3	Family's wish & helping people	3.05	3.01	Fail (2 of 8)
Mintra	3	Permanent job	2.86	2.95	Pass
Araya	3	Permanent job	2.73	2.83	Fail (1 of 8)
Rhoba	3	Like	2.67	2.74	Fail (3 of 8)
Aunchana	3	Like	2.64	2.77	Pass
Raiya	2	Self-care & helping people	3.67	3.51	Pass
Wana	2	Family's wish	3.46	3.37	Pass
Summana	2	Permanent job	3.37	3.33	Pass
Klaiwit	2	Permanent job	3.21	3.24	Pass
Nawin	2	Permanent job & self-care	3.19	3.31	Pass
Supat	2	Family's wish	3.00	3.02	Pass
Plyma	2	Like	2.70	2.81	Pass

DATA COLLECTION PROCEDURES

Data collection was undertaken from the second week of October, 2010 to the third week of May, 2011. After gaining Massey University Human Ethics Committee approval (HEC: Southern A Application—10/63), I accessed the setting and began the recruitment process by introducing myself at the evening Study meeting. I informed the prospective participants about what the research involved, including the purpose, processes and benefits of the study, ethical considerations and the participants' involvement, as well as giving each of them a Thai version of the information sheet (see Appendix E). I then invited them to participate in my project. In this process, I also noted that although I had worked as an instructor of the setting, this did not mean the prospective informants had to participate in my study. I confirmed my role as a researcher who had to respect their participant rights, so their participation was voluntary. With regard to the process of participants' involvement, however, I was very careful to inform and ensure that they understood about the two stages of my sampling, i.e. purposive sampling which needed some participants and theoretical sampling to clarify hypotheses and generate theory until theoretical saturation was achieved, and which phase they might be involved in. When prospective participants accepted the invitation and volunteered to participate in the project, I attempted to establish trust and rapport in the relationship before I asked them to sign a Thai version of the participant consent form (see Appendix F), fill in a Thai version of the socio-demographic and academic records before returning them to me, and made an appointment for interviewing that was convenient for them.

Data collection was started after I could fully establish trust and rapport and the participants felt comfortable to be informants. The data were collected by using in-depth audio-taped interviews, as well as observations and field notes enabling concurrent data validation with methodological triangulation¹². By applying within-method methodological triangulation, I could search for data drawn from multiple sources, which could then broaden my insight into a variety of issues underlying the realities of the phenomenon being studied. This triangulation “could be used to enhance the analysis

¹² Methodological triangulation is one form of triangulation that takes two types, across-method or between-method and within-method. Across-method studies combine quantitative and qualitative data collection techniques (Bekhet & Zauszniewski, 2012) whereas within-method ones use two or more data collection procedures of either quantitative or qualitative techniques (Bekhet & Zauszniewski, 2012; Magnusson, Finnerty, & Pope, 2005).

and the interpretation of findings” (Bekhet & Zauszniewski, 2012, p. 40), so it strengthened the findings of my study. In particular, I applied observation techniques to clearly understand nonverbal communications about how the participants refer to the objects in their conversations and sometimes interactions between them and others, especially, during their clinical practice. I took field notes for objective descriptions of events and interactions as well as jotting down brief notes on what I could observe during interviews before expanding those notes immediately following each interview. For practical observations, I spent time observing the learning activities of most participants, trying to watch interactions and listen to conversations between them and others. I then recorded what I could observe during that time (cited example in Table 3.2). These observations led me to more fully understand the situations and identify the issues about which I was still not clear to be discussed at the next interview. Moreover, after the end of each interview/clinical observation, I took methodological notes about the effectiveness of the strategies I applied and for instructions about how subsequent interviews/observations were made. I also took personal notes for reflections on my feelings to improve my data collection techniques.

Table 3.2 An example of theoretical field notes

Schedule	Field note
April 5, 2011 (8:45-12:00) Clinical observation at a neuro-surgery ward, regional hospital, one participant practised ‘Persons with Health Problem 1’	When arriving at this ward, I saw each student stayed at bedside of her case; they were waiting for morning shift round. At that time, their instructor was not there, but she arrived at the ward around five minutes later. While the nurses were starting their shift round, I saw my participant was busy with making her patient’s bed as well as helping him to change his clothes. Today was the second day for her to care for that patient. She did not ask any information about her case from the nurses there. After finishing her tasks, she then tried to follow the rest of that shift round. She had opportunities to observe other patients, but she didn’t take notes about them. Neither did her instructor. I noticed that she didn’t record any information about patients she rounded.

Table 3.2 An example of theoretical field notes (continued)

Schedule	Field note
	<p>... During taking part in a pre-conference (in the conference room), my participant reported that her patient (diagnosed with Subarachnoid Haemorrhage) was unconscious, but as I saw her case was alert. He could sit up and communicate with his relatives and others, but he could not speak and had right hemisphere paralysis. Also, she told her instructor that she was not sure about the sign of “stiff of neck”, but her instructor did not say anything; she left the issue her student was not clear about and then passed to talk to the nursing care activities.</p> <p>The student did not know how to help her case to do exercise. Actually, she did not understand about the concept of caring for paralysis. The instructor only asked her about the patient symptoms. She did not point out or add about how to help or tell the patient to do exercise, instead left this duty to his relative. ... My participant left the conference to care for her case before it was done.</p> <p>...At bedside, I asked my informant why her patient had to always lie flat on his back (because at the head of his bed was labelled that he had to do that). At that time, her patient lay down with a bed pillow. I asked her “how did you do?” She walked back and forth and tried to find out something in her case’s chart before taking the opportunity to talk to the nurse in the team. ... Around 10 minutes ago, she took the sign off and told me that the nurse told her it was forgotten about after her case was investigated with Lumbar Puncture last week. I asked her again “did you think about this label before this?” she said “No”. “I didn’t suspect anything”. (During the pre-conference, she and her instructor did not talk about the label at all). ...</p>

Once data collection was started, I employed the interview guide approach until the early concepts were derived. If participants, however, brought up another topic or issue that could prove to be significant to my investigation, I would follow through on that topic. After that, during the course of the next interviews, the questions used were more focused and specified, depending on what emerged from talking and observations at the immediate context and previous responses/actions/interactions, by using informal conversational interviews. This approach had been more often used throughout the process of data collection. In this stage, the data analysis process had been simultaneously conducted back and forth until I achieved theoretical saturation. Moreover, throughout the two processes, I had applied the field notes and theoretical memos—my developing ideas about codes and their interconnections during coding, data collecting and analysing, and theoretical sampling, which are sometimes developed from my field notes (cited example in Table 3.3)—as two parallel processes to stimulate my ongoing inquiries and theoretical development. Furthermore, theoretical sensitivity to the relevant literature and my personal and professional experiences would be also employed over these processes to add meanings to data, understanding and splitting the relevant data from that which was not relevant, and developing theoretical memos. I was very careful, however, to balance between important creative aspects from theoretical sensitivity and the reality of the investigation. Concerning this aspect, I followed the suggestion of Strauss and Corbin (1990) by employing the techniques of periodical *stepping back and asking* to reflect on and revise my interpretation of the reality of the situation; *maintaining attitudes* until the supported data were found to fit the situation; and *following the research procedures*.

Table 3.3 An example of theoretical memos

List	Theoretical memo
<p>Memo 29 (April 23, 2011)</p> <p>“not concerned about what the students had to learn”</p>	<p>For the issue no opportunity to learn due to “not concerned” approach of supervisors, I think what I saw in the junior students maybe confirms the negative conditions and learning strategies I found in the seniors. Taking part in conferences and having opportunities to care for patients [field notes on April 5, 21, 2011], did not well facilitate the junior students to clearly understand the problems and how to care for their cases. Besides “asking help” [memo 6], I have to find out more to know exactly about how the junior students, especially those with low GPA learn about the significant problems of their patients when encountering such situations during the next interviews/observations. “Not concerned” plays an important role in learning of the junior students or not? Why were the juniors not interested in pathologies?</p>

More than half of the participants were interviewed at least twice, although two participants were interviewed four times. This is because one of the participants helped me with verification of my new hypotheses. The other participant had limited time for each interview because she lived in the other dormitory that would be closed at 9 pm every day. Most interviews ranged from around 45-90 minutes, depending on the participants’ comfort and convenience. After each interview, I made another appointment for the next interview and expressed my gratitude for their time and willingness to be the informant of my study. Then, I listened to the tape-recording again to gain the essence of data and participant’s feelings, also compared and explained it with my field notes I had jotted during the interview, especially, the behaviours that I could not record on tape, which would be prepared for the next interview before transcribed it. After that, I read and validated the transcribed interview again, also returned it to the informant to validate; this was when participants signed a Thai version of the release of transcripts forms (see Appendix G), before translating it into an English version. Then, I hired proof readers who were Thai and proficient in English language to validate the meaning of the two versions before doing intensive data analysis.

When transcribing interviews, I did a full translation for two cases. For others, I extracted the data into English version by myself under the close supervision of my supervisors. To do that, a Thai transcribed interview version was scrutinised to examine words, phrases, or sentences and the key words underlined (cited examples in blue, purple, and black words in the excerpt columns of Table 3.4). Then the related one was interpreted into an English version by working out as far as possible the full meaning of what the participants said. That was coded based on maintaining the words of participants with the number of case and the page of transcribed interview in the right hand margin of Thai transcripts (cited examples in blue, purple and black words in the extracted columns of Table 3.4). In my ‘findings chapters’ (i.e. Chapters Five to Chapter Seven), I also validated all of the codes I used to support my paragraphs with my co-supervisor and a proof reader who worked at Massey teaching and learning centre. With regard to conducting the processes of data collection and analysis in Thailand, I was closely guided by my fieldwork supervisor and sometimes consulted my primary supervisor throughout this phase.

For transcribed interview translation and data extraction, because some Thai words have some different senses from English words and have a totally different sentence structure from English language (Stern, 2009a), I made the translation by focusing on the close meaning and the meaning contexts of English words. For example, the word “excited” can be used in the sense of both positive and negative feelings in Thai. When it was translated into an English word, its context words can guide what word is the close meaning. If it was used to represent the negative feelings of the participants, I translated this word into “nervous”. With some Thai words that are difficult to find the same meanings in English, I not only used the techniques mentioned, but also put Thai words in square brackets. All of the Thai words used were given explanations and meanings in English in both the glossary and footnotes.

DATA ANALYSIS

Data analysis was begun immediately after the first day of fieldwork because the analytic questions and hypotheses about categories and their relationships would inform the next information sought and theoretical sampling (Strauss, 1987; Strauss & Corbin, 1990). This process had been conducted by employing the techniques of open coding, axial coding and selective coding as guided by Strauss and Corbin (1998) moving back

and forth until the substantive theory was developed.

Open Coding

Open Coding includes the analytic tasks of “naming concepts, defining categories, and developing categories in terms of their properties and dimensions” (Strauss & Corbin, 1998, p. 103). This procedure was done through the mean of a ‘microscopic analysis’ (which would also be applied in axial coding). This process examines the specifics of data to describe incidents or happenings, produces the concepts that seem to fit the data, opens up the inquiries to discover new concepts and how they relate to each other, and systematically develops categories (Strauss & Corbin, 1998). Every interpretation, however, at this coding stage was uncertain. Unlikely data represented in the early interpreting would eventually be verified or then given up if later steps of the analysis showed the data did not fit. The process was carried out as follows (as shown in Figure 3.2), and outlined below.

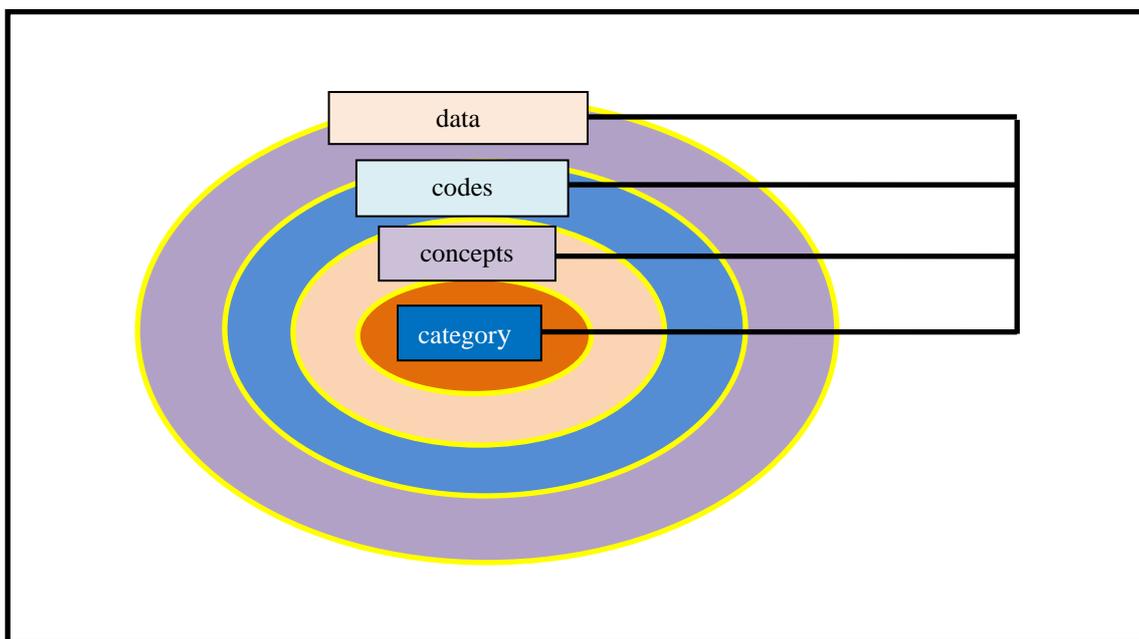


Figure 3.2 Open coding through a microscopic analysis

First, each Thai interview transcript was scrutinised to examine words, phrases, or sentences and the key words underlined. Second, the data were extracted into an English version in the right hand margin of the transcript. After that, the extracted data were

broken down into discrete incidents, ideas, events, acts, or happenings, and then each was labelled or coded. The name of the code came from either my ideas due to the imagery or meaning the data evoked when examined comparatively and in the context located, or from the words of the participants called “in vivo codes” (Glaser & Strauss, 1967). As data analysis continued, if I came across another incident, idea, event, act, or happening which was identified through comparative analysis as sharing some common attributes, I would give each of them the same code (cited examples in blue and purple words in the code column of Table 3.4). All codes were written in the right hand margin of each transcript. Also, I frequently interrupted the coding in order to begin theoretical memo writing to reflect how I was doing this early coding as suggested by Strauss and Corbin (1998).

Third, similar codes were grouped and named according to their characteristics or properties, under more abstract terms called “concepts”. As grounded theory uses the constant comparative method at all levels of abstraction data, the theory would not be discovered but rather formulated and then verified concurrently. When continuing my analysis, therefore, I moved through the microanalysis stage by comparing the concepts, and generating provisional hypotheses—statements about how concepts seem to relate. This led to asking probing questions (as suggested by Strauss and Corbin (1998)) such as who, when, where, what, how, and why, during the subsequent interviews (I also began some of these in the labelling stage). When asking questions, I kept in mind I was applying them not only to generate the data about what is going on, but also to reveal how the incident compares dimensionally along relevant properties with the others already specified. For instance, the students took basic case information as they were able. I thought that at that time the strategy might not lead them to know their case problems, or that they might employ several methods to learn about their case problems. These hypotheses led me to asking probing questions such as: They applied that strategy for what reason? Whether they applied another strategy or not? Did the students in a different year of study have different strategies? Did they ask for help? By whom? Why? With what results? How did they actually find the problems? (all of the questions were cited in pink in the concept column of Table 3.4). Moreover, by asking further questions, it was presumed that this might lead to other issues that I might want to look

Table 3.4 Open coding of “taking basic case information as they are able” concept

Excerpt from data	Extracted data	Codes	Concepts	Sub-category	Category
<p>In my second year when we were starting practice, weren't we? <u>The first time I went there, I took notes patient information. I didn't know what to record first or later. I just wrote it down all.</u></p> <p>...<u>took it all because I didn't know which one was important or not, so I took it all.</u> ...</p>	<p>-in my second year, I didn't know what information I had to get, <u>just wrote it down all</u> (5,8)</p> <p>-[in my second year], I didn't know which information was important or not, <u>so I took notes all</u> (5,8)</p>	<p><u>Taking as much patient information from the charts as they could</u></p>	<p>Taking basic case information as they are able (for what, how about the students in different year of study? whether asked for help, by whom, why, with what results, how to actually find problems)</p>	<p>Seeking case problem and how to provide nursing care</p>	<p>Continuing Practical Studies</p>
<p>I: On the first day, no! Normally, I planned...As I noticed on <u>the important symptoms I saw and diseases. I focused only on that. I meant I asked them their information to be my support data.</u> ...</p> <p>Ah! Like, “not being comfortable due to wound pain”, things like that. So I specified [their problems]. I meant <u>I asked them that “do you still have wound pain or not?”, things like that. If they said yes, I wrote not being comfortable because patients had operation wound pain.</u> ...</p>	<p>-on the first day of caring, I only <u>focused to plan on the obvious symptoms of my cases</u> (23,22)</p> <p>-[in my second year], I <u>set the diagnoses by following the obvious symptoms my case had at that time</u> (23,26)</p>	<p><u>Focusing on the signs and symptoms</u></p>			
<p><u>I noticed patient problems. The problems that brought them [to hospital]. Yes, their symptoms. So, I brought those problems to my nursing diagnoses.</u></p> <p>Before practising, we were allowed to observe on the day before first, weren't we?...Yes! I meant taking patient illness histories. <u>Asked them [patients] about their chief complaints,</u> things like that. <u>[For physical examination], I just a bit did that. Like, if a patient had anemia, for example, I would look at his eyes, things like that. Tried to find out whether his eyes looked pale or not.</u></p>	<p>-tried to diagnose my case's problems from the chief complaint (15,20)</p> <p>-on the observing day, I took the chief complaint and did noticeable physical examination from my case (15,17-18)</p>	<p><u>Asking patients and/or doing physical examination</u></p>			

Table 3.4 Open coding of “taking basic case information as they are able” concept (continued)

Excerpt from data	Extracted data	Codes	Concepts	Sub-category	Category
<p>...Looked at patients that <u>what equipment they might have on and then asked [about their symptoms], like, ah, “Do you have pain or not? How they were at that time? Could you eat or not?”</u> Things like that.</p> <p>...When finishing patient observation [finishing taking notes about a patient’s information from charts], I was then going to see patients. <u>They had urinary catheter or not? Or on some equipment? I had to see my cases as I could bring up [that information] to set diagnoses [for him].</u> ...</p>	<p>-[in my second and third years], I <u>knew my cases’ problems by observing the noticeable equipment they had, asking them about their present problems</u> (12,23)</p> <p>-[on the observing day, after taking notes about my case’s information from the charts], I looked at <u>what the noticeable equipment my case had</u> (12,21)</p>	<p><u>Focusing on the signs and symptoms</u></p>	<p>Taking basic case information as they are able</p>	<p>Seeking case problem and how to provide nursing care</p>	<p>Continuing Practical Studies</p>
<p>I read information in charts first. ... In charts, I found patient’s name, age, diag [medical diagnosis]. I then read a chief complaint, following by orders [doctor’s treatments]. At the beginning, I still couldn’t learn anything, could I? <u>I still didn’t know anything, so I recorded all [all information] [laugh]. I wrote all of what was in the charts.</u> After that, I could learn by taking part in conferences with my instructor. Which parts I had to focus on. <u>At the beginning, I couldn’t read [some information], just took it! Some [I took] might be wrong. When seeing my nursing care plan, my instructor said, “This one is the right copy?” “How to spell it?” I told her “I can’t read a doctor hand-writing”.</u> I tried to do but it was difficult for me. That what I responded her.</p>	<p>-I didn’t know how to take notes the information from the chart, <u>so I took all of the information as shown</u> (28,29)</p>	<p><u>Taking as much patient information from the charts as they could</u></p>			

for when I continued with the interviews and analyses. For these hypotheses, I also thought about whether the strategies were different in the students who had different GPAs, reasons for studying nursing, year of study, religions, and genders. This also led me to further theoretical sampling in the groups. Asking questions, therefore, could maximise my opportunities to understand more about a phenomenon because it could stimulate the discovery of properties, dimensions, conditions, and consequences.

Fourth, certain concepts were classified under a more abstract or higher order concept based on their ability to explain what was going on; this was recorded as a “category”. Eventually, these categories were developed in a process that reflected their properties—“the general or specific characteristic or attributes of a category”—and dimensions—“the location of a property along a continuum or range” (Strauss & Corbin, 1998, p. 117). Once I had some categories, I specified their properties and dimensions (and also formed some of these in concept definition). Also, I wanted to know how the categories varied dimensionally along those properties. By distinguishing attributes of each category for further clarification and specification into “sub-categories”, I could further differentiate it from other categories, so that the categorising gradually became more precise. In this process, I could see the patterns of the foundation and provisional structure of a theory. However, when I sensed that some of my analysis parts were not satisfactory or important relationships among categories might be more clearly developed, I engaged in additional open coding.

Axial Coding

Axial coding is the process of systematically developing and relating categories to sub-categories along the “axes” of their properties and dimensions by applying the paradigm model—a conceptual analytic device for organising and integrating conditions with the process in which a phenomenon arises. In this process, the relationships among categories form more precise and complete explanations about what is going on in the phenomenon (as showed in Figure 3.3).

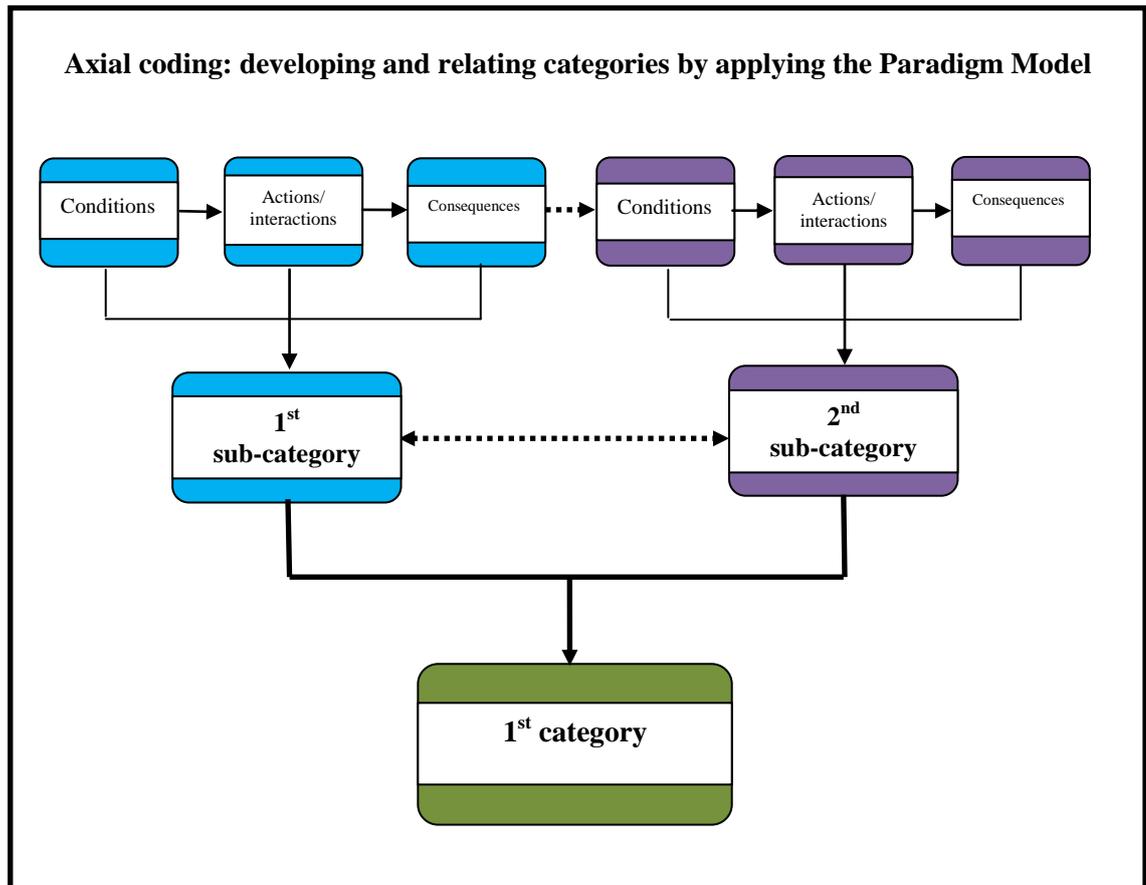


Figure 3.3 Axial coding through applying the Paradigm Model

The significant components of the paradigm model are *conditions*, *actions/ interactions* and *consequences* (Strauss & Corbin, 1998). Conditions are “sets of events or happenings that create the situations, issues, and problems pertaining to a phenomenon and, to a certain extent, explain why and how persons or groups respond in certain ways” (Strauss & Corbin, 1998, p. 130). Conditions may be micro or macro and can influence actions/interactions either directly or indirectly, with more or less impact depending upon circumstances. Also, they shift and change over time, affecting one another, and combining in various ways along different dimensions, which are represented by the set of questions “Why?”, “Where?”, “How come?”, and “When?” Although there are different conditions such as causal, intervening, and contextual conditions, Strauss and Corbin (1998) state that grounded theorists should not pay so much attention to which one it is; rather they have to focus on the complex interweaving of events (conditions) leading up to a problem to which persons have responded with some forms of actions/ interactions, and with some sets of consequences.

Actions/interactions (strategies) are the strategies or routine responses individuals or groups employ to deal with issues, problems, happenings, or events which arise under conditions. They evolve over time as persons define meanings to situations. They are represented by the questions “By whom?” and “How?” The last element of the paradigm is consequence. This describes the outcome of actions/interactions and is represented by questions about what happened due to the actions/ interactions (Strauss & Corbin, 1998).

To code axially, I followed four significant procedures suggested by Strauss (1987). There were, firstly, laying out the properties and dimensions of a category that were emerging during the open coding process; secondly, identifying the variety of conditions, actions/ interactions, and consequences that were related to the phenomenon; thirdly, relating a category to its sub-categories by statements indicating how they were related to each other; and finally, looking for key words in the data, denoting how major categories might relate to each other. Moreover, I concentrated on the answers to questions, such as why, how come, who, where, when, how, and with what results, to relate structures (conditions) and processes (actions/interactions) to eventually capture the dynamic and evolving nature of the phenomenon as suggested by Strauss and Corbin (1998). Examples of axial coding are showed in tables in each of the findings chapters (Table 5.1, 6.1, and 7.1).

Selective Coding

Selective coding is the process of integrating categories and refining the theory (Strauss & Corbin, 1998). I started with relating major categories to a provisional central idea through explanatory statements of relationships. I then reviewed the scheme for internal consistency and logic, filled in unsaturated categories and trimmed excess data off, and validated the theoretical scheme, all as suggested by Strauss and Corbin (1998).

In the process of integrating categories, I chose a central category or a core category representing the main theme of the research, by using all of criteria suggested by Strauss and Corbin (1998). These criteria are: 1) it is a central idea that all other major categories can be related to; 2) it appears frequently in the data; 3) its explanation evolves by relating to categories logically and consistently, with no forcing of the data;

4) the phrase describing its name should be sufficiently abstract for other substantive area research, leading to the development of a more general theory; 5) it is formed from the analytically refined concepts through integration with other concepts; and 6) it is able to explain the phenomenon although its conditions might vary and there may be contradictory or alternative cases. I also applied several techniques to facilitate the integration process suggested by Strauss and Corbin (1998) as follows.

The first technique was writing the storylines. Employing this technique, as the researcher who had been immersed in the data, I wrote a few descriptive sentences that explained a given situation, e.g. “the students made an effort to improve their nursing skills. This is because they needed to know how to provide nursing care for their cases, but in doing so however, most of them only roughly understood the problems of their patients, while a few others could reach the ultimate goal and clearly understood how to provide nursing care”. I then returned to reread several interviews and observational field notes to stimulate my thinking in terms of a general sense of the research essence. Based on the discussions with my supervisors, I tried to scope the central idea by thinking about the main issue which the informants grappled with. I considered the learning strategies the students tried to reach that persisted in striking me over and over although most of them could not come through the process. Finally, I could name the central idea as **Developing Effective Strategies for Nursing Care** and related other concepts to it.

The second technique was making use of diagrams. The use of integrative diagrams assisted me to work with concepts rather than the details of data. Diagrams also stimulated me to think about the logic of relationships among concepts and major categories, especially when the relationships were not clear. For me, I thought that applying diagrams was more useful than storytelling and one way to succeed was to apply them throughout my research process. In this study, I found that I made 16 diagram versions and my previous ones led up to the integrative learning process. While reviewing my previous diagrams, I attempted to discuss what is going on diagrammatically with my supervisors and colleagues. When further clarification was necessary, I asked directed questions (as the first technique). I also had opportunities to revisit and talk to 25 participants about the unclear concepts during the data validation process. These procedures led to stimulate my thinking about relationships which could

facilitate the integrative process and confirm the central idea I already found by storytelling. However, in using diagrams, I was careful not to make them too complicated. I focused on my major categories, flow with the apparent logic without many words, lines, and arrow explanations as suggested by Strauss and Corbin (1998). My last integrated version diagram is shown in Figure 4.1, which was split to demonstrate the details in each of the finding chapters (Figure 5.1, 6.1, 7.1, and 7.2).

The last technique that I found useful (because it confirmed my concepts and category integration developed by making use of diagrams), was the process of sorting and reviewing of memos. Strauss and Corbin (1998) stated that if the researcher has systematically identified the properties of concepts along with their dimensions, memos should contain the cues to integration. For this reason, I continued writing my memos throughout my research process. Although my beginning memos seemed not to be enough of a guide for data collection and analysis, as well as being simple, when my data and analysis research progressed, I found that my later memos could more and more clarify the previous ones and help me to keep in mind how my concepts, sub-categories, and categories were related. I could focus on the evolving of concepts and their cross-dimensional linkages. This involved a considerable amount of integration leading to a central idea, to begin the final construction of the theory.

In the process of refining the theory, during my final writing, if I realised that important data or concepts may be missing, I would review the scheme for internal consistency and logic by making use of more diagrams and reviewing the memos. If they still needed to be worked out further, however, I would redefine the properties and dimensions of the central category and then answered the question of how much of these had been constructed into the scheme. If they still were not clear, I would go back to the data and sort them out again. Also, I expanded poorly developed categories—the categories which are insufficiently developed in terms of properties and dimensions—by reviewing memos or raw data looking for data I might have overlooked. Furthermore, I trimmed off the excess data—the data which seem to trail off into nowhere or extraneous concepts that could not be developed because they did not appear frequently in data. In addition, I validated the theoretical scheme by presenting it to 25 informants, and asking for their comments on how well it seemed to fit with their ideas and whether anything noticeable had been omitted from it. Finally, I also related

outlying cases to my theory building to test and affirm its transferability and explanatory power (The process of **Developing Effective Strategies for Nursing Care** is shown in Table 8.1).

Because only some of the participants could fully accomplish the process of **Developing Effective Strategies for Nursing Care**, the findings of this study were reported based on how many of them gave their point of views about a particular issue. In this research, 2-12 cases were reported as “some”, 13-15 cases for “nearly half”, 16 cases for “half”, 17-25 cases for “more than half”, 26-29 cases for “most”, 30-31 cases for “nearly all”, and 32 cases for “all”. It could be argued that it is not appropriate to count responses in this manner given that in grounded theory method, the same questions are not asked of all participants. However, in this study with 32 participants in different year levels of the programme, I wanted to clearly represent the extent to which particular issues were reported by participants. Moreover, the results show the participants who were different in GPA had differences in some conditions, especially *motivation to learn*, and some obvious strategies they applied, so the findings in these related parts were reported with their GPA (as detailed in the finding chapters).

ETHICAL CONSIDERATIONS

Ethical considerations were applied throughout the research procedures as follows.

Firstly, before conducting this project, I prepared my research proposal, including the data collection instruments, participants’ information sheet, and informed consent form under the supervision of my main supervisor. After finishing the proposal, I sent a letter to the director of the setting to ask for permission to conduct my study (see Appendix B). After being granted the permission (see Appendix C), I applied for ethics approval from the Massey University Human Ethics Committee (MUHEC) (see Appendix D). Under these procedures, I was certain that the study had been properly planned and the rights of the informants had been protected.

After being granted the ethics approval, I advanced to the process of data collection by carefully following data collection and analysis procedures. In this process, before the first interview with each participant was done, he or she was re-informed that he or she

was under no obligation to accept this invitation and his or her participation was both voluntary and confidential. After the participants confirmed they were willing to be informants of the study, they had the rights to: 1) provide their information based on their opinions; there were no right or wrong answers and their responses had no influence on any of their academic subject scores; 2) decline to answer any particular question; 3) ask for the recorder to be turned off at any time during the interview; 4) withdraw from the study up until the data collection was completed if they wanted without effect on their studies; 5) ask any questions about the study at any time during participation; 6) provide information on the understanding that their name were not used unless they gave permission to the researcher; 7) listen to, or change their previous information record during the data collection process; and 8) be given access to a summary of the project findings in the process of validating the preliminary findings and when it was concluded. These procedures aimed to ensure that the participants clearly understood the information about the study, and also independently made their decision to participate in the study.

Moreover, to protect the participants' confidentiality, I used pseudonyms at the beginning of each interview record and in their stories described in my report and publications. Also, their interview transcripts and audiotapes as well as any document/ note/ record/ form emerging from the conducting of this project were kept in a safe locked place and will be disposed of a year after the study is completed. Besides me and my supervisors, therefore, no one knew where the data came from.

Finally, I applied well recognised ethical principles in writing and disseminating my research. To achieve this goal, I did not try to suppress, falsify, or invent the findings to meet my needs or make readers believe that they were true. Also, I will not duplicate the publication by publishing papers that present the same data, discussions, and conclusions. Furthermore, I presented the exact findings in all aspects, even limitations of the study.

ESTABLISHING RESEARCH TRUSTWORTHINESS

Lincoln and Guba (1985) suggest that trustworthiness, a term used in a naturalistic paradigm, is highly important and must be considered when presenting qualitative research findings. They have suggested four criteria for establishing the trustworthiness of a qualitative study: *credibility*, *dependability*, *confirmability*, and *transferability*. These criteria could be employed with many types of qualitative research but not necessarily for the creative aspects of grounded theory credibility (Corbin & Strauss, 2008). In this research, therefore, I applied the criteria as guidelines that are required for my study procedures, and complemented them in relation to credibility by criteria for evaluating the empirical grounding of grounded theory findings as suggested by Strauss and Corbin (1998).

CREDIBILITY

The credibility of research findings is a measure of the confidence that a researcher has adequately captured the occurring realities of the respondents on an interesting phenomenon in the context being studied (Lincoln & Guba, 1985). In other words, credibility is the evidence that testifies the findings can be trusted (Liamputtong, 2009). Lincoln and Guba suggest five major techniques to enhance credibility: 1) indicating the activities increased the probability that credible findings will be represented: a) by demonstrating a prolonged period of engagement in the field or going native to learn the context and establish trust, leading to the ability to detect and minimise distortions that might otherwise creep into data; b) by providing evidence of persistent observation for identifying the influential and contextual characteristics and elements in the situation that are most relevant to the interesting phenomenon and focusing on them in details; and c) by presenting the different modes of triangulation—the use of multiple and different sources, methods, investigators, and theories. 2) providing the evidence of external checking on the research processes (peer debriefing) for exploring aspects of the research that might otherwise remain only implicit within the researcher's mind; 3) presenting the negative case analysis—a process of revising hypotheses with outlying cases for refining hypotheses until they account for all known cases without exception; 4) making possible checking preliminary findings and interpretations against archived raw data; and 5) providing the study participants with data, interpretations, and preliminary findings, in order that they can verify or further provide their own realities

based on their experience.

Moreover, Strauss and Corbin (1998) suggested the criteria for evaluating the empirical grounding of grounded theory findings or creative aspect credibility of grounded theory. These include meeting the following questions: 1) Are concepts generated from the study? 2) Are the concepts systematically developed and linked to others? 3) Are there many conceptual linkages, and are the categories tightly linked? Do categories have conceptual density or many properties that are dimensionalised? 4) Is variation built into the theory? or has a concept been examined under a series of different conditions and developed across its range of dimensions? 5) Does the explanation of variation include the conditions and consequences? 6) Has process been taken into account of analysis? 7) Do the theoretical findings deliver new information or offer new insights or explanations, and to what extent? 8) Have the major concepts of the findings proven their usefulness although the specific results associated with them may have been modified and changed with time?

In regard to the above, I confirm that I could capture the occurring realities of the nursing students about how they had learned to be professional nurses for a number of reasons. The first was that I took a prolonged period, around seven months, to engage in the field. This let me to fully learn the context and establish trust from the participants, leading to the ability to detect and minimise distortions that might otherwise have crept into the data (Liamputtong, 2009; Lincoln & Guba, 1985). During this period, I could also persist in making observations, taking theoretical field notes, making theoretical memos, and applying theoretical sampling. To do that, I could identify the influential and contextual characteristics and elements in the situations that were relevant to the learning process of the students. The methods of making observations and taking field notes as well as in-depth audio-taped interviews could also validate my data as they offered evidence of methodological triangulation because “triangulation is the most powerful means for strengthening credibility in qualitative research” (Liamputtong, 2009, p. 26). In this study, I also refined my hypotheses with one outlying case until they could explain all known cases. Moreover, I had opportunities to present my research procedures and preliminary findings to the doctoral school meetings of Massey University. This was a process of external checking as it could explore the implicit aspects of my study. I also went back to revisit 25 of the participants to present them

with my preliminary findings in order that they could verify and/or further provide me their own realities. Finally, when checking my research findings with the suggestions of Strauss and Corbin (1998), I found that they met all of the criteria. These were, the concepts were generated from the study based on the different conditions and across their range of dimensions. They were systematically developed and tightly linked to others, so the findings delivered new insights for how the students learned as major concepts even though some may have been modified and changed with time.

DEPENDABILITY

The dependability of qualitative research is not represented by the concepts of stability, consistency, and predictability as in a conventional paradigm. Rather, it is seen as part of a larger set of factors that are associated with changes in the entity being studied due to changes in the emergent design as more understanding of the true nature of the study and the appearance of working hypotheses. Sociological naturalists therefore demonstrate dependability by seeking means for considering both factors of instability and factors of phenomena or design induced change (Lincoln & Guba, 1985). In this viewpoint, dependability can be claimed by demonstrating the credibility of the study. However, I thought that it was possible to employ the appropriate techniques outlined in relation to credibility to show that my study had that quality, so it was not necessary to demonstrate dependability independently as suggested by Lincoln and Guba (1985). Nevertheless, there are other techniques suggested to establish dependability. For example, there is an overlap method that represents a kind of triangulation (Bekhet & Zauszniewski, 2012; Magnusson et al., 2005) as discussed on page 72. This means a demonstration of triangulation is equivalent to a demonstration of dependability (Lincoln & Guba, 1985). Second, there is the technique of using an inquiry audit. In this technique, the auditors examine the process (by which the study will be investigated) and the product (by which the data, findings, interpretations, and recommendations). Then, they can be determined to what extent they should be accepted and whether the study should be attested as dependable or not (Liamputtong, 2009; Lincoln & Guba, 1985). Furthermore, the process of authentic product examining can also be used to determine confirmability simultaneously (Lincoln & Guba, 1985).

CONFIRMABILITY

In qualitative research, confirmability is the degree to which the findings are generated from the characteristics of participant data and conditions of the study, not from the biases, motivations, interests, or perspectives of the researcher (Lincoln & Guba, 1985). As indicated above, a significant technique for establishing confirmability is an inquiry audit (Lincoln & Guba, 1985). In an inquiry audit, I could provide at least six classes of raw records called “audit trails” for the auditor to determine trustworthiness of the findings (dependability, confirmability, and a secondary check on credibility) as claimed by Lincoln and Guba (1985). There are a residue of systematic records stemming from the study which includes raw data, data reduction and analysis products, data reconstruction and synthesis products, process notes, materials relating to intentions and dispositions, and instrument development information.

TRANSFERABILITY

The transferability of qualitative research is the extent to which the research findings have applicability in other contexts or with other respondents. Because the naturalists can not specify the external validity of a research study, they only provide the sufficient descriptive data that make transferability judgments possible (Lincoln & Guba, 1985). The transferability of a qualitative study, therefore, is determined by the degree of the context similarity between the findings and the sites to which the findings are applied (Lincoln & Guba, 1985). Mindful of this, after considering the similarities and differences of the context, the appliers can make decisions on whether they can transfer the findings of the study or not and to what extent. For my research findings, I thought that transferability is possible to the degree that other contexts have similarity to the setting represented by findings.

CONCLUSION

This chapter has presented various elements that cover the general and specific benefits of a grounded theory methodology as applied to this study. It has been maintained that grounded theory implies that people construct their own actions from the meanings they give to the situations they encounter. This is because people’s social interactions, processes, and even social change may be understood by grasping the viewpoints of individuals or specific groups of individuals when faced by a commonly shared

phenomenon. Subsequently, the design and methods utilised in this study allow for an approach that leads to an understanding of a given phenomenon via the grounded theory method. The more specific ways of researching the particular phenomena of interest in this study have also been explored in this chapter, i.e. how undergraduate nursing students who studied within the Thai college programmes developed their nursing skills to be a professional nurse. In particular, it has been argued that the chosen design and methods support the learning complexities and the variability of learning actions of Thai student nurses both in the processes of data collection and in a substantial analysis. This greatly helped the discovering of the realities of student nurses' learning processes. The design and methods in this chapter, therefore, provided a suitable analysis of what, when and which specific learning strategies should be considered or implemented. All of the findings derived from this investigation are outlined in the next chapter and then detailed in each of the finding chapters (Chapter Five, Chapter Six, and Chapter Seven).

OVERVIEW OF THE RESEARCH FINDINGS

INTRODUCTION

As mentioned in the previous chapter, in this study, I proposed to explore the learning processes of undergraduate nursing students who studied within the Thai college BNS programme within one campus setting. I aimed to discover how the students develop their nursing skills to become professional nurses. In this brief chapter, the process of **Developing Effective Strategies for Nursing Care**, the core category, and the influential conditions which together explain this phenomenon are over viewed, prior to a brief outline of the categories **continuing practical studies** and **learning how to provide nursing care**. This overview of the grounded theory provides a framework within which the detailed exposition of the four sub-categories in Chapter Five to Seven fits.

OVERVIEW OF THE RESEARCH FINDINGS

The learning processes of the participants emerged from their efforts to improve their learning strategies in dealing with their clients' problems during their three-year practical placements. The students made use of their previous learning experiences as bases to build up their learning strategies for the next stage(s). Throughout the learning periods, however, their learning strategies could move back and forth and they also faced difficulties in achieving some strategies because of the negative influences they encountered. One significant finding was that differently motivated influences led to very obviously different learning strategies. Although having been periodically held back by some factors, students who had developed some powerful strategies continued to further their skills until they accomplished their ultimate learning goals. This led them to reach the end of the process of **Developing Effective Strategies for Nursing Care**.

Figure 4.1 shows the relationships between the two categories and four sub-categories that represent the process of **Developing Effective Strategies for Nursing Care** for the undergraduate nursing students who studied within the Thai college BNS programme in the study setting. Students' progress through the sub-categories was strongly impacted by their learning strategy development.

WHAT THE DIAGRAM REPRESENTS

Figure 4.1 outlines a core category named the process of **Developing Effective Strategies for Nursing Care**. This process is stimulated by the influential conditions represented by double overlapping chevrons on the left. As these conditions affect the learning strategies the participants develop during their practical placements, the drive-through central arrow line shown represents the process. This process incorporates four stages (sub-categories) of learning strategy improvement related to reaching the two phases (categories) of learning development. The four overlapping ovals represent the four sub-categories—*attending to procedure training*, *seeking case problems and how to provide nursing care*, *modifying the strategies for case learning*, and *discovering how to understand case conditions*. The first phase is symbolised by the first two overlapping ovals and the second one by the third and fourth. These two categories are labelled **continuing practical studies** and **learning how to provide nursing care** respectively.

In this study, I found that the learning development of the participants was facilitated by stimulating factors, as well as being interrupted and/or prevented by negative influences throughout their courses, noted in the chevron and the rectangles above and below the process. When influenced by the positive factors, the students were able to further enhance their skills to progress through the next stage(s), symbolised by the forward semicircle broken arrow line(s). On the other hand, the students who faced the negative factors were not able to advance their skills, as symbolised by the backward semicircle broken arrow line(s). These situations represent the transitional points of the stages symbolised by the rectangle frames on three parts of the central arrow. To move to the next stage(s) and/or the next phase, these students made use of the learning strategies they had formed in the previous one(s) to develop better strategies. The development of enhanced learning strategies is symbolised by the use of light to darker colours for

overlapping sub-category ovals.

The factors that could play a role as significant conditions of participants' learning development during their whole learning period consisted of being *worried and afraid about practising, motivation to learn, supervision, and the learning environment*. Moreover, for each particular stage, there were other powerful conditions which combined with these factors and further facilitated these students' learning strategy development. In the phase of **continuing practical studies**, this was *concern about not understanding case problems*. During the period of **learning how to provide nursing care**, students were strongly facilitated by the influence of their *supervisors' expectations*, and in the last stage, by their own *desire to learn*. These influences made the students apply more advanced learning strategies when compared to the previous ones. They tried to achieve their learning goals. On the other hand, facing other powerful negative influences, being *upset and discouraged about practice, focused on providing basic nursing care, tired and exhausted with practising, and having left unclear issues* could significantly reduce their effort to learn. These factors together explain why some of the students could not further their learning development, whereas others went on to succeed.

Furthermore, all of the factors influenced each other, which led to some of them having more complex impacts on the learning development of the participants. For example, *motivation to learn* was a factor that could stimulate all students to somehow improve their learning strategies. It could influence them to develop their nursing skills from the stage of *attending to procedure training* through to the stage of *discovering how to understand case conditions*. In different learning stages, nevertheless, when *motivation to learn* became important because of other conditions such as *concern about not understanding case problems* and/or *supervisors' expectations* and/or *desire to learn*, its impact had greater power on the students' learning development. Some of these impacts are detailed in each relevant chapter.

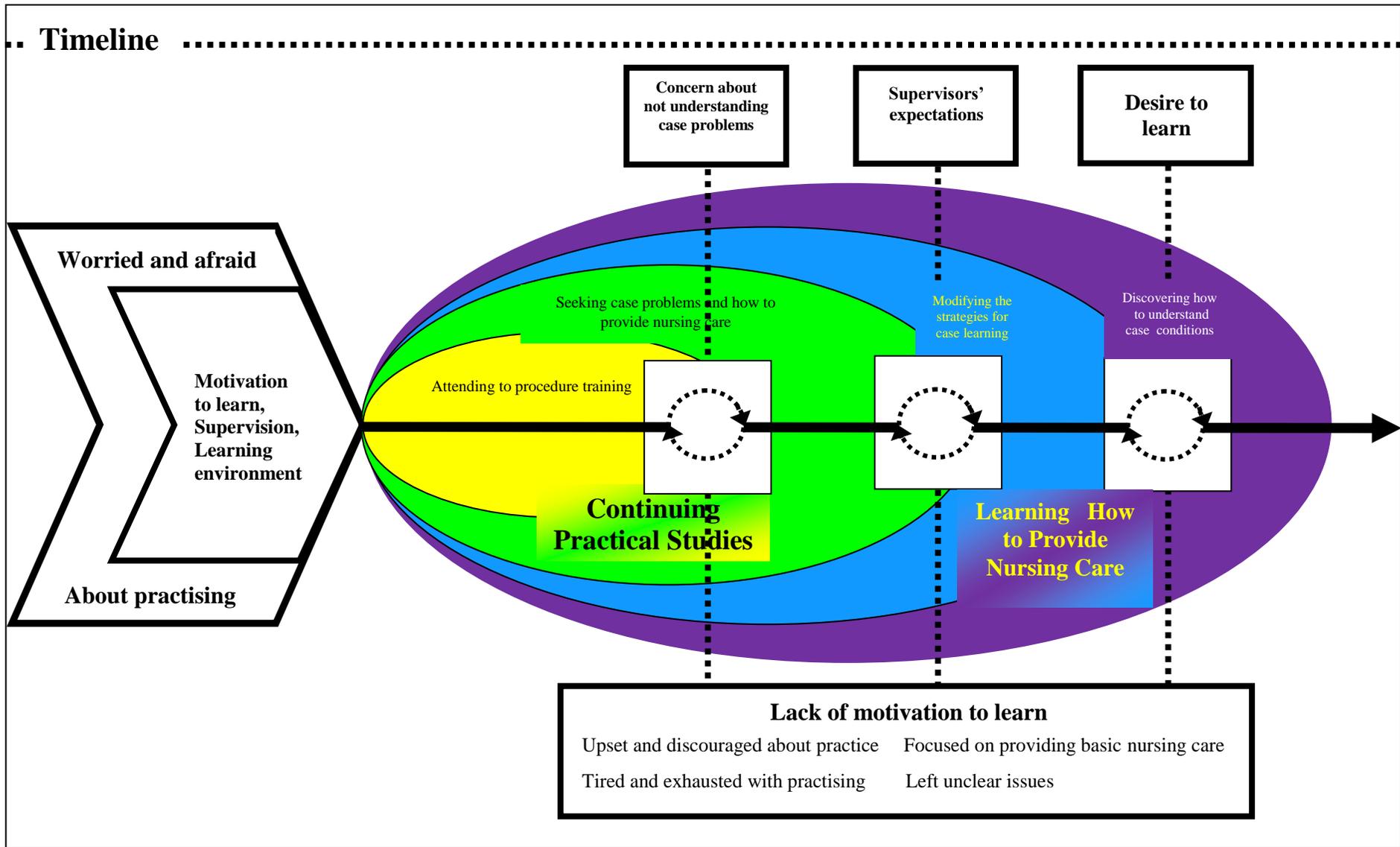


Figure 4.1 Developing Effective Strategies for Nursing Care

Even as the participants moved through the process, at times negative influences meant that students did not always use their evolved learning strategies, but resorted to less sophisticated ones. They sometimes returned back to the first stage where they focused only on providing basic nursing care for their cases. For this reason, the findings indicated that some students lingered in the procedure training stage (symbolised by the first overlapping oval blocked by the first vertical broken line), and still had to seek out case problems and how to provide nursing care for them. This meant they were likely to remain in the first phase—**continuing practical studies**—of the process (symbolised by the first two overlapping ovals blocked by the second vertical broken line). Others could further develop their nursing skills, but only some of them could accomplish the last stage—*discovering how to understand case conditions*. The majority of participants were in the first stage—*modifying the strategies for case learning*—of the second phase—**learning how to provide nursing care**—(symbolised by the third overlapping oval blocked by the third vertical broken line). They could not move to accomplish their ultimate goal. In other words, all of these students did achieve their nursing procedure skills, and most of them had begun to understand about how to care for their clients' problems. As a consequence, all students did develop their strategies to deal with their patients' problems, but the methods they applied were different. They formed their own strategies to care for their cases as the two tone colours represent each phase of the students' learning development.

The next two sections outline the two phases of the ways the participants had developed their nursing skills, which are **continuing practical studies** and **learning how to provide nursing care**.

CONTINUING PRACTICAL STUDIES

In the early phase of developing nursing skills, the participants spent their time on improving their basic nursing skills and starting case learning. As novices, they first focused on learning procedures that they could use to care for their patients. About case learning, because of *concern about not understanding case problems*, they attempted to find out as much information about their problems and how to provide nursing care for them from as many resources as they could. They spent more than half of their total practical study duration in this phase going back and forth through the learning strategies they were developing. Finally, applying not sufficiently advanced strategies

resulted in these students not clearly understanding their case problems and how to provide nursing care for them. Moreover, when influenced by other inhibiting and/or interrupting conditions, they consequently learned little about their patients, but put their emphasis on doing basic nursing skills that they were already familiar with. Although having *willing supervision* and a *facilitative learning environment*, they could not achieve their case learning. Learning in this phase, the students only thought that they practised the basic nursing skills. Not understanding cases' problems and how to provide nursing care for them meant the students tried to make use of the skills they had developed to complete the requirements so they could further their practical studies in the following year(s).

LEARNING HOW TO PROVIDE NURSING CARE

Being motivated by two significant conditions, *supervisors' expectations* and *desire to learn*, the participants paid attention to the problems of their patients and how to care for them throughout the phase of **learning how to provide nursing care**. These conditions were influential at differing transition points that indicated what stage in the process the students had reached. However, differences in conditions and strategies they applied led to these students achieving different learning goals. The students who were encouraged by *supervisors' expectations* and employed the strategies of the stage *modifying the strategies for case learning* could better connect what they tried to understand about their cases to what they had to do at settings. Meanwhile, those who were continuously motivated by *supervisors' expectations* and *desire to learn* and applied the strategies of the stage *discovering how to understand case conditions* could clearly understand why they had to care for their cases in particular ways. As a result, when these students advanced through this phase, they could provide nursing care for their patients based on what they understood more and more. Even though most students could not accomplish the full process of **Developing Effective Strategies for Nursing Care**, they were able to better direct themselves in caring for their patients than those who were still in the previous phase.

CONCLUSION

The learning process of undergraduate nursing students who studied within the Thai college BNS programme in this setting was developed from their efforts to improve their learning strategies throughout their practical study courses. They made use of their previous learning strategies as a foundation to adaptively advance to the next stage(s). During the stage(s), however, they faced different influential factors. These students had to learn through the long process and had to overcome the three transition points. The powerful influences and the advanced strategies they applied helped them discover how to understand case conditions. This led them to know effective strategies to diagnose the significant problems of their various patients and the corresponding nursing care for them, so they could apply the strategies they learned to many new care situations. Why and how the significant conditions played a role in developing learning strategies of the students in each phase are depicted in the relevant chapters to follow and then discussed in Chapter Eight.

ATTENDING TO PROCEDURE TRAINING

INTRODUCTION

As outlined in Chapter Four, *attending to procedure training*, which is represented by the first overlapping oval of the process of **Developing Effective Strategies for Nursing Care** (Figure 4.1), is the stage (sub-category) where the participants develop their basic nursing skills. It is the first sub-category of the first phase (category) of their learning development, i.e. **continuing practical studies**. In this stage, beginning with their first placement and continuing through subsequent placements, students start caring for their assigned cases, as well as seeking opportunities to perform basic procedures on other patients. In this chapter, the conditions under which students developed their basic nursing skills, the strategies that they adopted in the face of those conditions and the consequences of those conditions and strategies are summarised in Table 5.1 and further detailed with supporting excerpts from participant interviews in the sections that follow.

CONDITIONS

Four sets of conditions (Table 5.1), relating to individual, interrelationship, and environmental factors, impacted on the skill development of students during this stage. These were *worried and afraid about practising*, *motivation to learn*, *supervision*, and *learning environment*. This section details how these conditions influenced the skill development of the students. It focuses on explaining why, when, and/or how much the conditions facilitated and/or inhibited the students' learning development.

WORRIED AND AFRAID ABOUT PRACTISING

The condition, *worried and afraid about practising*, was the first issue that all of the participants raised when asked about their practical studies, especially when describing their first placement as everything was new to them. It seemed to be the most powerful factor that drove them to develop basic nursing skills.

Table 5.1 *Attending to procedure training: Conditions, strategies (actions/interactions), and consequences*

Conditions	Strategies (actions/interactions)	Consequences
<p>1. Worried and afraid about practising</p> <ul style="list-style-type: none"> -stressed and worried about everything before practising -starting practising and being really nervous -learning under pressure <ul style="list-style-type: none"> :very nervous and worried to try procedures :afraid and worried about doing something wrong :anxious about causing harm to patients :nervous and ashamed of not being trusted :anxious about blame/reprimands/punishments :fear of new experience in settings <p>2. Motivation to learn</p> <ul style="list-style-type: none"> -awareness of the need for best care -learning motives -lack of motivation to learn <p>3. Supervision</p> <ul style="list-style-type: none"> -willing supervision <ul style="list-style-type: none"> :preparing students for practice :providing learning opportunities, help, and encouragement :not blaming/reprimanding within patients/relatives' sight -inattentive supervision <ul style="list-style-type: none"> :focusing on analysing patients' problems :not interested in teaching/giving learning opportunities :having poor relationships with students :different supervisors applied different techniques <p>4. Learning environment</p> <ul style="list-style-type: none"> -facilitative learning environment <ul style="list-style-type: none"> :conducive learning supports :appropriate practical study management -unsupportive learning environment <ul style="list-style-type: none"> :difficult learning conditions :inadequate learning support resources :inappropriate practical study management 	<p>Strategies used to improve nursing skills</p> <p>1. Building up self-confidence</p> <ul style="list-style-type: none"> -asking seniors and friends for advice -reviewing how to perform procedures -asking to observe first -utilising self-talk and relaxation techniques <p>2. Beginning procedures with help and support</p> <ul style="list-style-type: none"> -seeking help and support from friends -seeking help and support from supervisors -seeking help and support from other experienced persons <p>3. Becoming familiar through performing procedures</p> <ul style="list-style-type: none"> -learning by observing and trying procedures -improving skills from previous mistakes -seeking opportunities to perform procedures <p>Strategies used to maintain learning</p> <p>1. Avoiding trouble</p> <ul style="list-style-type: none"> -preventing/mitigating difficulties with nurses/preceptors -following the practice of settings <p>2. Completing assigned tasks</p> <p>3. Seeking opportunities to learn</p>	<p>Desirable results</p> <ol style="list-style-type: none"> 1. More skilled, confident and happy to practise 2. Getting more trust from supervisors/nurses <p>Unwanted effects</p> <ol style="list-style-type: none"> 1. Fear to contact and work with some nurses/preceptors 2. Incomplete skill development 3. Confused and conflicted over technique differences 4. Upset and discouraged about practice

After practising for a period of time, their generalised worry and fear would decrease, but periodically it would increase again, with new experiences, especially in new settings. Participants reported feeling worried and afraid throughout their training, however, the reasons for those feelings differed over time. The reported worries and fears in this stage have been coded into three sub-concepts.

Stressed and worried about everything before practising

Nearly all of the participants reported that they felt stressed and very worried about their first practical placements. Although they had had opportunities in laboratory sessions to demonstrate the basic nursing procedures, they felt they started practise without enough knowledge and skill to provide nursing care for their patients. Hearing from seniors and friends about the settings where they had to practise made them feel stressed and worried about everything they might face. More than half reported worries both before and when going into settings, such as whether they could do what they had to do or not, how to conduct themselves, how supervisors¹³ and the nurses¹⁴ would treat them, what they had to do or what they would be allowed to do. Therefore, when explaining about being *stressed and worried about everything before practising*, participants tried to describe it together with not having enough skill and other interrelated factors they might face. A fourth year participant related:

...Practising like, the first time isn't it?...Like 'BCPN'¹⁵, I didn't have enough skill. Also my knowledge, I didn't know when practising, what my instructor might ask. I mean what I had to face because I had never practised. I was worried too. Yes! Could I do it at that time? If my instructor or preceptor asked me, how could I respond them? I felt more stressed when practising than studying in class. ...[laugh] worried and stressed! Because the first time, I didn't know what I had to face there. Also my skill, like demonstration, I felt, like injection, iv injection, I felt I couldn't do those at all... (Needa, Interview 1, page 6)

As well as feeling stressed and worried about everything they might face at settings, the participants started their practice being really nervous.

¹³ Supervisors are instructors, preceptors, and qualified nurses or public health providers who supervised the students during their practical studies.

¹⁴ The nurses are nursing staff who might or might not be qualified; they worked on the same shifts as the students, but often did not like to work with or teach students or were too busy to do this.

¹⁵ 'BCPN': Basic Concepts and Principles in Nursing (the previous paper name of Principles and Techniques in Nursing)

Starting practising and being really nervous

More than half of the participants described their first practice as a really nervous experience. This was because there were so many different situations and they had no idea how to start their practice. They could not imagine practising; they did not know what they had to do for their patients or when. They also did not know how to approach the nurses and were very worried about their responses. Although their seniors practised in the same settings, they were also too worried to ask them for help. They did not know how to conduct themselves in the practice setting. Some said that they had only walked around the ward in groups with friends. Even when the nurses asked for help with something, they did not dare to do it alone. They had to ask friends to do it with them. As one example, a third year participant recalled:

On my first day, at the...ward, I wondered who I was. The nurses were busy with their work, so I didn't know where it was best for me to stand. Sometimes we were all in a cluster. The nurses there said ah, "What are you doing?" "Why do you stay in a cluster?" "Why you don't work?", things like that. So, we tried to contact them and ask, "What could I do to help you?" I felt really nervous that day.I just followed my friends. If the nurses told me to do something, I had to ask for a friend to be with me. I mean I did it with the nurse and my friend. ...I didn't dare to do anything alone... (Kasaree, Interview 1, page 9)

Others also described that on their first day, they felt confused, not really brave and not really afraid, and only talked to their allocated cases. They did not dare to do or touch anything. From all of these explanations, the significant reason that made them very nervous was that they had never experienced nursing care activities in the real situation and were afraid and worried they might do something wrong (detailed in the next sub-concept).

Despite being so nervous, the participants had to begin to develop their nursing skills while feeling under pressure.

Learning under pressure

Most of the participants reported that during their first clinical placement, they were not only *very nervous and worried to try procedures*, but also had intense concern about the impacts of their performance on both their patients and themselves. Learning under such situations made them feel pressured as summarised in the following six codes.

Very nervous and worried to try procedures

When asked about performing procedures, more than half of the participants related that as novices, at first, they were *very nervous and worried to try procedures* in real situations because they were new to them. They felt they were stressed, tense, and not ready to do them at that time. Some also did not want to be the first one to try procedures because they were worried that they could not perform them. When having opportunities to try procedures, they thought that performing them was difficult. A third year participant described her nervous feeling during the early stage of trying procedures:

That day was the first day. The preceptor allowed me to try an iv injection. She asked me, "You learned about it, didn't you?" Yes! I was very nervous! I responded her, "Yes!" ...Yes! All sweat! [showing that she was sweating from her face to all of her body with laugh]...So nervous! [speaking with high volume]. ...as I did a demonstration, it was not alive. It was a model, so I could do it whatever, but that one was a patient and she also had relatives who were looking at me. She hoped I could do it.I was very nervous! Everyone was looking at my performing, especially the patient who hoped that I could do in the first time. ... These forced me to feel I was doing the most difficult thing... (Nirin, Interview 1, page 2-3, 5)

These students also described their early performance as awkward work. They had to do procedures while feeling confused. They could not imagine what to do or the order of actions, thus their supervisors had to help them a lot. For example, a second year participant said:

... I felt confused too much. If compared to today...like, I didn't know anything at all [laugh]. ...I didn't know how to do it [injection preparing] first or later. ...I had to do even though I didn't know how to do it, like, confusing. I couldn't get the picture to prepare that procedure at all. ...During the early stage, I frequently caused contamination. Like, a glass syringe, isn't it? I mean I had to hold it like this [showing how to hold it at a chest level] to prevent it dropping, things like that...but I frequently held it up, so my instructor had to remind me to take it down... I couldn't vacuum it and hold the syringe like I might contaminate it frequently, so my instructor helped me to draw it in to be taken to inject. (Raiya, Interview 1, page 20)

In this stage, some felt they were not sure whether they could further their practice or not. When recalling their awkward work and/or thinking that the opportunities to achieve the procedures they were going to perform might be rare, some of the students (who had moderate-high GPA) felt discouraged to practise. They did not want to try procedures and/or were not motivated to further their skill development, especially during the time they still could not adjust themselves to their practice.

The feelings of worry and fear about trying procedures in this stage not only made the participants afraid they could not perform them, but were also closely related to their

anxiety about doing something wrong.

Afraid and worried about doing something wrong

Some of the participants emphasised in their explanations that during practising, they were *afraid and worried about doing something wrong* when at a placement. This situation arose from hearing about how to conduct themselves when practising, as well as thinking that they did not have enough knowledge and skills to provide nursing care. They felt they did not have any right to do anything there, so they had to be very careful to deal with anything that was necessary for their studies. One of the fourth year participants said:

In my second year, I felt like ah! Was walking in that area wrong or not? Things like that. Walking past the counter, I meant the area that was not allowed for us to walk past as it was the area for nurses to work, things like that. Yes! I had heard that working as a nursing student, I couldn't sit down, things like that. I mean I was worried about anything at all [laugh]. Even asking for a chart from the nurses...I mean I wanted to look at something on a chart, I had to tell them to let me to look for something on the chart. I was told something like that. I felt like I didn't have any right there, like so tense there. I was quite afraid about doing something wrong. ... (Areeeda, Interview 2, page 17)

The participants reported that feelings of worry and fear continued to pressure them even in later years of training, however, in that context, the feelings arose from lack of understanding of case problems, (which is addressed in Chapter Six). For procedure training, when thinking they might do something wrong, the participants were concerned about the impacts of their performance on both their patients and themselves.

Anxious about causing harm to patients

The most common concern for participants, which arose from performing procedures based on not having enough skill, was harming patients. As novices, some reported they were very worried and afraid they might do something wrong, which might cause harm to patients. They explained that they were just nursing students who were still practising. They had never experienced or had insufficient experience performing procedures with patients, so they were not confident about whether what they did was right or wrong. A second year participant said:

...at that time, I fed the patient who was on the Bird respirator¹⁶. I practised 'BCPN'. While I did that, the patient had symptoms like coughing and secretion. I thought the food might have obstructed his throat. I tried to think about that. What happened with him, so I tried to observe. The patient coughed and had

¹⁶ A Bird respirator is a respiratory device using oxygen that was developed for breathing assistance.

secretions, so the nurse did suction for him. Nothing wrong with him. He coughed again. That made me try to think what happened with him, even when I already came back [to the college]. The day after that, I saw he was still there and nothing happened. He slept comfortably. I thought too much. Yes! Afraid!... (Nawin, Interview 2, page 58)

The students recognised their lack of skills and were concerned about the risks to their patients. Not only were they worried and afraid about causing harm, when being allowed to try procedures, the participants were also anxious that their patients and relatives did not trust their competence.

Nervous and ashamed of not being trusted

Not having enough skill in any procedure also led more than half of the participants to be worried patients and their relatives were not confident in their competence and might be reluctant to allow, or even refuse permission for them to provide nursing care. Some who experienced these situations described concerns about how to respond to relatives who thought that the way they were preparing for or performing a procedure was wrong as it seemed different from what the nurses did. As such, performing procedures, especially the first time and/or in front of patients' relatives made participants very nervous and lacking in confidence. A second year participant talked about her experience:

...That patient was a woman. She didn't want students to care for her, if possible. Anyway, the patient was not quite so concerned, but her relatives! At the ...ward, the relatives were very concerned, I thought. They were very afraid of anything. Even a little thing, they tried to tell me the nurse(s) did like that/this....[I was] afraid of the relatives...I thought that they might see what the nurses did, but what I did was different, so they tried to tell me. I thought they were afraid that maybe, I did something wrong.how I responded the way I did, but it was different from the nurse(s)... (Summana, Interview 1, page 24, 25, 26)

Moreover, if they could not achieve the procedures, some were more worried that the patients and their relatives might feel negative towards them and would not allow them to provide any procedure in the future.

Shame was another feeling that some students reported if facing situations where patients and relatives were not confident in their competence. A second year participant talked about her experience of 'losing face' with relatives:

... I was afraid of patients and their relatives. I was afraid their relatives might reprimand me. I was afraid that their relatives knew more than me, so they tried to tell me [something]. I felt I lost face too much [speaking with high volume]. I was a nurse. They were just relatives. Mmm! ...Like, they told me,

“Why you don’t put it [suction tube] here” ... “Take two suction tubes”, they said. I would, I said like that. Like, I was quite slow, but they saw and said like that, so I just said, “Ok”, “Ok”, things like that. I felt lost face. Yes! Lost face with the relatives of other patients too [speaking with high volume]. (Plyma, Interview 1, page 22, 23)

Even with their supervisors and/or the nurses, the participants also felt pressure in case they might blame/reprimand/punish them.

Anxious about blame/reprimands/punishments

Due to performing procedures based on not having enough skill, blame/reprimands and/or punishments were another intense concern of the students, especially those who heard about reprimanding supervisors and/or nurses at settings. Half of the participants reported they were anxious that their supervisors, the nurses, or even their seniors would blame/reprimand and/or punish them if they did something wrong, did not know how to perform, and/or could not perform procedures. In particular, they feared that they might be blamed for not paying attention to what they had learned in their theoretical studies, if they could not perform when practising.

Moreover, the blame/reprimands within patients’ and/or relatives’ sight even for other reasons were another significant issue that made the students feel worried about not completing procedures. They were worried that if their patients and/or relatives could see/hear them being reprimanded, they might lose the trust they had tried to maintain for a period of time. Others also felt stressed, and developed low self-esteem after being reprimanded, so they were not confident enough to care for their patients on particular shifts any more. Sometimes, they felt they did not know how to conduct themselves with the supervisors/nurses who reprimanded them on anything, even though they tried to adapt themselves to them. A third year participant confirmed that:

...The nurses there were very critical. So serious! Yes! They spoke to us rudely and angrily, like “Ku¹⁷” [personal pronoun used in the past, but now considered impolite], things like that. They frequently said “Tea¹⁸”, “Ti¹⁹” [impolite words to say to educated persons]. Yes, that is what they said. I sometimes felt discouraged. Like, I didn’t dare to care for patients because they frequently reprimanded me in their sight, things like that. ...No! no! [speaking with high volume] no confidence to do at all. Patients might have no confidence in my competence too. Being scolded like that! ... (Mintra, Interview 2, page 40)

¹⁷ Ku means I, me (personal pronouns)

¹⁸ Tea means to put on airs

¹⁹ Ti means to hit

Even later in their training, blame/reprimands were often still their greatest concern. The students thought they should be skilful in doing procedures at that time, especially when they were seniors. Some revealed that the longer they practised, the more stressed they felt if they could not complete some procedures even though in some cases, they had never experienced them before. A fourth year participant said:

...One more thing I was worried was... I felt different from when I was in the second year. I felt like I was worried that I couldn't complete it because I was in the third year at that time. ... I was quite concerned more about that...and the nurse/preceptor had to blame.I felt pressured because I was a third year student. Like, why I still couldn't do catheterisation. If I couldn't, that pressured me...I mean it was the thing that I could, things like that.if I couldn't do, I felt bad! (Noree, Interview 1, page 29, 30, 31)

Finally, the participants reported that, anytime they had to move to the settings or new fields, they felt fear. This could cause them to feel pressured again.

Fear of new experience in settings

Even after experiencing clinical studies for a period of time, when entering new settings or new fields, some of the participants reported that they were fearful of everything they had to face and deal with in the new settings. However, they would focus on the differences of the new settings in nursing procedures and nurses/preceptors to which they had to adapt.

Moreover, some of the third and fourth year students revealed that when they had to move to new fields—obstetrics, psychiatrics, and critical care, they had to learn to perform new procedures. Even though all of these fields were new to them, these students emphasised the stressful experiences they encountered during their obstetrics training. They felt the other fields, i.e. psychiatrics and critical care, were not very different from the previous fields they had experienced. However, those who had completed the obstetrics field placement revealed that among the obstetrics procedures, labour procedures were the ones that were most likely to make them feel very tense. When describing their early stage experience of this field, they frequently mentioned that the dominant feelings were stress, fear, and sometimes panic, especially, when having to do delivery procedures. Particularly, as they had to do many procedures quickly and accurately to help their clients to survive without any risk from labour. During the first week, they were very unhappy to practise in this field. They often tried to think about why they could not do it. These students had to read and try to practise

more than at their previous fields to adapt themselves to the field. A fourth year participant said:

...I feared helping at delivery. If bathing a baby, I just did what I was doing, but helping at a delivery, whether it [baby] could breath or not; or if I had to do suction and whatever urgently. Like, so many steps!Practising obstetrics was more pressured for me, I thought because it was new to me. I had never experienced, things like that. ...it was a subject that made me really fear, the most fear. (Kanda, Interview 1, page 13, 20)

Students disclosed that they felt tense because they were always concerned about causing harm to patients. This led them to practise based on the concept of *awareness of the need for best care* (detailed in the next concept).

Although the participants thought that their worry and fear about practising seemed to be the most powerful condition that forced them to improve their nursing skills in this stage, *motivation to learn* is another condition that influenced their skill development.

MOTIVATION TO LEARN

Motivation to learn was a condition that influenced why and/or how much the participants tried to continuously improve or abandoned their intention to develop basic nursing skills. In this concept, the students reported that *awareness of the need for best care*, and having a *learning motive* could drive them to further improve their skills during the stage, whereas *lack of motivation to learn* could sometimes inhibit and/or interrupt them from paying attention to their practice. All of these influences are detailed in three sub-concepts.

Awareness of the need for best care

Nearly half of the participants reported a strong awareness that when working as a nurse, they had responsibility for human life and if they provided the wrong nursing care, their patients' lives were threatened. Some stressed it was their duty to provide the best care for their cases to help them get better as soon as they could. They tried to check the nursing care they were going to provide to their patients with their supervisors or the nurses to make sure it was right. They sometimes asked their supervisors or the nurses to do some nursing care activities for their patients because they thought they had done everything they could, but there were some procedures they could not do for patients. Others also reported that they tried to review more to know exactly what they

were going to be doing for their clients, so they were ready to care for them. For example, a second year participant stated that:

...Yes! I thought as a nurse, I had to do something really right. Yes! Otherwise, I mean patients' lives depended on us, things like that. And one more, the knowledge! I mean we had to know exactly, we had to know. (Sput, Interview 1, page 2)

Meanwhile, others reflected their awareness of best care using other conceptual ideas such as “patient centred”, “holistic care”, and “assisting patients in time”. The nursing care they gave had to benefit their patients, as well as not harming them. Some explained they paid attention to their patients by caring for them conscientiously all the time. For instance, during the provision of basic nursing care, they tried to observe whether the symptoms of their patients changed or not, to provide them with the corresponding nursing care without delay. A fourth year participant said:

I thought about if I was a patient first. If I were a patient, so what would I need? Supposing that I was short of breath. OK! You had to help first. ...you needed to do blood puncture, iv injection, things like that. Yes! If I had shortness of breath, a nurse would have to care for me in the aspect of respiration first. It was the same! The same as the needs we would like to have... (Siripat, Interview 1, page 32)

Based on being aware of the need for best care, the participants also reported they tried to continuously develop their nursing skills because they had strong motivation to learn.

Learning motives

The participants reported many factors that motivated them to improve their skill in this stage. Nearly half thought that wanting to be skilful in basic nursing skills was the significant driving motive that encouraged them to continuously develop their skill. They revealed that many influences could inspire them to meet their goals, such as not performing procedures awkwardly, wanting to be as skilful nursing providers as the nurses they had observed, hoping to be skilful from practising, attempting to do their best after finding they had not paid attention to their studies, making mistakes, being blamed and/or punished, and being refused by patients. A fourth year participant with high GPA stated that:

Like, sometimes, patients refused...For example, an iv injection, yes! in the first time, if I couldn't [complete it], then the second time, patients would begin to lose trust in me. Yes! they might ask me whether they could ask for another nurse to continue or not. That made me lose a bit of confidence. ...I thought the next time(s), I couldn't do like that. I had to do it more accurately because if something like that frequently happened, it was sure I always couldn't do it. As patients didn't allow me to do it again and again. ...Yes! Next time, I had to train myself more. ... (Arun, Interview 3, page 34)

However, wanting to be nurses and/or hoping they could be nurses to fulfil their families' wishes were the important reasons that together facilitated more than half of the participants' attempts to improve their basic nursing skills. In this study, I found that some of the students who had low GPAs had to study nursing because of their families' wishes. The students reported they and/or their families had many reasons for wanting them to be nurses such as helping patients to get better, getting a scholarship and working in their hometown, being government staff members, having a permanent job after graduating, being perceived as an attractive person by others, and being a good model for family members. A participant with low GPA who studied in the fourth year disclosed:

...One more thing, at first, I didn't quite like nursing. I mean my family supported me to study this. So, I had to adapt myself. I mean I had to love this career more. ... (Nutsaree, Interview 1, page 7)

Alternatively, some of the students revealed that the caring of their supervisors could promote them to further their practical studies. They also indicated that getting trust or admiration from their supervisors and/or patients, and/or discovering the value of nursing could combine with the other motives to encourage them to make an effort to improve their nursing skill. A fourth year participant with moderate GPA said:

...I even broke an injection amp...and even prepared for an injection by taking a very long time [speaking with high volume]. Anyway, my instructor didn't blame me anything. She said, "That's alright", things like that. I felt she tried to support me, so I didn't feel bias [to nursing] anymore. ...and like, I had encouragement. When my instructor or preceptors praised me, I felt I would like to improve my skill. I mean I needed to do it better and better. ... (Laina, Interview 1, page 13, 17)

Other participants who had a moderate-high GPA attempted to improve their skill because they needed to get good grades to further their studies after graduating and make their families satisfied and proud of them. Some of this group, however, also reported other reasons that had power to motivate them to pay attention to their practice. They disclosed that being part of the *Project* put them under pressure to make an effort to develop their nursing skills to prove that they were competent. Also, one of them described that because her parents did not agree with her choice of programme, she tried to develop her nursing skills to show that she could make a success out of nursing.

In addition, some participants reported that the support of their families, the help and support from the patients and the patients' families motivated them to improve their

skill in this stage. For instance, when having some difficulties from settings, the participants' families tried to support and told them to be strong. They could also get help and support from patients' relatives and patients. Some relatives helped the students to complete the routine care for their patients. Particularly, when seeing the students were reprimanded for not completing the nursing care they were responsible for in time, relatives were enthusiastic to help. They sometimes also encouraged the students with some words to make them feel better after being reprimanded by a preceptor or nurse. These students perceived relatives and their patients as very nice. Relatives and their patients allowed them to do procedures even though they were students. When the students could not achieve procedures the first time, they gave them encouraging words, as well as allowing them one more opportunity to try. This made the students feel good and more motivated to learn. A third year participant talked about this experience:

...That nurse?...She was so serious in everything. Like, I was in the first block of the ward, while she was in the last [one], she could shout at me! Sometimes, patients said ah, "It doesn't matter, just be patient". Patients tried to encourage me, "It doesn't matter, not a long time to graduate", things like that. She really reprimanded, so sometimes patients told me not to be interested that. ...One day, while a little boy was drinking milk and I would record the nurse's note, she asked me what about his I/O²⁰. ...He just drank like that; it was enough or not. ...I responded to her, "Not enough".I told her, "Feed milk more" she said yes! Go and do that now! If he couldn't, you weren't allowed to finish [that shift]. Anyway, it was good that his mother [helped me]. "Ah, you [a little boy] drink this milk otherwise your nurse [I] can't take a rest" [laugh]. ...She [the mother] helped me to feed milk until it was finished. That made me feel better. Sometimes, patients could influence me too. ...Their encouragement motivated me too. ... (Nirin, Interview 1, page 7)

Although having *awareness of the need for best care* and *learning motives* to develop their nursing skills, some of the participants revealed that not wanting to study nursing often influenced them to have *lack of motivation to learn*.

Lack of motivation to learn

Even though most of the participants reported they had significant learning motives from differing factors, eleven of them had *lack of motivation to learn* sometimes because they did not like or want to study nursing. Based on their negative feelings for nursing study, four of them who had low GPA also explained that they did not do their best in their practice because, although they tried to adapt themselves to nursing studies, they still could not do as well as their friends. When the situation of lacking in

²⁰ I/O: Intake/Output

motivation to learn occurred for individuals, their families were often influential in forcing them to further their studies. The students thought they had to improve their skill only to fulfil their families' wishes that they would be nurses. For this reason, most of the group sometimes did not pay enough attention to develop their skills in this stage, especially during the beginning of the stage when they still could not adapt themselves to their practice. They sometimes felt exhausted and did not have any motivation to learn. Sometimes they thought they should not study nursing. For example, a fourth year participant with low GPA who strongly disliked nursing recalled asking herself why she had to care for patients, which was not her calling. She reported feeling bored and reluctant to go to practice at this stage of her training:

...I lived with my auntie...she was a nurse. ...She told me to study what I like, but I still hadn't told her what I like. ...So, she said, "Ah! study nursing first"...that affected my study, you know? I felt bored! Really bored! I didn't want! Like practising, so boring! I didn't want to practise on the following day(s), things like that. On the next day(s), I didn't want to go there [setting(s)]. ...I tried to count down to when were they [placements] finished?. You know? That day was the second day of my placement. So, It was so long to the end...Particularly, ...I wasn't quite familiar with wards, things like that. ...I mean the patients who couldn't take care of themselves, I had to care for them, do everything...I wasn't familiar with patients with Cath's [Foley Catheters] and... Why did I have to care for them? ... (Siripat, Interview 1, page 4)

In addition to the conditions of worry and fear about practice and *motivation to learn*, the participants reported that *supervision* evolved as a significant interrelationship condition that influenced their skill development in this stage.

SUPERVISION

When participants were training with supervisors who were interested in what they had to learn and the adaptations they had to make, they developed more self-confidence which then furthered their practice. In contrast, when practising with inattentive supervisors, they were likely to lose many opportunities to learn, so they could not improve their skills as much as they should. Because the supervisors are located at particular settings, these students, however, experienced both types of supervision. The details of how different supervisors supervised and/or treated the students are described in the two following sub-concepts.

Willing supervision

Most of the participants reported that they had been trained to develop their basic nursing skill under the *willing supervision* of their supervisors. They perceived that their

instructors and preceptors had taught them with a very caring ethos. Nevertheless, the participants revealed that there were some differences, depending on what they had experienced during the time, as illustrated in the following three codes.

Preparing students for practice

Some participants explained that their instructors helped them to adapt themselves to their practice. Before their practical placements, these instructors prepared them by demonstrating how to do procedures and then allowed them to try by demonstrating to the instructors. Their instructors also told them about how to conduct themselves during their practice, including how to adapt themselves to working with the staff members in settings. In particular, students who had faced problems on the first day they arrived at settings gave examples about the help given by their instructors in responding to the difficulties that arose for them. They indicated that their instructors would explain why they had encountered the difficulties before giving them support and suggestions on how to respond those problems. A second year participant who was in this situation said that:

...When [name of their instructor] arrived [at the ward], we were standing there with pale faces. I mean we just stood; we didn't want to do anything. She [our instructor] was quite alarmed. She told us to go back to the college. She then asked, "Which preceptors/nurses talk to you like that?" They might feel tired. Actually, they were friendly, she said. "Yes! This ward was quite good for you to train". So, try again! Tomorrow, I will go there with you in the morning. Yes! She was very friendly! [speaking with happy sound]. She went to the ward with us at seven o'clock. Yes! She walked there with us. (Wana, Interview 1, page 13-14)

When training with willing supervisors, the participants also described another aspect of attention of both their instructors and preceptors that impressed them.

Providing learning opportunities, help, and encouragement

More than half of the participants reported that their supervisors paid attention to teaching them throughout the stage of *attending to procedure training*. Their supervisors were interested in what their students had to learn and tried to provide them with opportunities to try some nursing procedures, even though they were new trainees. Their instructors also attempted to tell them about what and when they had to provide nursing care for their patients. If patients and/or their relatives were not happy about allowing the students to carry out the care, they explained why they could be confident in the students' competence and asked for opportunities for the students to do

procedures. Some revealed that when they told their supervisors they had never done a procedure, they tried to explain how to perform it before encouraging them to try by performing those procedures together, or providing them with other cases. Their supervisors were available at bedsides all the time they were performing procedures, as well as giving them full encouragement. When seeing their students might do something wrong and/or faced difficulties, they quickly helped and gave them feedback on how to do it correctly. If their students could not achieve procedures, they would help them to complete and give them supportive words to try later. Their supervisors trained them on the same procedures again and again until they could do them. The help and encouragement of supervisors were important in building up students' confidence in this stage. A fourth year participant cited this example of the help and encouragement of her instructor:

...When I walked in, the patient seemed to be doubtful like, it was me [student] to do that, wasn't it? Some [patients] asked, "Do you [instructor] allow your student to do this?", things like that. ...my instructor said, "Well! She [student] already did this for several times". I looked at him [instructor] and thought, "It is just my first try" [laugh]. He [patient] was the first one for me [laugh]...My instructor gave me full power like, "She already did this for many times, you can be confident, she is my student" so, I felt confident even though I had only ever done the demonstration one time. (Areeda, Interview 1, page 3)

Moreover, another fourth year participant described her feeling when her instructor was at settings that:

...When I was in second year, I thought if my instructor was at the ward, I felt at ease [xunci]²¹. Like, if I did something wrong, my instructor would suggest, or solve that problem for me. If they [instructors] were at wards, I felt relieved like, I felt really good. Yes! In my second year, I felt defended [thiphung]²², things like that [laugh]. (Laina, Interview 4, page 57)

Although their preceptors tried to teach them any time they supervised them to prepare or perform nursing care activities, some participants reported some preceptors told them to observe what they did, because they did not know what to teach. They only focused on teaching what they knew. If the students did not understand some issues, they could ask them for more explanation. When practising with these supervisors, the participants stated that in these settings, they could learn all the time, and sometimes even had opportunities to do more advanced procedures. They learned about what the nurses were doing at that time. They indicated that when practising with their preceptors who were

²¹ Xunci means to feel encouraged, to feel relieved.

²² Thiphung means a supporter.

kind, they were happy to approach and ask them for help doing procedures. They paid more attention to learning procedures because they had this encouragement to practise.

Lastly, the participants also confirmed that willing supervisors were attentive to their feelings and did not blame/reprimand/punish them within patients/relatives' sight.

Not blaming/reprimanding within patients/relatives' sight

Some of the participants indicated that willing instructors and preceptors never reprimanded them within patients/relatives' sight or hearing. Sometimes they did reprimand them away from patients' sight but the main reason for this, they perceived, was that they needed them to learn more. The students revealed that when they made mistakes, normally, these supervisors attempted to explain to them about what they had to improve later. The students felt that not blaming/reprimanding within patients/relatives' sight was the way their instructors honoured them, which made their patients trust them. A third year participant said:

...Our instructors didn't reprimand us within patients' sight. They tried to explain like, as you did it a moment ago, that was wrong. This kept students' honour to some degree. Yes! I mean they told me after that. Ah! You know? What was wrong when you were doing that? Which skills do you need to improve to do fetus palpation...If we were reprimanded within their sight, the clients didn't felt confident in nursing students too... (Araya, Interview 1, page 5)

However, when being trained with supervisors who were not attentive, the participants reported they encountered a different set of experiences.

Inattentive supervision

Although most of the participants were satisfied with the supervision they received, more than half of this group also revealed they had experienced *inattentive supervision* during this early stage. In this study, most of the participants thought they were unable to develop their skills as fully as they should because some supervisors were not concerned enough about what they had to learn or how much they had to adjust themselves to their practice. The following four codes present why the students perceived the behaviours of these supervisors as making them lose opportunities to learn.

Focusing on analysing patients' problems

Some participants revealed that they did not have enough opportunities to do procedures because some instructors focused more on conferences. In the afternoons, their instructors frequently held post-conferences. They emphasised the students needed to know detailed case information to analyse the problems of their patients. These students reported that at that time, they were still placed in areas to develop their basic nursing skills, so they thought the conferences made them lose opportunities to improve their skills. They had less time to be in settings and practise compared to other friends who were placed in different settings. A second year participant revealed she was worried about how to complete many of the requirements of the field because she did not have enough time to practise; i.e. she had to take part in post-conferences very often. She said:

...Some instructors only focused on the 11 patterns [of Gordon]²³. ...Coming back in the afternoon, I always had to take part in conferences. Only did conferences about 11 patterns! 'BCPN'! ...We got only the 11 patterns... We had to complete around 93 cases [requirements]. ...So, we felt pressured that we had to complete all.during the first two weeks, we hadn't quite done. ...It was different from other instructors whom my friends practised with. I mean they were allowed to do procedures really often. They were allowed as they practised 'BCPN', didn't they? The skills that had to do frequently. Other friends got around 40-50 cases before moving to another ward. For me, I got only nine cases. Mmm! How could I further my practice? Only nine cases... (Summana, Interview 1, page 20, 21)

Even when moving to the next stage(s), these students were still concerned that their instructors took a very long time for pre-conferences, so they sometimes could not provide nursing care for their cases or only did some care during the morning of day shifts.

Not only did participants not have opportunities to practise basic nursing skills when they had to take part in frequent or lengthy conferences, but they also did not have enough learning opportunities when working with some preceptors/nurses who were not interested in what they had to learn.

Not interested in teaching/giving learning opportunities

The findings also showed most of the participants encountered problems when practising with some preceptors and/or nurses (especially those who were opposed to

²³ The 11 patterns of Gordon means Gordon's Functional Health Patterns. It is a method developed by Marjorie Gordon in 1987 to be used as a guide for nurses to establish a comprehensive nursing assessment of patients (Somantri, 2011).

students from the *Project*), who were not interested in teaching, or even giving them opportunities to learn, (even though the students spent much time practising with them) because their instructors did not come to settings very often in the afternoons. Some participants disclosed the nurses only focused on completing their tasks; they did their work without letting the students know what nursing activities they had to do, even for the students' cases. Some nurses did not communicate with the participants. They did not want the students to work with them because they worked very slowly. A third year participant said:

...They [nurses] were quite silent. Really silent! [speaking with high volume]. ...Sometimes, I tried to ask them, "What can I do to help you?" They didn't say anything [speaking with high volume]. Moreover, even students' cases, they did all the care. ...These nurses didn't ask us or something. If they would like to do something, they did through, like, not having us, things like that [slight laugh]. They said that was their duty, so they had to complete it. If they allowed us to do, it was slow.Sometimes, I would like to observe [what they did], but they didn't respond. So, I didn't dare to observe. ...They didn't talk anything and had no reaction. I thought I had to go. Ok! Didn't observe! ... (Hana, Interview 2, page 57, 58)

Moreover, others also revealed that sometimes they lost opportunities to practise because they were not allowed to do some procedures at some settings because their preceptors or the nurses were worried that they might make mistakes, and the head nurse would blame them.

Even when asking students for help, the nurses were not concerned about what and/or how much work the students had to do for their cases. They focused on completing their own work rather than being considerate towards what the students had to learn about how to provide nursing care for their cases. Another third year participant said:

...Ah! Sometimes! She [the nurse] said "help me to care for that patient first", things like that. But! I still couldn't complete my case. She said again "Why you are very slow?". I was not happy. Anyway, I was a junior. As a student, I had to smile. Just smile! Yes! And then told her that "I can't complete my case yet. If it is done, I will". ...I thought I should finish my case first. Sometimes, I just let that sound pass my ears [laugh] because I thought she didn't see what I was doing. She should not say like, I was slow. She just asked for a little bit of help, but I refused, things like that. (Araya, Interview 1, page 34)

Sometimes, the participants not only lost learning opportunities because some preceptors/nurses were not interested in what they had to achieve, but also they did not have opportunities to practise as some nurses had poor relationships with them.

Having poor relationships with students

Unfortunately, more than half of the participants (mostly those who reported that some nurses were not interested to teach, or even give them opportunities to learn) disclosed that they also had to face the impolite behaviours of these nurses. Some reported that the first time they arrived at settings, the nurses reprimanded them. Meanwhile, others said, due to performing procedures awkwardly, slowly, and sometimes making mistakes, these nurses frequently talked negatively to the students and sometimes scolded them, rather than teaching them how to improve their techniques. The students thought the nurses were annoyed for no reason in particular. A fourth year participant said:

They [the nurses] said, "You practise! Just practise!" "Don't contact me. I don't teach. It's not my business." That what they said, I heard. They said, "Don't contact me". ...Anyway, if they needed to ask for help, they told us. If about teaching, they didn't teach. They weren't interested. ...They said like, "Don't work with me. Doing like that was very slow. Slow! ...Don't see me. I am not your preceptor. You have to ask another [who is your preceptor] ." ...They said mmm! Can't do this. Can't do that, things like that. But! They didn't teach us... (Chuntira, Interview 3, page 53, 54)

During training with inattentive supervisors, the participants not only lost opportunities to learn, but also they had to adapt themselves to the different techniques supervisors applied.

Different supervisors applied different techniques

Nearly half of the participants complained that different instructors, preceptors, and/or nurses applied different techniques. Moreover, some settings had different care guidelines, so they could not always use what they had demonstrated (in the lab) for care with patients, but they had to follow the protocols of the settings and supervisors and/or nurses that they were working with (detailed in the sub-concept of *avoiding trouble*, in the concept of *strategies to maintain learning*). They had to make themselves familiar with the different techniques of different supervisors and/or the nurses. Encountering such situations made the students not only lose confidence in what they already knew, but also made them unsure how to perform a procedure next time, or even whether they would work as nurses after graduating. A second year participant said:

Yes! Always adapting myself!. Each ward! I have to adapt. Adaptation was most important for me as it [each setting] was different. Each ward was different. ...For example, catheterisation was quite a big problem. I had ever seen that nurse used scrub 'providine'. ...If in medical ward, the nurses just applied normal saline and did it through. I felt confused. ...She (the preceptor) asked me why I brought that solution. It can be used like that, can't it? (Summana, Interview 1, page 27)

Finally, practising with inattentive supervisors, the participants also felt no motivation to learn when they had to tolerate biased behaviour, i.e. where supervisors favoured some students over others.

In this stage, along with the factors detailed, the participants also reported that aspects of the *learning environment* influenced their skill development.

LEARNING ENVIRONMENT

The last condition the participants reported that influenced their skill development during this stage was the *learning environment*. Participants were mostly satisfied with their college learning environment, though more than half recommended some aspects should be improved. They thought the *facilitative learning environment* they had could support them to learn, even though they sometimes encountered aspects that lessened their learning. These have been labelled *unsupportive learning environment*.

Facilitative learning environment

In the viewpoints of most participants, conducive learning supports and appropriate practical study management in the *learning environment* facilitated their learning.

Conducive learning supports

More than half mentioned that their college provided them with learning supports that were generally conducive to their nursing skill development. They could make good use of the library because it had enough modern textbooks, as well as a convenient accessible retrieval system. There was sufficient equipment in laboratory rooms, so they could practise by demonstration what they had to do before going to settings. When needing to research to answer questions or do self-initiated follow up, they could access the Internet any time. Moreover, some also stressed that their dormitories were appropriate places for doing their own studies. The rooms have been designed to support their learning. Every student has his/her own space that was convenient for

carrying out his/her study. A third year participant confirmed that:

Learning conditions in our college are conducive to our learning, I think because we have a library that has quite a lot of textbooks...Also we are provided with a good Internet. We have wireless Internet. Most students have computer laptops, so that is conducive as our college provides us with wireless. We can search. ...About bedrooms, they have proportional bedrooms as we have a new dorm that has only eight beds [per room]. Everyone has their own space. We have tables, cabinets. We can sit down and do our many works. ...We have a demonstration room and lots of equipment. I think it [our college] is conducive to a good extent. (Nirin, Interview 2, page 31)

Not only did the college provide *conducive learning supports*, the participants also reported that they could practise within another *facilitative learning environment*, as their college managed appropriate practical study for them.

Appropriate practical study management

More than half of the participants overall reflected on the practical study management of their college. They thought most of the practical study management did facilitate development of their basic nursing skills. They were allowed enough time for learning most of what they had to practise. Most of the course requirements they had to complete were also appropriate to what they had to learn about each field and were relevant to the practical duration. Most of the rotations also provided them with enough opportunities to develop their nursing skills. When specifically asked about the practical placements during the period of their basic nursing skill development, they were satisfied with the practical study management that directly placed them in the real situations, straight after finishing their first few theoretical subjects. They explained that they could make use of what they had demonstrated during their theoretical studies to develop their basic nursing skills. A third year participant cited the example that:

...I think study and then practice is good for me. ...Like, we didn't leave what we had studied too long before practice. As we studied theoretical content and then we went to settings, to practise, it [content] like, it still stayed with me. ...Like, when I was in the second year, after finishing demonstration of 'BCPN', we had the opportunity to directly practise [that subject] at wards. I think I could get [the picture] because I hadn't forgotten any [any content]. (Rhoba, Interview 2, page 66)

Furthermore, because of concern about the basic procedures they had to learn in this stage, some also reported that the settings they were placed in provided them with enough modern equipment to learn with. Even in community settings, the students thought their college could manage and provide them with prepared settings. A fourth year participant said:

Like...[said the name of the regional hospital] hospital is ready in everything. Like, [the amount of] patients is ok as it is enough. Equipment is also enough. ...[In community] Yes! I mean during our practising, the preceptors there held conferences. They taught us. Each of them was responsible for the cases we made conferences. They had very good preparation. ...They were very attentive and taught us everything. (Alfa, Interview 2, page 38)

Sometimes, however, the participants accepted that their college should improve some of their learning environment as it did not fully support their skill development.

Unsupportive learning environment

Although participants reported that most of the learning environment their college provided did facilitate them to develop their skill in this stage, more than half thought some aspects should be improved, especially learning support resources. Their recommendations are presented in three codes.

Difficult learning conditions

Some of the participants reported that the difficult learning condition they were most concerned about was the rules of living in their college's dormitories. They thought their college had many rules that contradicted their learning styles and/or made them stressed. For example, a requirement to get up early to take part in the respect for the national flag ceremony every day before starting classes, when students may have gone to bed late due to studying hard during the night; having to tidy learning materials in the dormitory every day, or to clean the dormitory at times when students wanted to study. Moreover, there were set times to buy food and a requirement take part in the Study period, an evening meeting every day.

... Time was limited! ...going for buying foods, I had to do by six o'clock. Someone who came back at four o'clock, they might have some issues from the wards as they just finished caring for their patients. Their cases had symptoms that they might further [their nursing care plans] or activate them as they just finished. Instead, they had to go out for buying foods. So, that knowledge was gone with food shops.When coming back, we had to join the Study. ...So, I wasted the time from four until around eight o'clock.As I had friends in another college, they had techniques. Like, they tried to jot down some things they learned first to prevent forgetting. But for me, after coming back, I had to buy food first... afraid that I didn't have dinner. It was different. (Nawin, Interview 2, page 52, 53)

The communal context of dormitory living also impacted participants' learning. For example, one female student revealed that sometimes she could not concentrate or even read what she needed to learn because she had to do the activities her friends did at that time. She could rarely find surroundings that were conducive for reading. In contrast,

two fourth year students who lived outside disclosed they not only could not exchange or ask for more explanations from friends and/or seniors, but also it was difficult to follow their review timetable. Living outside made it hard to concentrate on their studies as there were many distractions.

Furthermore, the participants indicated that sometimes friends could influence their learning opportunities in different ways, as the following examples illustrate. One female student revealed she could not concentrate with her readings as her friends would say she took them seriously. She also gave up asking for more explanation from preceptors and/or nurses when perceiving that her friends did not really like her to do this. When asking for more explanation from some friends, another female student also revealed she got nothing. One could not do her group assignment because she had some problems with her friends. A fourth year participant explained the impact of friends on her learning:

...Sometimes, when I read then, my friends say, "Why you look so serious or things like that". I am quite a quiet person. If my friend said I read too much or things like that, I was so quiet. Then, I go away from my room. After that I came back and went to bed. ...I am not happy when I read and look so serious in my friend eyes. I can't concentrate on the things I read. ...You know? I find it difficult to understand some things. ...But my friends, they understand easily, everything is easy for them. They can understand the things they read the first time. For me, I don't know why I can't understand. So, I read it again and again. ...That's why my friends say I am so serious. (Yarat, Interview 4, page 4)

As students who lived in the same dormitories, the participants not only had to encounter *difficult learning conditions*, especially from the rules of living in their college's dormitories and friends, their learning was also limited by *inadequate learning support resources*.

Inadequate learning support resources

Inadequate learning support resources was a major concern that students said kept recurring throughout their theoretical studies. Some of the *Project* students reported when starting their nursing course, they did not have enough textbooks and many of them were out of date, but during the following years, their college did provide them with more textbooks. Others in this group, nevertheless, revealed until recently they still could not get enough textbooks when students were using them for both the period of their practical studies and preparing for the licence test. A fourth year participant who was a *Project* student said:

...I mean we were big in number. When we had to take tests, I mean we had to use the library all at the same time. Sometimes, that was too noisy! because of lots of us. And textbooks are quite few. Sometimes, I tried to look for some books, but they were all gone. My friends had borrowed them all. Even during our practical studies, if friends in the previous groups hadn't come back, I mean we had to further that practice, sometimes the textbooks weren't enough. We solved this problem by making copies of some of the texts we needed first... (Suvadee, Interview 2, page 31)

Moreover, some of the normal programme students also confirmed that their library did not have enough textbooks and some of them were out of date. Others reported they had also faced difficulties accessing the electronic retrieval system. They could not find the content they needed to read. A third year participant said:

I would like to have more textbooks. I would like mmm! Sometimes, I couldn't find [what I wanted] and when I asked for help from librarian(s), they couldn't tell me where they were [laugh]. I sometimes like, I hadn't practised that ward. When needing to find some books, so I didn't know where the books I needed were. ...Sometimes, I took a half an hour to find them. I would like to have an accessing system that could use. Like, ah! This book, this author. ...I needed a convenient way to find my topic(s). (Mintra, Interview 2, page 58)

With regards to the Internet and learning equipment, students in both the *Project* and normal programme reported they sometimes encountered difficulties using these facilities. Sometimes they could not connect to the wireless Internet. If accessing the Internet from the college computers, they had to use passwords to enter the room, and had limited time to use them. A second year participant commented:

If using our college's computers, I'm afraid not... I felt it was quite difficult. Our college provided computers, but I felt like I couldn't use them [laugh]. ...Like, sometimes the battery was flat while others were full with friends, things like that. I couldn't use them. ...Wireless! Sometimes I couldn't get access but sometimes I could. It wasn't stable. (Raiya, Interview 2, page 62)

The demonstration room did not have enough equipment, especially for the number of students studying in the *Project*. When the students needed to use it, they had to apply in writing to the instructors for permission.

...If the learning environment wasn't conducive and there was not enough equipment [slight laugh], my skills couldn't develop. Yes! Like, when dressing wounds, in the set, it didn't have something; the set wasn't completed. That couldn't develop my skills. Ah! Like, less cotton, so we had to make do [slight laugh]. Like, I couldn't develop sterile skills... (Hana, Interview 2, page 58)

Besides, the *unsupportive learning environment* presented, the participants also revealed that sometimes, they lost learning opportunities because of the *inappropriate practical study management* of their college.

Inappropriate practical study management

Nearly half of the participants suggested that the practical management of their studies sometimes resulted in limited opportunities to learn. Examples included being placed in inappropriate practical settings that were quite short of equipment, some learning procedures, and/or learning support for them to learn; placement at the same time as medical students and/or other groups due to the big number of students in the *Project*. This meant they did not have enough opportunities to learn some procedures. When practising in a big group, they also did not have enough close supervision from their instructors. One example from a third year participant was:

...I was placed at the same time as medical students. ...They had to practise about injection, dressing wounds, or something like me. So, sometimes, I had to fight for the cases with them.That made us have less opportunity. After this, I didn't know medical students would be placed with me again or not. Last year, lots of them were there. Placed at the same time, and fighting over the cases! (Nirin, Interview 2, page 30)

Another second year participant who was first placed in the community setting also reported he forgot how to do procedures because in the community setting, he could not try the procedures. As well, he was worried that he did not have enough nursing knowledge to make suggestions to his clients as he had not had enough experience on how to do nursing care for real patients. He said:

...The group that was placed in community would forget about performing procedures as they hadn't applied that after finishing. Finishing and then going to the community made them forget! ...I couldn't get the picture about nursing care. Yes! Like, I just finished 'BCPN'. I hadn't done nursing care at all. When going to community, I had to use [nursing knowledge]. I mean I had to talk to clients. I had to talk to them about many issues, not only one. So, I had to know more [about nursing care] to tell them, things like that as their questions like, I had no idea about what they wanted to know. (Klaiwit, Interview 2, page 52-53)

Moreover, practical duration was another issue that some participants raised as management issue. One second year participant who had just finished 'BCPN' field reported the practical duration given for developing their procedure skills was limited and therefore she never experienced some procedures. She thought she should be allowed enough time to develop her basic nursing skills until she was skilful in all the ones she would have to use when going to the next field(s). Meanwhile, a third year participant thought the practical duration for procedures of labour settings was not enough. She had to move to another setting before becoming skilful in the new procedures, then had to take some time to adapt herself to the procedures there, resulting

in lost opportunities to perform procedures. She said:

...I was placed here [regional hospital] for two weeks and another two weeks there [community hospital]. The first week was an adaptation duration as it was a new paper for me. ...In the second week while I could [adapt myself], I had to move to another setting. At [said the name of a community hospital she had to move to], the set preparation wasn't the same as [said the name of regional hospital], so I had to adapt myself again. ...on the first day I arrived there, instead of having opportunity to try, the preceptor had to show me how to do things first. (Leeya, Interview 2, page 49)

Overall, some students revealed the practical time given for the obstetrics field was inappropriate when compared to the requirements they had to complete. A third year participant cited the difficulties and her attempt to complete them:

...For example, ten cases for labour, I thought it was too many! Like, ten cases, I had to complete that in one month. But! During the time I practised there, there was no case. I mean if I didn't do the on call shift, I didn't get any labour cases at all.No labour cases! Sometimes, I had to stay at the ward for the on call shift. ...You know? During evening and night shifts, I stayed there over night. ...Yes! You know? On that Saturday, my friends had already finished [the placement], ...I had to extend it for another one day. On Saturday! (Rhoba, Interview 2, page 66, 67)

In addition, other participants thought that the section structure also made them lose opportunities to learn. One fourth year participant revealed that she was not allowed to provide nursing care for some patients who had different conditions from those she had already learned because of the structure of sections of some subjects her college provided. She said:

...Like obstetrics, I thought why we weren't allow to practise some things at the same time. Like normal obstetrics and abnormal obstetrics, we should have opportunities to practise them together. Because when practising, we didn't have options to choose patients that didn't have normal conditions at all or abnormal [ones] at all. When I practiced the 'normal' paper, the abnormal cases were admitted, but I couldn't [try]. When practising abnormal [obstetrics], the cases I had were quite normal [conditions]... (Laina, Interview 3, page 54)

Practising based on all of the conditions detailed in the above section led the participants to develop particular strategies to respond to them.

STRATEGIES

In this beginning stage, the participants reported two main strategies, depending on the conditions they were encountering at that time. These are respectively presented in the sections, *strategies to improve nursing skills* and *strategies to remain learning*.

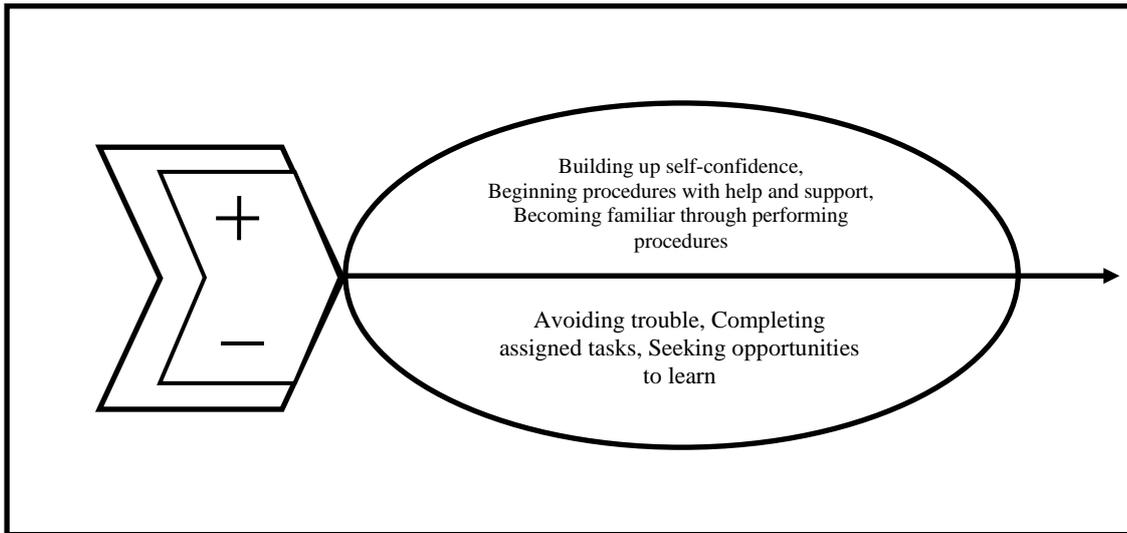


Figure 5.1 Learning strategies used for *attending to procedure training*

STRATEGIES USED TO IMPROVE NURSING SKILLS

When encountering conditions that facilitated their learning, the participants could develop strategies to improve their nursing skills. As novices who were very worried and afraid about practising and had no idea how to start their practice, these students applied many strategies to develop their skills as much as they could (Figure 5.1). The participants explained that the strategies were used repeatedly back and forth throughout this stage and their use overlapped, so that it was not always possible to differentiate one from the other. It was the combining of the strategies that made learning the skills possible. Three sub-concepts detail the strategies they employed.

Building up self-confidence

The first thing that most of the participants who were *worried and afraid about practising* attempted to do before starting to develop their nursing skills was building up their confidence. They made a lot of effort to make themselves ready for their practice and make their patients trust in their competence. The details of the strategies they made use of to adapt themselves are reported in the following four codes.

Asking seniors and friends for advice

Knowing only a little bit about practising drove nearly half of the participants to ask for advice from their seniors and friends who had more experience. Before going to

practice, these students reported they had many questions. They needed to know about the settings where they would be placed, and how to conduct themselves and work there, especially on the first day they arrived. They tried to ask seniors and friends about what they had to do and/or what they could do at the settings, including how to prepare for their practice. This information enabled them to prepare for their placements. For example, a fourth year participant explained:

At first, I asked my third year code senior. I consulted her. Ah! When practising, how should I conduct myself? Do you have any techniques to suggest to me? Things like that, I talked to her. ...She [senior] told me many things. Like, when needing to approach preceptors/nurses there, I had to ... During practising, if I didn't understand something, I shouldn't hesitate to ask my instructor. So, that could help me. ... (Nutsaree, Interview 1, page 8)

To build up their self-confidence before going to their practice, the participants not only used the technique of *asking seniors and friends for advice*, but also applied the strategy of *reviewing how to perform procedures*.

Reviewing how to perform procedures

After learning a little about what they had to do at settings but still being *afraid and worried about doing something wrong* when performing procedures, more than half of the participants tried to review how to perform them before going to practise each day, especially during the beginning of this stage. They tried to read about the procedures by themselves and/or asked seniors to help them revise. Sometimes, the seniors also taught them the techniques for preparing, performing, and achieving procedures. This gave them more confidence to try. A third year participant said:

...Memorised what I had studied. Yes! Like suction, what I had to do first or later, I tried to memorise at the time I did demonstrations. ...Yes! When getting close to practice, I tried to memorise that again. ...at that time, I reviewed that with my senior too. ...quite often too. Anyway, I had to practise many skills, like, a few skills per night. I mean depending on the free time my senior had. ...Reviewing many times helped me to remember. My senior suggested her techniques to me too. ... (Sorphee, Interview 1, page 4)

These students also helped each other to prepare for procedures and/or interchange the techniques they and their friends were taught in different settings. Those who had more skill in particular procedures would teach others in the group. They continued repeating demonstrations and practices until they had more confidence for performing each procedure. When they could describe how to do procedures, they confirmed that their supervisors would allow them to try and sign off the required procedures if they thought their students were competent. Therefore, needing to have more opportunities to

perform procedures, and complete their requirements were significant reasons that made these students try to train themselves before going to practice. A fourth year participant commented:

Yes! I reviewed procedures every day. Like, today what I experienced there [setting]. If I couldn't do a technique there, I asked my friends. Ah, "What techniques did the preceptors teach you?" Sometimes, they experienced iv [iv injection] whereas I had opportunity to try catheterisation, things like that. So, we could exchange those experiences. (Nutsaree, Interview 1, page 9)

Apart from trying to prepare for their practice with friends and seniors at the college, when being at settings, the participants also applied the technique of *asking to observe first* to build up their self-confidence.

Asking to observe first

Because of being *very nervous and worried to try procedures* and the pressure related to their attempts, some of the novices asked if they could observe their supervisors, the nurses, or seniors do procedures. They could then see what and how to prepare, how to perform, and the techniques their supervisors and/or friends used, including the defects friends had to improve. They then could recall what they saw to apply to what they were doing for their first attempts. This decreased their nervousness and tension, and gave them more confidence for performing those procedures, especially when they were in the following year(s) as by then they had observed them many times. A fourth year participant said:

...At first, I asked to observe. ...Like, when I could observe first, at least, I could see ah, how to prepare, how to do that, including the techniques she [preceptor] used. I mean I might remember that. So, next time(s) ah, I would like to try.It benefitted me to some degree! Anyway, I was still nervous. At least, that [observation] could make me more confident as at least I already saw [how to do], things like that. Like, reviewing it.If some skills I had seen but didn't have opportunity to try. Maybe, I could try that when I was in the third year. I mean my anxiety was quite less than when I was in the second year. At least, I had seen that ah! That skill! Ah! What I had to do for it was, just that I had never done it. (Needa, Interview 1, page 6, 7, 10)

While at practical settings, the participants also tried to build up their self-confidence by ensuring that they could practise there. Even before their attempts, they had to make sure they could perform procedures.

Utilising self-talk and relaxation techniques

When at practical settings, the participants revealed they made a lot of effort to encourage themselves that they could practise, perform procedures and earn their patients' trust. Some of them recalled that they tried to make up their mind before going to practice that they might face some difficulties based on what they perceived from seniors and/or friends. They also thought the uniform they wore could make them feel rather more confident and that they knew some health issues more than patients. During the shifts, they attempted to make themselves feel relaxed by talking to patients who they thought they were as new to the settings as them. A fourth year participant talked about how she built up her confidence:

...On the first day I went to a ward, ah, the first time [for my practising], I felt nervous, things like that. I felt like that [the nursing practical study uniform] could encourage me [laugh]. Even though I knew I quite didn't know [speak and laugh at the same time], I thought well, wearing that uniform! I mean like, I had to know, at least, a few issues, I might know more than patients, things like that. I felt like that. Like, maybe I could tell them some. ...like, the uniform could give me confidence. ... (Areeda, interview 2, page 18)

Before starting to perform procedures, nearly half of the participants tried to encourage themselves by using techniques such as self-talk, deep breathing, thinking about what to do next and next, and deliberately shifting their focus of attention for a few minutes. Some reported they told themselves they had to dare to do it whereas others thought in different ways. For example, they could do it; this was the first time for them, the next time(s) would be better; it did not matter if they could not achieve the procedure the first time and/or they were just juniors. They disclosed that these thoughts helped them to control their nervous feelings. Meanwhile, deep breathing was an important strategy the participant applied with other strategies to control their nervous feelings. At the time of performing procedures, taking deep breaths and thinking about what they had to do next and next made them concentrate with the procedures they were doing. All of these techniques decreased their fear, and helped them feel relaxed, so they could do the procedures more confidence. A fourth year participant confirmed that:

[slight laugh] I did deep breathing and expiration and then told myself about what I was doing now. Because like me, I told you [researcher] I was a non-concentrating person, wasn't I? So, I had to tell myself what I was doing now. I mean I tried to think about. Mmm! What I had to do next, and next! If didn't do it like that, I felt in a blur. I couldn't hear what my instructor said, things like that. I mean I was nervous! (Kanda, Interview 1, page 13)

Furthermore, others also explained they applied these techniques to keep the trust of their patients. Employing the techniques helped them show that they had enough competence to provide nursing care for their clients. Even when advancing to the next stage(s) in which they further developed their basic nursing skills, these students still used the techniques of self-talk, taking deep breaths, and thinking about what to do next and next.

To develop their nursing skills in this stage, after attempting to build up their self-confidence, the participants applied the technique of *beginning procedures with help and support* to facilitate their performing.

Beginning procedures with help and support

All of the participants recognised that they made much effort to develop their skill during this early stage. Besides building up self-confidence to be ready for practice, they needed a lot of help and support to facilitate them to begin learning procedures. Three codes were derived from their answers.

Seeking help and support from friends

Friends were the persons that more than half of the participants were likely to ask for help and support first. Previously, these students implicitly mentioned some of the help and support from friends (in the codes of *asking seniors and friends for advice* and *reviewing how to perform procedures for building up self-confidence*). In this code, they focused on reporting they asked for help from friends, and helped and supported each other to improve skills during this stage. When they were told or allowed to do procedures, if they were not sure about how to perform and/or what equipment they had to prepare and/or felt very nervous, normally, they asked for help from friends, especially those who had experience those procedures. They would try to prepare equipment and review/confirm how to do procedures with friends. A fourth year participant said:

...When my preparing was done, I would go to see the patient, so I felt so nervous! Sometimes, I might talk to my friend(s) too. I asked for them to confirm what I was going to do. Like, I was going to do injection, so could you please help me? Ah! Is it right? I mean at that time, I still didn't see the patient yet. I tried that [injection] with friend(s). "Find the position like that?" [showing how to find the position for injection at deltoid muscle]. I felt ok some degree. I felt that ah! Ok! Right! So, I went [to a patient].
...(Alfa, Interview 1, page 10)

Also, while performing procedures, they asked friends to stay with them and/or help them sometimes. Moreover, groups of students placed together often attempted to help and support each other in the clinical setting. Another fourth year participant said:

...After the first time we were blamed, ...we talked together. We tried to find out why we were [blamed like that]. ...We tried to release tension first [speaking with laugh]. Then we tried to read together. When going to a setting, ...some [friends] might do something wrong, so those friends would tell us and then remind us that "Don't let that happen again" like, they were already reprimanded, things like that. We helped each other, yes! (Kanda, Interview 2, page 29)

Normally, when needing help or facing some difficulties, they asked for help from their friends first, followed by instructors/preceptors, and the nurses respectively.

Seeking help and support from supervisors

When asked about how they began their procedure training, nearly all of the participants reported that they worked with their supervisors. During their first try, some specifically described that they tried to follow their supervisors' techniques. Their supervisors, however, had to help quite a lot. After their first try, the participants became more confident to do the same procedures the next time. A fourth year participant said:

...about the first case I tried, my instructor stayed with me, [said the name of her instructor], so I dared to do [laugh]. I had never done that. She [instructor] showed me how to do. After that, she still stayed with me. I meant she did and I helped her to do that task. In the following day(s), ... I had opportunities to do that every day. That patient presented stool every day. ... (Chuntira, Interview 1, page 14)

Apart from their friends and supervisors, the participants revealed that they also asked help and support from other experienced persons who they had contact with.

Seeking help and support from other experienced persons

The other experienced persons who the participants referred to were seniors, nurses, and medical students/internship physicians. Besides the implicitly mentioned help and support of seniors (on the codes of *asking seniors and friends for advice*, and *reviewing how to perform procedures for building up self-confidence*), some participants also reported that at the setting where they were placed together with seniors, they started to try procedures by working with them. As they did not know any nurses or were not familiar with their preceptors, their seniors were the persons who these students asked for help. They told their seniors that they did not know what to do to care for the cases or had never done particular procedures and then asked help from them. Their seniors

showed them how to perform procedures before allowing them to try. They then tried to follow how their seniors action. If they could not achieve procedures, the seniors helped them to complete them, as well as supporting them by offering their help when they had to care for another case with the same procedure. A fourth year participant recalled:

...I was quite lucky as the period I practised 'BCPN', it had my fourth year seniors. They practised administration there. ...they could suggest juniors because during the early period, I didn't know what to do [to care for my patients]. ...I could ask help from them. Ah! "If things liked this, how could I do?" ...I liked to match myself with seniors.I told them I didn't know, so they said, "Ok, come with me". They tried to teach me. Ah! "Do it like this", things like that. Like preparing medications, they worked closely with me. ...If I told them, "I had never done that", they taught me. ... (Suvadee, Interview 1, page 14, 15)

Moreover, during this stage, participants also asked for help from the nurses and/or medical students/internship physicians sometimes, especially when their friends could not help, or they could not ask for help from supervisors; for example help with deciphering the information on the charts. A second year participant explained:

...I tried to take notes [from charts] as my instructor taught. If I couldn't read [something in charts], I would ask help from the nurses there. If the nurses couldn't, I tried to ask for that help from externs²⁴ or interns²⁵ [laugh]. (Wana, Interview 2, page 22)

After using the technique of *beginning procedures with help and support* for a period of time, the participants attempted to become skilful in basic nursing skills by applying the strategy of *becoming familiar through performing procedures*.

Becoming familiar through performing procedures

Becoming familiar through performing procedures was another significant strategy that all of the participants also applied during this stage. Based on *motivation to learn*—*awareness of the need for best care* and *learning motives*—they tried to make full use of the time they were at settings to gain experience at performing procedures as much as they could before moving to start case learning (in the second stage). The attention to developing nursing skills in this way is detailed in the next three codes.

²⁴ Extern is a medical student who is studying in the final year of study (6th year). An extern can treat patients under supervision of experienced physicians or medical instructors.

²⁵ Intern is a graduate medical student who is registered as licence physician and is working in the first year of internship, a period of time for working as physician in order to learn particular skills needed in medical field.

Learning by observing and trying procedures

Most of the participants reported that they tried to follow their supervisors and/or the nurses to observe how they did particular procedures and/or supervised their friends doing them. Particularly, when their instructors were not at settings, they frequently observed the nursing activities that were happening. These students confirmed that contact with preceptors and/or the nurses helped them to become more familiar with performing procedures. The result was more opportunities to do procedures because these persons were willing to teach the students who were perceived as enthusiastic about learning. These additional observation and practice experiences that they created to support their own learning helped them to better remember how to perform procedures. A fourth year participant said:

“Free time? ...not at all” I mean like, I walked around all the time. ...Normally, I tried to help the nurses there. If they were going to do something [some nursing care procedures], I said, “Could I help you?”, things like that. ...If at that time, I didn’t have something to do, I tried to observe. Like, sometimes, my case didn’t need anymore care and my friend(s) might do [some procedures], I tried to observe that. Even when our preceptors taught my friends, I tried to take part. ...Sometimes, I tried to observe first. ...after that, I asked the nurses to try. I tried to contact and tell them I would like to do this/that. I often did like that. (Noree, Interview 1, page 17, 28)

To become familiar with performing procedures, the participants not only attempted to observe and ask to try nursing procedures, but they also made use of their previous mistakes to improve their skills.

Improving skills from previous mistakes

Learning from their previous mistakes was another strategy that some of the participants used to become familiar with performing procedures in this stage. When recalling the comments about their mistakes and/or awkward performing, they recognised that they needed to improve their skills so as not to make the same mistakes. They tried to do the best they could, so they were improving with each time. A fourth year participant disclosed:

...I was very frightened! On the first day I suctioned, I did so under the supervision of [said the name of her instructor]. You know? I used a sterile glove to turn on the suction machine. I forgot! I turned it on. Ugh! It was contaminated. I knew, but I continued to take the suction tube. I tried to suction. Suddenly, my instructor hit my hand. You know? That time, I was very frightened! I feared that my patient would be infected. He was just a boy. However, the following day, I had to suction with the instructor again. Of course, I could remember. So, I could do it for him. (Yarat, Interview 1, page 3)

Finally, the participants disclosed the technique that helped them get really familiar through performing procedures was doing them frequently.

Seeking opportunities to perform procedures

After having opportunities to practise for a period of time, most of the participants reported they tried to continue to improve in the basic nursing procedures by seeking opportunities to do them frequently over the rest of the stage. Nearly half revealed that they rarely paid attention to case conditions/pathologies even though the patients' diseases were discussed by instructors. They put emphasis on training themselves in basic nursing procedures only. They asked the nurses to provide them with the procedures they should be able to do, especially for their requirements of their stage. A fourth year participant said:

When I was in the second year, I didn't think about that [conditions/pathologies]. ...In my second year, I was worried more about procedures. ...Like, if having any procedure that I could train, I tried to do that frequently. I mean I quite focused on that more than took care of patients. Ok! My cases, I took care. I cared for their comfort, things like that. ...Anyway, I tried to ask preceptors/nurses there. "Do you have any injection cases?, if so, please tell me". ...I sometimes told them, "If you have blood puncture cases or something, please let me try". I frequently did that. (Areed, Interview 1, page 4)

Another method that led these students to have opportunities to do procedures frequently was helping nurses and friends to complete tasks. They offered their help to the nurses, as well as completing all of nursing activities the nurses told them to do, especially when their instructors were not at settings. During shift rounds, some also attempted to make observations and/or take notes about what nursing care the nurses had to carry out for the patients, particularly if there were procedures they had not experienced or were not accomplished enough at or that staff expected them to be able to do. Performing procedures frequently also gave them more confidence to do them again. For these reasons, after the beginning of the stage, the students tried to read about the procedures and to seek opportunities for them, so as to be more skilful before moving to the next field(s). A second year participant cited an example that:

If about learning at wards, I thought I could learn by doing. I meant I had to do [procedures] frequently. I had to ask preceptors/nurses to try, things like that.When taking part in morning shift rounds, I tried to record the diagnoses of patients and the procedures the nurses had to do for them. What procedures they had been given. ...I recorded about that of all patients because if I knew which patients had procedures, I could ask for nurses to try... (Klaiwit, Interview 2, page 31, 40)

The learning strategies of the participants were also initiated when encountering inhibiting/interrupting conditions. This means the students attempted to improve their nursing skills as well as maintain their learning at the same time.

STRATEGIES USED TO MAINTAIN LEARNING

Hoping to try or wanting to be skilful in basic procedures was the main concern of the participants in this stage. When practising under condition(s) that inhibited/interrupted their learning development, they applied different strategies from the ones previously presented to maintain their learning (Figure 5.1). The following three sub-concepts detail their explanations.

Avoiding trouble

Whether encountering or hearing about inattentive responses and/or supervision or not, *avoiding trouble* was the significant strategy that the participants used to maintain their learning opportunities. As nursing students, they had to learn how to conduct themselves and work at particular settings, and to be careful about creating difficulties with staff. Their explanations about why and how they had to avoid trouble with these persons are detailed in two codes.

Preventing/mitigating difficulties with nurses/preceptors

Some participants revealed that at clinical settings, they had to be humble and adaptable with nurses/preceptors to prevent/mitigate difficulties they might develop. These students raised many examples on this issue. When needing to ask for help from them, they had to wait for the appropriate opportunities. Normally during clinical practising, they had to be more careful about irritating or offending the nurses and preceptors. A second year participant said:

...For example, when performing iv injection, one nurse applied different techniques from the one I had practised at the college. ...She told me if she did it like I said, the needle would cut the vein and then make it leak. ...I felt quite nervous, but I didn't argue with her. If I said something like that, she might not be interested to teach me anymore. I just listened and observed that. If she could, I thought her techniques might work maybe for some patients or for all.Which one was good, I thought it was better for me to decide by myself. If she thought hers was right, but I told that one was wrong. I didn't have enough knowledge to do that. She might think I was a know all student, things like that... (Nawin, Interview 1, page 4; Interview 3, page 59)

Although being reprimanded and/or encountering inattentive responses, the participants could not show any negative reactions to these persons because of social mores of Thai culture. They could not argue. If needing to learn with them, the students had to conceal their feelings, as well as pretending acceptance that what they were reprimanded for was true. Even when being asked for help, as participants, they could not refuse, even when they were busy with caring for their patients and/or the tasks were unpleasant. Concerned that the nurses and/or preceptors might not be interested in teaching them in the future, these students tried to cope with their conflicting emotions and the cause(s), rather than make these persons more irritated or angry. If facing inattentive responses and/or supervision, they perceived that the only thing they could do at that time was release any tension by talking with friends, seniors, and/or their significant persons (as previously detailed in sub-concept of *beginning procedures with help and support*), including thinking in positive ways. A third year participant talked about this experience that:

...I knew sometimes I was right, but anyway, as I was junior and as I was a student, I thought it was better if I concealed my feelings. It was good to keep good relationships. Sometimes, if I didn't talk about that problem, when they felt better, maybe in the following days, they might teach me something. But if I argued with them, it like I was anti them first, so bad relationships would be formed. Next time, they might not be interested to teach me anymore. I mean I thought more about the future as I might return to practise there again. (Araya, validated interview, page 3)

Apart from *preventing/mitigating difficulties with nurses/preceptors*, as nursing students who were trying to avoid trouble, the participants followed the practices of the settings.

Following the practices of settings

Another strategy to avoid trouble was focusing on the regular practices of settings. Some of the participants reported when finding the differences between what they had learned and how they had to perform the same procedures at settings, they followed the practice there. One second year participant explained that during the beginning of the stage, she thought what she knew from her theoretical sessions was really wrong, so she was not confident to do what she had learned. She only did procedures as her preceptors and/or the nurses told her to do. When moving to new setting(s), she tried to ask about the practices there to make sure she did not do something different from the nurses there. She said:

...She [preceptor] allowed me to do a wound dressing, but it was different from the way I demonstrated. ...I didn't really know it was really different in each ward. ...What she told me to put, I put that, things like that [laugh]. She told me! She told me not to use 'providine', but used that [solution]. That ward used that ah! ...She asked me about what I had learned. At first, I didn't dare to respond because what I had learned was not the same thing. It was not the same thing as hers. I felt that [what I had learned] was really wrong. If she said like that, it was really wrong and I would have to change. (Summana, Interview 1, page 22, 23)

Another fourth year participant confirmed this strategy by changing her note-taking style. She could not write everything about how she had cared for her patients; she had to record only the dominant problems for which she had provided procedures or obvious nursing care that the preceptors or the nurses agreed with. She said:

...Like, when recording nurse's notes, ...preceptors/nurses there [setting] recorded like, the issues. Like, patients had problem about wound, so they recorded only wound issue, not another. I mean I had never done it like that in my nursing care plan as patients had problems, like 4-5 problems. ...If I wrote them all, they said ah, "Just write one or two is enough". After that, I recorded only the main issues as noticeable in my nurse's notes. ... (Needa, Interview 2, page 31)

After having opportunities to practise for a period of time, however, these students tried to stick to the concepts they had learned, but they adapted their performance to setting-based practices. They revealed that by that time they were confident enough on the equipment they had to use for particular procedures and knew how to perform them. They did not cause harm to patients because of this greater experience. For these reasons, they thought they should have opportunities to practise as they had learned. Particularly, they should provide their patients with the right nursing care as they knew. For techniques, they were most concerned about sterilisation, so they tried to be more careful to adapt what they had experienced to the practices of settings where they were working.

Another strategy the participants applied to maintain their learning when they had to train under the inhibiting/interrupting condition(s) was completing assigned tasks.

Completing assigned tasks

When on duty with some nurses and/or preceptors who were not interested in teaching them and/or were inattentive or unfriendly, even though they did not have as high motivation to learn, they tried to complete their assigned tasks. They explained it with

the word “Tunjai”²⁶. This means they had to attempt to accept *inattentive supervision* or the responses that happened to them because they could not avoid it. They then tried to ignore the reprimanding/scolding before continuing to care for their patients. Concerned about the duties they had to be responsible for, these students attempted to work to complete all nursing care activities for their cases, even though they had to work with supervisors or nurses they did not like. These were the only opportunities to practise at that time. A fourth year participant explained:

“Tunjai!” Yes! [laugh] “Tunjai” and continued my duty [speaking with laugh].Like, I had to work in that block with that nurse who I didn’t like or who reprimanded quite a lot and I had to care for a patient under her supervision. ...I meant I had to do my best on duty. ...She had to supervise me, things likes that. I wanted my instructor to do that (more than her). ...but she had to do it as she had duty to care for patients in that block. So, I had to work with her. ...OK! I already “Tunjai” that I would be reprimanded. Sure! ...She had to ask. Sure! (Siripat, Interview 1, page 8)

However, even practising under the condition(s) that inhibited/interrupted their learning development, the participants reported that they tried to seek as many opportunities as possible to maintain their learning in such situations.

Seeking opportunities to learn

Another strategy that some of the participants used to maintain their learning when encountering difficulties from inattentive preceptors/nurses was *seeking opportunities to learn*. After feeling upset for a few minutes about the difficulties that had happened to them, some of the participants revealed that they thought about what to do. They tried to concentrate on what they were practising. They knew they could have encouragement from other preceptors/nurses who were willing to teach them, thus they contacted these preceptors/nurses to seek opportunities to do procedures. A third year participant offered this example:

...If I faced that [serious reprimanding], I might feel upset a little bit. Anyway, it [my feeling] returned back while I did another thing. I still had patients and another preceptors/nurses. Sometimes, if that nurse was a reprimanding nurse, I tried to avoid her. Avoid that nurse and then contact the one(s) who were friendly and taught me. Then, I had more concentration than when working with her.I avoided that situation and then contacted another nurse who could teach me ...who were willing to teach students... (Nirin, Interview 2, page 22, 23)

Others also disclosed when working with nurses who were not interested in teaching them, they tried to only observe what they did. If they helped them with procedures,

²⁶ Tunjai means to restrain one’s mind

they did not ask anything.

In the following section the consequences of the conditions of learning and the strategies students developed in the stage of procedure training are outlined.

CONSEQUENCES

Applying the strategies for improving nursing skills and/or maintaining their learning opportunities, the participants were able to develop their skill to a certain degree. Not having enough opportunities to learn was the significant reason they gave for not fully developing their skills in this stage. The consequences of these strategies are respectively detailed in the following concepts, *desirable results*, and *unwanted effects*.

DESIRABLE RESULTS

Having opportunities to practise for a period of time enabled the participants to develop more skill in doing procedures and feel confident to further their practice; they felt good that they could help their patients with their skills. Moreover, they gained more trust from their supervisors and/or nurses. These two sub-concepts are discussed in more detail.

More skilled, confident and happy to practise

After adapting themselves to the settings, and *seeking opportunities to perform procedures* for a period of time, nearly all of the participants reported they definitely were more skilled, which led them to be confident to practise and happier when practising. At first, however, more than half implicitly reported their development skill in terms of “being familiar with practising”. Although reaching the point of familiarity at different times, they knew what and when they had to provide nursing care for their patients even in new settings/fields. They could adapt themselves to preceptors, the nurses, equipment, or even patients and knew their duties when practising. Also, being able to do procedures more competently made them feel less stressed, tense, or afraid. For these reasons, some revealed they did not feel settings were frightening places any more, but they thought they were like outer classrooms for their learning. A third year participant talked about her feelings that:

When practising that [‘Persons with Health Problems’²⁷ I’], I felt quite familiar with wards. Even with preceptors/nurses, I didn’t feel too much pressure.In my third year, I felt more comfortable as I didn’t fear anything much. Going to practice, I knew what I had to do to care for my patients.I didn’t feel stressed too much if compared to my second year.When I was in the third year, I felt like I had more experience. (Sorphee, Interview 1, page 5, 6, 12)

When asked about how much skill they had developed, more than half of these students reported that after experiencing procedures frequently, they felt they had more skill in doing basic nursing care. They positively explained their skill in terms of “more confidence to practise” together with “happy with practising”. Their first achievement with difficult procedures or procedures for patients with serious condition(s), motivated them to ask to try others. This made them happier to work at settings. Half of them specifically reported that they liked practising at this stage because they could now understand how to do procedures, much more than from reading and memorising or attending lectures.

Nearly half of the participants also reported they were happy because they sometimes had opportunities to help other persons and/or their families with the skill they had. They felt good when seeing their clients happy and getting better with the care they provided. Even some who did not like nursing changed their attitudes to nursing, and thought it was valuable job that they should do and be happy with it. A third year participant who did not like studying nursing talked about her feelings:

Difficult yes! Anyway, it [changing attitude] depended on my idea and environment too. Sometimes, if I went to a ward and I could [do procedures] and I saw my patients getting better, that made me feel good more and more. It gradually changed, I thought. ... (Fatou, Interview 2, page 24)

As they were more confident and happy with practising, when coming to the end of this stage, the participants noticed that they were more trusted by their supervisors and the nurses.

Getting more trust from supervisors/nurses

After having opportunities to practise procedures for a period of time, more than half of the participants reported they noticed they received more trust from their

²⁷‘Persons with Health Problems’ is the name of a group of practical papers that include Nursing Care of Persons with Health Problems Practicum I, II, and III.

supervisors/nurses. They were allowed to prepare what they were going to do for their patients by themselves or with friends. Supervisors and the nurses only observed some of their performances and/or taught them to do procedures the first time, especially for procedures that might be dangerous to patients if students made a mistake. Sometimes their supervisors only checked what the students had prepared and/or asked about their experience with and/or how to perform the procedures they were going to do. They then allowed them to do the procedures within their sight. A second year participant said:

About some procedures which needed careful performing, preceptors still observed. Sometimes, if about DTX [Dextrostix], things like that or 'external' procedures, normally, they allowed me to do. Like, wound dressing, they allowed me to go ahead; they didn't observe. ...But! If about injections, things like that, preceptors sometimes followed me as administrated medicines could not be taken off [laugh]. Anyway, if about DTX or blood puncture, things like that, they just said to me 'that bed' [patient] and I could. (Nawin, Interview 2, page 41)

Another consequence that happened over the stage of *attending to procedure training* was unwanted effects. They are detailing in the following section.

UNWANTED EFFECTS

Participants could not avoid unwanted events affecting their practice. Some conditions and/or situations they encountered made them lose opportunities to develop their skill and brought feelings of fear, confusion, conflict, or even discouragement. In this stage, they reported many unwanted effects resulting from *attending to procedure training*. These are discussed as four concepts.

Fear to contact and work with some nurses/preceptors

Some participants feared to contact and work with nurses and preceptors who reprimanded or were unfriendly. Hearing about their reputation or experiencing their inattentive responses influenced the students' confidence to talk to them or ask for help, especially when they looked busy. If possible, they avoided doing procedures with these persons as much as they could. A third year participant cited the example that:

In my second year as I started my practice, at first, I felt so tense because my seniors said the nurses at that ward reprimanded students. Like, everything I would like to try, but I didn't do it at all. ...Normally, if the case was mine, I tried to contact my instructor to supervise me. That helped me to have an opportunity to try. With the nurses, I didn't contact them much. In my second year, normally, I worked with my instructors. (Rhoba, Interview 1, page 22)

Fear to contact the nurses/preceptors occurred along with preventing/mitigating

difficulties with these persons (as previously detailed) throughout training, not only during the procedure training phase, but also when these students had developed their skills for understanding their cases' problems. These more experienced students, however, emphasised reporting it in the sense of being “worried” to ask for more explanation about some case learning issues they still had questions about (as detailed in Chapter Six, the code of *rarely asking for more explanation* under the sub-concept of *lack of motivation to learn*).

As well as finding their learning limited by this problem, many of the participants also found it difficult to completely learn all the different skills when practising.

Incomplete skill development

Although having opportunities to train under *willing supervision*, and using strategies such as making use of the help and support from many resources, as well as attempting to train themselves to be familiar with performing procedures, more than half of the participants reported they could not fully develop their skills. The significant reason that affected the development of some skills was not having enough opportunities to practise; this was especially caused by inattentive supervisors and/or nurses as illustrated in the following quote. A third year participant talked about how little her skill developed when she was placed in the first field:

[slight laugh] In my 'BCPN' field, I really didn't know anything. ...Injection or preparing injection? No! I wasn't skilled that at all [shaking her head]. ...I mean I felt like I went there to do nothing. I was quite a quiet person. When I asked the nurses, "Could I help you with something?", they didn't respond. If they had asked me for help, that would have been ok, but they didn't. They didn't have enough time to talk [to me], so I just walked around there. (Hana, Interview 1, page 16)

Another unwanted effect that occurred from practising in this stage was feeling confused and conflicted about the technique differences of some preceptors/nurses.

Confused and conflicted over technique differences

When finding the techniques some preceptors/nurses applied to procedures were different from what they had learned and/or were listed in the texts, some of the participants revealed they felt confused and conflicted. They did not understand why these persons did as shown, or whether these persons' ways were right or wrong, or even whether such techniques could apply for the procedures in particular situations or

not. Although they thought that what some preceptors/nurses did was not right, they did not dare to ask for their reasons, or even more explanation, because of being concerned about irritating these persons while at settings (as detailed in the code of *prevent/mitigating difficulties with nurses/preceptors*). Even though the students tried adapt what they had learned to these settings to avoid trouble (as presented in the code of *following the practice of settings*), they still felt conflicted. A fourth year participant said:

...Like assessing the Apgar score, ah, practising with instructors, I could assess as the theory listed. I mean in the first minute, if students and instructors assessed that, it was around 5 or 6 [score]. But! When preceptors/nurses did that, it was up to 7 to 8, things like that. ...I asked my instructor ...My instructor explained that ah, they might have more experience. Sometimes, they might think in the fifth minute, a new born might get higher to 10 [scores]. Like, they were sure that in the next minutes ah, it would get higher, so they assessed that [in the first minute] higher first. ...I felt like conflicted that ah, why my assessment was lower and which item(s) I might make wrong.I recorded that as I assessed it, but a preceptor/nurse told me to rewrite it.Why they didn't record as what they saw. (Needa, Interview 2, page 32, 33)

The last unwanted effect the participants reported in this stage was that they experienced situations that made them upset and discouraged about their practice.

Upset and discouraged about practice

Nearly half of the participants revealed they felt upset and discouraged when encountering inattentive responses and/or behaviours that did not show enough concern about what they had to learn (as previously detailed in the sub-concept of *inattentive supervision*). These students felt tense, and bored with their work when practising with the serious/reprimanding supervisors/nurses. Some were very worried and afraid about whether their attempts would be wrong. They did not want these persons to “jubpid²⁸” them with their fault finding attitudes. A third year participant said:

...Ah! Like, somebody tried to “jubpid” or the situation wasn't conducive to practising. ... Yes! Like, I didn't want to do anything as I thought my attempt might be wrong or not. The preceptor/nurse there would reprimand me or not, things like that, so I didn't want to practice there. Like, I was so worried about their staring at me when I couldn't do them [procedures], it meant they reprimanded or blamed within patients' sight, so I felt like I didn't want to do them anymore. (Araya, Interview 2, page 38)

Moreover, the bias in favour of completing assessment forms or approving required cases, training, and/or giving learning opportunities shown by some supervisors/nurses

²⁸ Jubpid means to find faults.

towards certain students also made some students discouraged and unhappy about their practice. When facing such situations, some revealed they also did not want to read and/or practise any more. Another third year participant said:

....When preceptors asked [something], they couldn't respond. Even when preceptors asked them again, they couldn't respond at all. Anyway, they got the highest scores in our group. ...They always tried to talk and contact preceptors/nurses. I mean they tried to talk like, "Could I help you with that?", things like that. ...So, preceptors scored the ones they knew. ...as I noticed, it frequently happened likes that.They [preceptors/nurses] favoured the ones that were close to them. The ones who were talkative and contacted them might get the opportunity to try. ...For me, I didn't contact them much, sometimes I didn't want to do that at all. Absolutely not! I didn't know why I had to do as they hadn't seen [what I did]. (Hana, Interview 2, page 25, 57)

Some students revealed they faced inattentive response situations throughout their nursing course. For these reasons, during practical placement, they felt they had tolerated something that made them unhappy and discouraged, and this was a common thing that the trainees could not avoid.

CONCLUSION

The participants, as novices, attempted to adjust themselves to their practice to have opportunities to develop basic nursing skills. Several conditions played a significant role in facilitating them to use feasible strategies to achieve their goals, so they could improve their skills to a certain degree. Not having enough opportunities to learn, however, led to less skill development. They lost many opportunities to learn from conditions that inhibited and/or interrupted their skill development, especially from *inattentive supervision*. Even though they tried to maintain their learning, it was not enough to become skilful in the basic nursing skills they should develop during this stage. Moreover, they had to develop more skills during the next field(s) where they had to focus on case learning. These hindrances to improving basic nursing skills could make their learning more difficult in the next stage(s). Unfortunately, perceiving and/or facing inattentive responses during this stage not only reduced the opportunities to develop basic nursing skills, but also created an unsatisfactory practice experience. Such conditions, the strategies they adopted and/or some unwanted effects, *fear to contact and work with some nurses/preceptors, confused and conflict with technique differences*, and being *upset and discouraged about practice*, were not simple to deal with. They were rooted in Thai nursing culture, which is reflective of the values of the broader Thai culture. This will be further discussed in Chapter Eight.

SEEKING CASE PROBLEMS AND HOW TO PROVIDE NURSING CARE

INTRODUCTION

The previous chapter portrayed how the novices develop their basic nursing skills during the early stage of their practical studies. This chapter focuses on the details of why and how these students began to address the problems of their clients throughout the stage (sub-category) of *seeking case problems and how to provide nursing care*, which is represented by the second overlapping oval of the learning process (Figure 4.1). It is the second sub-category of the first phase (category) of their learning development—**continuing practical studies**.

Students started case learning during a period that overlapped with basic nursing skill training; thus they applied learning strategies that were relatively similar to those employed for procedure learning. They learned about their patients and how to provide nursing care through strategies that novice case learners could develop. For these reasons, although experiencing *willing supervision* and a *facilitative learning environment*, they gained a limited understanding of how to handle their cases' problems. When influenced by the inhibiting and/or disruptive conditions listed in Table 6.1, these novices rarely learned about their patients, but emphasised doing basic nursing skills they were familiar with. The relevant conditions, the strategies the students employed, and the consequences emerging during this second stage are detailed in this chapter. A summary of these is also provided in Table 6.1.

Table 6.1 *Seeking case problems and how to provide nursing care: Conditions, strategies (actions/interactions), and consequences*

Conditions	Strategies (actions/interactions)	Consequences
<p>1. Concern about not understanding case problems -worried and afraid about -not knowing how to care for patients’ problems -doing pre-conferences -learning under pressure :worried and afraid about not being trusted :anxious about causing harm to patients</p> <p>2. Motivation to learn -awareness of the need for best care -learning motives -lack of motivation to learn :not interested in learning pathologies :rarely asking for more explanation :not interested in finding out what they did not know</p> <p>3. Supervision -willing supervision :most instructors and some preceptors focused on students’ clear understanding of case problems and how to provide nursing care :most instructors and some preceptors provided enough help, support, and opportunities for case learning -inattentive supervision :most preceptors/nurses did not have enough time to teach about cases :most preceptors/nurses were not interested in teaching and/or providing learning opportunities :some instructors did not provide sufficient feedback and/or teaching :some instructors limited learning opportunities in conferences :different supervisors applied different concepts</p> <p>4. Learning environment -facilitative learning environment :appropriate practical study management :appropriate practical settings -unsupportive learning environment :inappropriate practical study management :inappropriate practical settings</p>	<p>Strategies used to improve case understanding</p> <p>1. Building up self-confidence</p> <p>2. Taking basic case information as they are able -taking as much patient information from charts as they could -asking patients and/or doing physical examination -focusing on the signs and symptoms</p> <p>3. Using frameworks to start case learning</p> <p>4. Seeking help from experienced persons -asking help from seniors -asking help from friends, supervisors, and some nurses</p> <p>5. Seeking information from other accessible resources</p> <p>Strategies used to maintain learning</p> <p>1. Completing the requirements</p> <p>2. Completing routine care, orders, and helping with nurse tasks</p>	<p>Desirable results</p> <p>1. Familiarity with case learning 2. Learned how to provide nursing care for some problems 3. Interested in case learning</p> <p>Unwanted effects</p> <p>1. Focused on providing basic nursing care 2. Tired and exhausted with practising 3. Left unclear issues</p>

CONDITIONS

Not understanding case problems was the significant condition in this stage that led the participants to be concerned about practising. This issue together with differing aspects of conditions identified in the previous stage, impacted on the case learning development of the participants throughout the stage. This section reports how these conditions facilitated and/or inhibited/interrupted the learning of the students. Four concepts detail the circumstances of these novice case learners that contributed to the particular learning strategies that they developed for their case learning.

CONCERN ABOUT NOT UNDERSTANDING CASE PROBLEMS

Concern about not understanding case problems is represented in Figure 4.1 by the left rectangle above the second stage, *seeking case problems and how to provide nursing care*. This condition stimulated the participants to improve their skills to progress through the first transition point in the learning process, by developing learning strategies that enabled their learning about cases' problems and how to provide appropriate nursing care.

When expected to provide nursing care for patients who had particular diseases, the participants again expressed worry and fear about their practice because they did not know how to care for their cases as they did not understand their health problems. This created incredible stress for them when doing pre-conferences with instructors and led them to be worried and afraid about the impacts of caring for patients, without adequate knowledge. Their worries and fears during this stage are detailed in three sub-concepts.

Worried and afraid about not knowing how to care for patients' problems

Participants reported they did not know what health problems their patients had because they did not understand the pathologies of their patients' conditions. Sometimes, they knew what information was abnormal but they could not connect this to what pathologies it came from and why their cases had been treated in particular ways. Although they knew the actions of the medications that were being used in treatment, they did not understand how they functioned to assist the patients. A second year participant cited an example that:

As I saw, most were CHF [congestive heart failure] patients, they were treated with Lasix. Yes! I knew. Ah! Lasix could dehydrate fluid out. Anyway, I didn't know why it had to be injected. Injected for what? The fluid was there [extracellular fluid] and the fluid came out as urine here. I mean it was in the different parts, I thought about that [laugh], things like that. ...Until now I didn't understand much [laugh]. I had to learn more. (Supat, Interview 2, page 40)

Some participants who had moderate-high GPA reported that they tried to review the pathologies but they still did not understand what problems their patients had. They could not explain how those pathologies were connected to their patients' symptoms. They had memorised the symptoms of their cases, but still could not respond to their supervisors about what health problems the patients risked. They could not analyse how the conditions they could see and/or the symptoms their patients reported affected them. A fourth year participant with high GPA said:

At that time, if asked whether I could understand or not, only some, I thought. ... Like our instructors taught, I thought I understand. But! When I saw patients, there were more things to know.Like each disease, as I read, if [patient] had symptoms listed in pathology part, so I knew. But! If about its complications, I couldn't connect. When I was in the second year, I couldn't make a right connection that was a complication. Like, why a bed ridden patient had atelectasis, things like that. I meant I only knew that patient had a stroke. He [patient] couldn't move himself, things like that. If I had to...like, my instructor asked ah! What complication(s) he might risk, ...I had no idea. ... (Kanda, Interview 1, page 7; Interview 3, page 36)

Others with low GPA revealed they could not see the problems of their patients. They thought at that time, they did not have any problems any more. As a third year participant said:

...When I was in the second year, I couldn't specify many [nursing] diagnoses. Yes! I felt [laugh] my patients didn't have any problems. ...When in my second year, like, I couldn't see the problems of my patients. (Rhoba, Interview 2, page 33)

In this stage, the participants felt they could not assess the significant problems of their cases. Their uncertainty affected their communications with the relatives of their patients. They could not respond to questions about whether the conditions could be treated or not. They also could not tell the relatives how to rehabilitate their patients when they were being discharged. A second year participant talked about her concerns about her patient with subarachnoid haemorrhage:

...I still didn't know, not fully understand! ...I thought I didn't understand all of his problems, maybe. I didn't know what condition(s) he might have tomorrow. ...Why my case couldn't speak, as before this he could. Why he couldn't speak after the x-ray. ...Or why he had more hemorrhaging. Eh! Why the doctor made an appointment on the twenty-second. Apart from iv fluid, why she [doctor] didn't give him other treatments first. Just let him do active-passive exercise on a bed, things like that. I had lots of questions about this case. I didn't know why the doctor didn't give him any medication or something or whether she

was waiting for the investigations to make sure before treating him with any medication. ...Mmm! His relatives also asked me too! You know? "Could he walk or not?" "Could he speak or not?" Mmm! Today was his rehabilitation period. How about his rehabilitation? Mmm!! What could I do? (Plyma, Interview 2, page 55)

Not knowing what problems their patients had, led the participants to feel worried and afraid when they had moved to the next subject field that focused on the diseases and problems of their cases, as they thought they should have more knowledge and skills to care for them. They also thought their supervisors might expect that they should know more about their cases' problems and how to provide nursing care for them than they actually did. These concerns made the participants who were somewhat familiar with practising feel pressured again. Nearly half of them revealed that in this stage, they considered they needed to know more about the diseases and pathologies of their cases. Without that knowledge they could not identify appropriate nursing care for their patients, so they felt stressed about having to care for them. They had to adapt to practices that were new to them and to the expectations of supervisors and their clients, based on not understanding case problems and how to provide appropriate nursing care. A third year participant described:

Yes! Starting to practise about diseases led me to feel more stressed. Like, I had to write. I had to read and know more. I had to know about pathologies, things like that. ...Like nursing care plans in 'Adult'²⁹ had a pathology part, and 'labs' [lab results] that I had to know the reasons for. Before that, 'BCPN' field, I only indicated that [lab results] were lower or higher [than normal ranges], no more explanation. But! In 'Person with Health Problem', I had to specify the reasons [why they were abnormal]. I had to know. I had to read more. ...Practising in this period, I had to read more and more. If I couldn't respond to [supervisors' questions], I had to search more and then tell them in the following days, things like that. (Kasaree, Interview 1, page 11)

Some also disclosed that they were worried that their assigned cases were difficult, which made them even less confident as they did not know if relevant content could be found in the texts to prepare for caring for them. Sometimes, they felt they were not ready to go to clinical settings if their search did not find enough information about the problems and how to provide nursing care. A fourth year participant said:

Like, sometimes, I was assigned a case and I didn't know whether I could find the information [about that disease] or not.Like, I had to prepare something for tomorrow, and if I could, I felt good and ready to go to a ward too. But If I felt I couldn't find enough information, I didn't want tomorrow to come. I didn't want to go to a ward at all as I didn't know the information I had was right or wrong, so I wasn't ready. Yes! I meant I was worried when I went there. Eh! Whether I might be reprimanded or not because the

²⁹ 'Adult' is the previous paper name of the practical papers, Nursing care of Persons with Health Problems.

answer(s) I found might be not enough for what my instructors needed me to obtain. (Arun, Interview 3, page 28)

Thinking about not knowing how to care for patients' problems led the participants to be stressed about participating in the pre-conferences before starting their nursing care activities every morning shift.

Worried and afraid about doing pre-conferences

Nearly half of the participants revealed that taking part in daily pre-conferences put pressure on them. They were very worried and afraid that they might not be able to respond to their supervisors' questions. This was especially the case when they had to confer at bedsides, without any friends to help them, about nursing care for patients who had diseases they had never studied, or when they were suddenly changed to a new case which they had had insufficient time to research. Some indicated that they had to tell their supervisors that they had not had enough time to prepare. Also, if they could not respond to their supervisors' satisfaction, they revealed that they were very worried that what they did know about their cases was wrong, particularly if they had only roughly read up on them. They could not remember the contents that they did not understand, especially during the beginning of this stage. A second year participant said:

Stressed! Because I was a person who had just roughly read up. I had not really investigated more! When I responded to my instructor and she [instructor] asked me more and more until I couldn't answer, so I stopped. That made me stressed [laugh] because I didn't read enough. I meant I didn't fully understand. ... Sometimes, I just responded to her by what I thought about, things like that. So, she said like, "Are you sure?" That made me really stressed [laugh]. If she said, "Are you sure!", I thought, "Am I wrong?" What part I read was wrong, things like that. What I read should be right, I thought. So, I felt confused. (Supat, Interview 2, page 33)

During participation in pre-conferences each day, even though they had done their nursing care plans, they again tried to look up what they had to tell their supervisors about their cases, to make sure that they knew the problems and how to provide nursing care for them. Some of them revealed that they could not learn well from what their friends reported and/or their supervisors taught them during pre-conferences, because they were so nervous and worried about what they had to contribute next. A third year participant said:

... I felt nervous at that time. The next one was me [who had to confer next], things like that. My instructor was asking my friend now. When she [instructor] was conferring with my friend, she tried to teach others in the [group] sometimes. But! I tried to look things up in textbooks. Like, ah! I already did

my nursing care plan, but sometimes I tried to look at that [what it had to tell her about my cases] again to make sure. So, I couldn't listen what my friends said, could I? I was worried about mine. I thought I didn't quite get anything more during pre-conferences. ... (Araya, Interview 2, page 51)

Participants were worried about pre-conferences every day. They were concerned about what they had to research for their pre-conferences in the next few days. Moreover, because the case learning stage overlapped with the stage of procedure training, not knowing case problems and how to care for their patients contributed to participants feeling that they had to continuously develop their nursing skills under pressure.

Learning under pressure

Caring for patients based on a self-perceived lack of understanding of case problems led half of the participants to express concern about pressure situations they might face. The following two codes describe those fears.

Worried and afraid about not being trusted

Not knowing how to provide nursing care for cases' problems made participants concerned that their clients and/or the relatives might not trust in their competence and thus not allow them to give care, especially those who had already faced similar situations in the previous stage. Always concerned about developing and/or keeping the trust of their patients and the relatives, these students tried to make themselves competent in the nursing care activities they were going to do and the issues they were going to discuss with their clients so as to be able to respond to the questions their clients might ask. A second year participant said:

In 'Persons with Health Problems 1', the nursing activities focused on particular diseases and how we [nursing team] could care for them [patients], not only procedures. They [nursing activities] related to others too. For others, I meant like, moving patients into a high Fowler's position, ...giving them suggestions too. ...Yes! I had to read. Sure! Otherwise, if they asked [some questions] and I couldn't respond, they weren't confident in my competence, I thought. (Klaiwit, Interview 2, page 38)

Furthermore, these students were concerned about situations that they thought might make their patients doubt their competence. For example, when having pre-conferences within patients' sight, some were very worried that their patients would not trust them if they could not respond to their supervisors' questions. A third year participant said:

Fear! Patients might...[paused]. Sometimes, I felt tense too, about a conference within patients' sight...[paused]. If my instructor asked and I couldn't respond, turning to see patients, they might not...[paused]. I thought they might not be confident to allow me to care for them. ... (Mintra, Interview 2, page 39)

As in the previous stage, when reprimanded by nurses, participants were concerned that might make the patients not trust them. A third year participant said:

If our instructors reprimanded, they didn't reprimand within patients' sight. But! Nurses/preceptors did [reprimanded] so loud [slight laugh]. Sometimes, I felt ashamed and low-self esteem. Like, I would do that [nursing care activity], they said, "Ah, what are you doing?" [speaking with small sound]. So, it looked funny. Like, patients didn't trust me, I thought. ...they spoke so loud! ... (Hana, Interview 2, page 40)

However, some explained this concern in relation to causing harm to patients. They were not only afraid that they could not respond to some questions of their patients who might have more knowledge about those issues than them, but also worried about giving the wrong information (detailed in the next code).

Anxious about causing harm to patients

Not knowing about how to care for the problems of their cases made the participants feel anxious they might cause harm to patients and/or be blamed/punished as during the previous stage, especially when they had to provide nursing care for the patients at crisis times and/or they did not have enough time to prepare. A fourth year participant cited an example:

...At that time, I practised in a pediatric ward and I had to care for the DHF [dengue haemorrhagic fever] patient who was in the crisis stage. ... I was so stressed. Yes! I thought why has my preceptor assigned such a case to me? I felt I didn't have enough knowledge and competence [to care for the patient]. If he [patient] got worse or something, I would feel terrible. ... (Suvadee, Interview 1, page 11)

They were also nervous that they might cause harm to their patients by giving wrong advice thus they rarely gave their patients advice. A third year participant talked about this concern:

In my second year, I didn't dare to give some suggestions [to patients]. I feared that might not be right. ...Or sometimes preceptors/nurses allowed me to do that. I meant I had to tell them what I would suggest and then I did that. Even when caring for my cases in my third year, if I wasn't sure, I had to ask preceptors/nurses first, it was right or not if I suggested [patients] like that. (Rhoba, Interview 2, page 39)

Based on their perceived lack of understanding of case problems, these students reported concern about giving the wrong nursing care and causing harm to patients, throughout their training course. Meanwhile, in some settings, the students were told not to do any nursing care activities arbitrarily. That meant they always had to tell preceptors/the nurses about what they were going to do first. This situation seemed to remind the students of their fears that led them to practise based on the concept of *awareness of the need for best care* (as previously mentioned in Chapter Five and again further in this chapter). Some reported that even when their patients had some changed symptoms and they knew how to care for them, they always told their supervisors or the nurses what they were going to do and had already done to make sure that it was right. If something they did was wrong, then it could be solved before it affected the patients. A third year participant said:

I would ask the nurses first. I would tell them first. Ah! Like, "That patient had dyspnea". I asked the nurse how to care for him [patient]. She told me, "Mmm, move him into a high Fowler's position." Even I knew I had to do that and might give him Oxygen and told him to take deep breaths too. I knew that, but I didn't dare to tell him. ...I was afraid that I might do something wrong. ...the nurse there always told us as a student, if you want to do something, you have to tell the nurse/preceptor first. "Don't do it arbitrarily at all". Even suggestion(s), we had to tell them first as they had more knowledge than us who might do something wrong. (Aunchana, Interview 1, page 12).

Being *concerned about not understanding case problems* seemed to be the most powerful condition that forced the participants to learn in this stage. However, *motivation to learn* was another condition that influenced their skill development. In this study, I found that the participants who had moderate-high GPAs reported more enthusiasm to learn than those with low GPAs.

MOTIVATION TO LEARN

In addition to emerging as a significant condition that motivated or inhibited participants' intention to learn basic nursing skills, *motivation to learn* could promote or reduce their efforts to understand the problems of their patients and how to care for them. Why and how much these students tried to learn about their cases, and also why they did not pay attention to case learning during the early period are explained in three sub-concepts.

Awareness of the need for best care

Always being aware of their responsibility for the human life in their nursing care, the participants recognised they had to pay full attention to case learning. In this stage, these students focused on understanding thoroughly about the illnesses of their patients, and providing them with the care that corresponded to their conditions. Some reported they thought that it was important to ask their cases for accurate information even though their friends told them not to do so; they did not just assume how it should be or get it from the charts. As nurses, they felt they had to know how their patients perceived the information about their illness to be able to give them corresponding nursing care and they had to fully understand about their patients' illnesses to provide them with suggestions for practicable self-regulations that corresponded well to their problems. The students thought these could assist their patients to recover in the appropriate time, and protect them from the risks their illness threatened. A third year participant talked about her awareness:

...Some patients, like my case when I practised at male surgical ward, he [patient] had a UTI.[urinary tract infection] ...He was discharged with a Foley cath. During recovering at his home, he pulled the cath off. That case was my first case that made me feel ah! If we [nurses] explained to patients something that is not right ...I felt working as a nursing professional meant everything we did, we had to do in steps and we had to think over time about what we are going to doHe thought mmm! His urine was flowing well, so he pulled it out. That made him have lots of hemorrhage. Like, nearly a ruptured urethra. ...So, he had to be admitted for many days, many weeks. Yes! Like something, we [nurses] thought patients already knew, so they just roughly explained. Actually, we had to tell them every detail. That made me feel working as a nurse, I had to pay attention to the care I provide. (Rhoba, Interview 1, page 2; Interview 2, page 30)

In addition to being aware of providing the best care, the participants reported that their *learning motives* also prompted them to make an effort to learn about the problems and how to care for their patients.

Learning motives

The participants were stimulated to learn by the same conditions as the previous stage. These were wanting to be skilful in basic nursing skills/or hoping they could be nurses to fulfil their families' wishes, having caring supervision, getting trust and/or admiration, discovering the value of nursing, wanting to be like the good nurses they worked with, getting good grades, and needing to show they were competent to be nurses.

In this stage, however, some emphasised that significant learning motivation also came from their need to understand cases' problems. Seven participants with high GPA and five with moderate GPA indicated that they paid more attention to their practical studies because they needed to know more about how to provide nursing care for their patients. They hoped to understand fully about the problems of their cases and accumulate more knowledge after passing each of their practical settings/fields. Although perceiving that nursing was a gruelling subject and feeling stressed when influenced by some inhibiting and/or interrupting factors, these students devoted their effort to completing the course, even those who had not attended to their practice during the previous stage. A fourth year participant with high GPA outlined why she could develop her nursing skills in this stage:

...When practising, some issues I didn't know, I tried to ask until I could understand. ... When seeing cases, I had to be diligent to search for the case information. Sometimes, preceptors asked [other nursing students], "Why didn't you search?" But for me, I had to find out.In some wards, I wasn't happy, so I wanted to finish that practice soon. Anyway, I had to know the problems of my cases. ...I had to understand!I was aware of continuing as I had always done. I mean that I have tried to do this well over time. ...When practising in some settings the environment affected [me]. The negative factors made me feel unmotivated [not wanting to do] in some situations. But! I had this [point at positive conditions] as the facilitative factors that were more than [negative ones], so I felt I could continue [my learning]. ... (Noree, Interview 2, page 62, 70-71; Validation Interview)

Even though most of the participants stated they had many factors that motivated them to learn in this stage, more than half of them had also had *lack of motivation to learn* sometimes.

Lack of motivation to learn

Lack of motivation to learn was the significant condition that had the most power in holding back participants' attempts at developing an understanding of patients' problems and how to care. This condition could not only make them less interested in knowing about their cases, but also caused boredom about case learning near the end of the stage. When they felt the effects of *lack of motivation to learn*, these students stopped paying as much attention to their case learning, as reported in the following three codes.

Not interested in learning pathologies

More than half of the participants implicitly reported they were not interested in learning the pathologies of their cases in the early stage of case learning, which then led to not understanding the problems. Some thought that it was not necessary to focus any more on pathologies. Rather, they had to know about their patients' information and nursing care activities they had provided, as they had to present them to their instructors when taking part in pre-conferences. Meanwhile, others revealed that they felt the pathologies were really difficult for them. Therefore, although recognising that knowing the pathologies of their cases could assist them in understanding how to properly respond to the problems that happened because of particular causes, they were still not concerned enough to overcome their difficulties in learning about them. Most left completing the pathology part in their nursing care plans until last, because they felt there were too many details to fill in. A third year participant disclosed:

...Like, I didn't quite read it [pathology]. I just tried to find what pathology I had to use for [completing] my case report [nursing care plan]. I found that in texts and copied it. ...just copied, not read it [speaking with laugh].[About doing my nursing care plan], I completed the important parts first. I meant I did the parts I had to confer with my instructor first. Like, patient's information, I had to know. For pathology, that wasn't needed to fill in at that time. Just read it to roughly know, but didn't need to do [fill in the form]. ...The important parts I had to do were nursing care activities and some of 11 pattern information.Maybe, a few days later, as another part was quite completed, so I started working on a pathology [part]. Normally, I did that for the last thing. ...I felt it had too much content, so I wrote it last! ... (Sorphee, Interview 1, page 7; Interview 2, page 26, 27)

Apart from *not being interested in learning pathologies*, in this study, I found that the participants could not understand about patient problems and how to provide nursing care because they rarely asked for more explanation of the issues they were not clear about.

Rarely asking for more explanation

Another feature of *lack of motivation to learn* that could reduce the case learning opportunities of the participants in this stage was *rarely asking for more explanation* from their supervisors and/or the nurses when they had some questions during their practical studies. Nearly half, especially those with low GPA, accepted that it was quite uncommon for them to ask about the issues they were not clear about. A number of reasons were used to explain why they did not do this, but all of them were reported as the sense of "worried" (as previously introduced in the sub-concept of *fear to contact*

and work with some nurses/preceptors in the concept of unwanted effects of attending to procedure training, Chapter Five). Being worried about reprimanding/inattentive responses still seemed to be the most significant condition that meant these students did not want to ask. As a second year participant with low GPA said:

Yes! Normally, when patients were admitted, I sometimes asked [preceptors/nurses] why they had symptoms like that. So, the preceptors/nurses explained to me. Anyway, they gave me a short explanation. ...I didn't get that at all. The first time I heard, I didn't understand, but I didn't dare to ask [for more explanations]. I was quite worried that they might say like, "I already told you, but why do you not understand?" Things like that [laugh]. ...I didn't get that at all [speaking with laugh]. (Plyma, Interview 2, page 54-55)

Some were worried that their supervisors might blame them for not reading the textbooks enough, whereas others felt ashamed to ask. These participants were concerned that their supervisors or the nurses might not have enough free time for them; they did not want to annoy them while they were working. This led them to use the word "krengjai" to explain why sometimes they did not want to contact their supervisors and/or the nurses. It means not wanting to create trouble for another person or make them feel annoyed. Concerned that they should not make the nurses unhappy with their questions, especially when seeing their preceptors and/or the nurses were busy with their work, the students revealed they not only did not ask for explanation, but they also did not dare to talk to them. Out of all of these reasons, however, some stressed the main reason that inhibited their asking was being worried about the reciprocal questions. They were concerned they would not be able to respond to follow up questions their supervisors and/or the nurses might ask. Some reported they did not want to have more questions to research, so they avoided asking. They sometimes tried to read and understand by themselves if possible. Others disclosed that during their first and second year, they had never asked for more explanations from their supervisors. Actually, they had never asked anyone about the issues they had questions about or did not know how to deal with. Even the participants with moderate-high GPA revealed that they asked for more explanation only when they really did not understand. A third year participant with high GPA gave her reasons that:

They looked like reprimanding nurses. I was quite worried that if I asked them something ah, they might think I was hampering them, things like that. They had to work. Seeing they were quite busy, so they might not have time to talk to me. If I asked something, they might say ah, "You would like to ask me, but did you read about that?" Things like that. So, I was quite afraid I couldn't respond [to their reciprocal questions]. I feared that I wasn't ready, things like that, so I didn't want to talk [to them] or ask something [quiet for a minute]. (Hana, Interview 2, page 24)

Besides the issues influencing *lack of motivation to learn* already mentioned, the participants also had some ideas that could have acted as barriers for learning the problems of their cases and how to provide nursing care in this stage.

Not interested in finding out what they did not know

In this study, I discovered that the participants sometimes were not interested in finding out more about the issues they did not understand and/or they did not store notes for reminding themselves methodically. Some revealed they thought it did not matter if they could not respond to the questions of their supervisors because they were only in the early stage of their practical studies. A third year participant with low GPA said:

I thought that I was only in second year, wasn't I? Even if I didn't know the right answers or couldn't respond or something, I meant [smile] the instructors still gave me forgiveness at that time. As ah! [I was] so young, things like that. Just my first practising! ... (Araya, Interview 1, page 21)

Some participants, especially those who were in the third or fourth year, disclosed that they often thought that patients with diagnosed diseases would have similar problems to those they had cared for before. Therefore, they thought it was not important or necessary to ask their new patients for some information. Normally, they focused on taking case information from the charts; they rarely did physical examinations, or asked patients because they thought they already knew their problems. A fourth year participant with moderate GPA said:

Mmm! Normally, I quite knew patients' problems, so I didn't need to do a physical examination. Yes! ...Like, excretion, normally, I didn't ask. I meant I sometimes checked that from charts. Like, how many times patients voided, things like that, so I got that information.How many years they took medication? Sometimes, that information might be on family folders at PCU³⁰. I meant normally I got quite a lot of information from PCU. Like, chronic patients, as I practiced at wards, I was sure why they had those symptoms. If asked why you had sickness, because of quitting medication right? Ah! They didn't take medications, so they got faint like that. ... (Alfa, Interview 1, page 22; Interview 2, page 28)

Moreover, one male participant with high GPA thought he had enough knowledge on those issues to care for the patients as he understood what the nurses knew. He said:

...So, I thought ah! It was enough for me to know like that as the preceptors/nurses who were working knew. Sometimes, preceptors/nurses talked friendly that they didn't know any more. They just also knew only that, things like that, so I sometimes thought it was enough for me. As I knew the things I used for my practice. (Arun, Interview 2, page 25, 26)

³⁰ PCU: Primary Care Unit

In addition to *concern about not understanding case problems* and *motivation to learn*, the participants also reported that *supervision* had influenced their learning throughout this stage.

SUPERVISION

Supervision evolved as an important condition that facilitated or inhibited/interrupted their developing understanding in this early stage of case learning. When training with supervisors who paid attention to students' case understanding, they were able to learn more about the problems of their patients and how to provide nursing care for them. If practising with supervisors who were not concerned about what the students had to learn during this stage, they lost many opportunities to know about their cases. Why and how much *supervision* influenced the case learning of these students is coded into two sub-concepts.

Willing supervision

In this stage, when being asked how their willing supervisors helped them in case learning, all of the participants recognised that most instructors and some preceptors paid full attention to facilitating their learning about their cases. They made more effort to train their students to assess and diagnose the problems, leading them to understand what nursing care activities they had to provide. The details of how these supervisors facilitated these students to learn about their patients over the early period are reported in three codes.

Most instructors and some preceptors focused on students' clear understanding of case problems and how to provide nursing care

In trying to educate their students to clearly understand the problems, most of the instructors and some preceptors focused on the causes of the problems, i. e. the pathologies. When holding conferences, instructors pointed out that the students first had to know about the diseases that could affect the health of their cases. After that they guided their students to find the data that supported those problems, before linking this to how to specify the diagnoses and design the nursing care. As well, some preceptors, especially those who worked at critical wards and community hospitals, not only educated their students in the same ways instructors did, but they also recommended

some ways to assess the problems and nursing care issues they had not thought about, as well as guiding them to search for more information. Practising with these persons, participants could learn more about the nursing care for different conditions, especially from particular experiences which were not covered in textbooks. Moreover, during evening shifts, some preceptors tried to teach these students about the cases they were caring for and their significant problems, again extending discussion to aspects they may not have considered.

If their students were still not clear about some parts of the pathologies, instructors/preceptors gave the students more explanation and/or guided them to search more. Instructors always gave their students feedback when finding that they had not planned for all of the problems and/or the plans did not correspond well and/or these did not have enough information in some parts. Instructors/preceptors would guide their students about the how to care aspects for the omitted sections, before telling them to search more and include those parts in their nursing care. Principally, when taking part in pre-conferences, the students reported that they could confirm what they planned to care for the cases with these supervisors who also had suggestions for the parts they had overlooked. The supervisors also checked that the students had followed up with research and amended their nursing care plans, as well as giving students more explanation on the parts which they could still not clearly explain. A third year participant explained the way her preceptor taught her to clearly understand her case problems and how to care:

...You could specify he [patient] had IICP³¹, but that should be a later issue. I didn't know what to set for his [nursing diagnoses] at that time, so she told me ah! Your patient now still has a Radivac drain³² in the head. ...During the early stage, I didn't know that. When she told me, well! I had to assess each part; I had to examine from his head to his feet to find out what problems my patient had. If the drain line wasn't working very well or blood was draining more than it should, that might cause brain infarction, things like that. You know? I had never seen a diagnosis like risk to brain infarction in the texts. Oh! Where did it come from? I meant I knew that [knowledge] from my preceptor. ...It [knowledge] was deeper than [texts listed], the things she told me. ...Then what nursing care activities should we do? She said, "How do you care for that [speaking with high volume] if you needed the drain line unblocked or prevent hemorrhage?"...She also further asked me, "How do you observe if you don't know how much blood he could lose?" So, she told me to search out more. ...how I could do this if he lost too much blood and how that affected his brain, things like that, you know? So [her methods] made me understand more. ... (Hana, Interview 2, page 32, 33)

³¹ IICP: Increased Intra Cranial Pressure

³² Radivac drain is one type of surgical closed drain. It is attached to an evacuated glass bottle providing suction used to drain blood beneath the skin or from deep spaces.

Training with willing supervisors, the participants not only had been guided how to clearly understand about cases' problems and how to provide nursing care for them, but they also attained enough help, support, and opportunities for case learning.

Most instructors and some preceptors provided enough help, support, and opportunities for case learning

As for the previous stage, *attending to procedure training*, the participants reported that willing instructors/preceptors continuously gave them much help and encouragement, though this time the attention was on case care. Nearly half revealed they could obtain help and support from their instructors/preceptors as caring supervision in many ways. For example, some reported that instructors sought the more interesting cases for them, taught them to take the information from the charts, gave them suggestions about how to provide nursing care for their patients and enough time to learn about their immediately assigned cases, which could relieve their tension about caring for the cases when they did not have enough time to prepare. Meanwhile, others reported that their instructors were also concerned that they still did not understand about how to care for their cases, if they were trying to learn alone, so they suggested that they should review the contents with friends. A second year participant described the help of her instructor:

At first, I didn't know how to start and the chart was quite thick [documents]. I didn't know what I should take for notes. So, I just wrote down anything with no direction. If the page I opened I could read, I took notes on that. After that, my instructor taught me if taking information from a chart, you should start with patient's histories and then come along with each page, things like that. That meant checking from the back page up [to the front]. ...My instructor also told me to look at every detail and then think about that. Like, what problems my patient had that connected to the diagnosis of the doctor, things like that. ... (Wana, Interview 2, page 22)

In trying to explain the instructors' efforts when assisting students in case learning, these students also reported that they gave them enough opportunities to learn and welcomed their students asking for more explanation on the issues they were still not clear about, even during their late hours. They also attempted to provide opportunities for some students who were very reluctant to ask about what they did not understand, as well as suggesting some texts to their students for more reviewing. A third year participant claimed:

... Our instructor was interested in us, and paid attention to teaching us, even when she [instructor] got pregnant and had other workloads or something. She sacrificed much time for us. Yes! Like, if we didn't understand something, we could bring texts to her and tell her I already read that, but I didn't understand

it or something. "What could you please suggest for me?" So, she said like, "Let me see the texts please." Then she checked that and told me like, ah! It was like this/that. Yes! She also recommended the texts or journals I could use to make things clear. (Araya, Interview 1, page 10)

These students also indicated that their instructors attempted to assist them to learn the problems of their cases as much as possible. When their students were going to learn about nursing care in communities, they also sought opportunities to help their students to make suggestions for their clients. Before holding content conferences, their instructors tried to guide their students about the problems they had to analyse. A fourth year participant revealed:

Yes! Our instructor first asked us which case we were going to hold a content conference about. Then she [instructor] checked information from charts. She also took more information from students, the owner of that case, other friends in our group, and the patient. Like, she asked, "What are the problems this patient has?"...after that she would guide us that ah! "It is still another". "Try to analyse more". "Try to find out more", things like that. Also, like about 'labs' [lab results], if we didn't understand, we could ask for more explanations. She might tell us or suggest the texts where we should search more, things like that. ... (Laina, Interview 2, page 27)

Moreover, to provide more opportunities to learn, both instructors and preceptors tried to make post-conferences possible to help these students learn about how to provide nursing care for their cases, especially when finding that their students still did not have much idea of what to do. These willing supervisors also taught them about important related issues, even when there were no relevant cases at the settings. A third year participant said:

...It wasn't common for another ward to call nursing students for clinical teaching in the afternoon, as I never experienced that before. But, in that [critical] ward, the head-nurse [said the name of the head-nurse] assigned the nurses there as to which nurse should teach us about which issue. So, each preceptor there would make appointments with us. Like, "This afternoon, 3pm, we will talk about that". I mean they would teach us according to which one was good at which issue. I thought preceptors there paid enough attention to nursing students. ... (Araya, Interview 1, page 10)

Although nearly all of the participants stated they experienced *willing supervision* in this stage, most of these students also encountered significant difficulties when they had to practise with inattentive supervisors.

Inattentive supervision

Besides making less opportunity for the participants to develop basic nursing skills as detailed in Chapter Five, *inattentive supervision* could also interrupt and/or inhibit their case learning. When practising with supervisors who were more focused on completing

their own tasks, the students were concerned that they had no opportunity to learn from them, especially in the afternoons of day shifts, afternoon or night shifts, and when placed at outside settings. The facets of *inattentive supervision* that limited the students' learning opportunities are reported under five codes.

Most preceptors/nurses did not have enough time to teach about cases

More than half of the participants reported that most of their preceptors and/or some nurses did not have enough time to teach them. Normally, when their instructors were not at settings, these students could not learn much about their cases; they could not have conferences, or even pre-conferences. The preceptors and/or the nurses who had work overload, especially in the regional hospital, did not have enough time to be interested in the nursing students; they were busy with their work. Practising with their preceptors and the nurses, these students mostly learned about the techniques of the nursing procedures they were doing and/or from the tasks the nurse needed them to help with (as previously detailed in sub-concepts of *willing supervision* and a code of *seeking opportunities to perform procedures* of Chapter Five). A fourth year participant disclosed:

...Some days my instructor didn't go to the ward. I meant when holding pre-conferences with preceptors/nurses, sometimes we [nursing students] could, but sometimes we couldn't. If they could... [incomplete sentence]. I meant some who...[incomplete sentence], because they had to rush to do the ward tasks, didn't they? They didn't...[incomplete sentence]. For others who were quite concerned [about what we had to know], they sometimes asked about nursing care activities and a bit about pathologies, maybe. ... (Laina, Interview 2, page 29)

Participants realised that focusing on completing tasks with their preceptors and the nurses meant they lost opportunities to learn about their patients and could not provide their cases with some nursing care activities they had planned. A second year participant who had just started case learning said:

...When I practised in a ward, normally, it was about procedures. I mean preceptors/nurses told me to do this/that, so finally, I just did quite a bit nursing care for my case. ...I meant the nursing care activities I already planned. You know? In general, I only advised them about foods and self-regulations. For others I had a beautiful plan, but usually I couldn't [do] [laugh]. ...Like, doing physical examinations. I mean about observing the symptoms such as cyanosis as I planned [laugh], things like that.Normally, if about case learning or nursing care [for my patients], things like that, it was quite rare. As preceptors/nurses were busy, so I didn't quite ask [something]. If I had question(s), I didn't ask them much. ...They were busy; [they usually said.] "I am still busy, wait! Not now," things like that. ...Doing procedures, yes! All procedures they told me to do [laugh], normally, blood puncture. (Supat, Interview 2, page 37, 44)

Sometimes preceptors/nurses also limited the participants' learning by not being interested in teaching them and/or providing them with opportunities to learn about cases.

Most preceptors/nurses were not interested in teaching and/or providing learning opportunities

Nearly half of the participants thought their preceptors and the nurses were at times not interested in teaching and/or providing them learning opportunities, especially the nurses who were opposed to the students of the *Project* (as previously mentioned in Chapter Five, sub-concept of *inattentive supervision*). They gave many examples of those situations. Some revealed sometimes they asked preceptors or nurses to teach them about some issues, but they refused to do this. Others reported that even though they were not clear about assessing some abnormal sounds from their patients, their preceptors and/or the nurses just named the abnormal sounds without further explanation. A second year participant noted:

... Like crepitation³³ [sound], I thought it was like ruffled hair, things like that. Mmm! I couldn't identify it. When listening, I told a preceptor/nurse that it was another [sound], even though it was [crepitation]. I was confused why I couldn't still identify it. I mean I didn't know it.No! [no more explanation from them]. They just told me [that's what the sound was]. So, I and my friend still felt confused. Eh! Why was it that sound? ...I would like to know. I would like to be skilful in physical examinations. If possible, I hoped I could do percussion, identify abnormal sounds, or do a heart examination. But! For the teaching and learning I got, I just learned something basic, things like that. No in-depth teaching, not providing the things students could apply. (Raiya, Interview 1, page 26, 28)

The preceptors and/or the nurses also only gave them rough information and told them to search by themselves when they asked for more explanation about some issues, as illustrated in the following extract:

[Sometimes], I asked them why doctors had to treat patients with this/that. I meant about some treatments I didn't know. What was this/that? Normally, they told me to search by myself [laugh]. When I was asking, they responded like, "Not telling", things like that. They needed me to search by myself. I meant sometimes they just explained me a little bit and told me to search more, things like that. (Raiya, Interview 2, page 42, 43)

Sometimes, when the students could not respond to their questions, these supervisors also reprimanded them as they did when they were developing their basic skills. Moreover, some third year participants also revealed that they faced a problem when

³³ Crepitation is a soft fine crackling lung sound like that made by rubbing hair between the fingers close to the ear. It is caused by a build-up of fluid that associated with different medical conditions.

practising at the same time as medical students/internship physicians as the nurses provided medical students with more learning opportunities than them. One of them said:

...We practised there at the same time as externs and interns. They [the nurses] acted differently. If the medical students held charts, they didn't say anything, but when nursing students did, they immediately interrupted. They said, "Can you take that later? Now is so busy", things like that. If medical students did, they didn't say anything. They said like, "You [nursing students] just directly look at charts...charts! Why do you not observe patients?" [that situation happened on the observation day]. ...Hearing things like that, we didn't try to look at charts. I accepted that while practising at that ward, I wouldn't get to take nurse's notes, as the nurses there didn't want us to work with the charts or fore-charts... (Araya, Interview 1, page 9)

These factors reduced their opportunities to learn and meant some students who often worked with these preceptors and/or the nurses learned less than their friends who had been able to work with instructors who, as previously discussed, supported their case learning. A fourth year participant revealed:

Sometimes, I felt jealous of my friends. Like, they could train with instructors, but I had to practise outside [the settings] quite often. ...Like, many things, I didn't know. I accepted practising outside, there were many things I didn't know as well as friends who practiced with instructors. ...When practising with instructors, I could learn more relevant knowledge. ...I could get more benefit than [practising with preceptors]. Our instructors had enough time to talk to us, like we could have mini-conferences. Also our instructors told us about each issue [how to care for a particular problem]. Practising with instructors, I had what I couldn't get [from preceptors]. I mean I could ask for more explanations related to knowledge—like the problems of my patients, I also dared to ask them. (Noree, Interview 1, page 3, 36)

However, the participants implied they also faced situations that showed some supervisors were less interested in teaching and/or providing them with learning opportunities. These issues are reported in the following three codes.

Some instructors did not provide sufficient feedback and/or teaching

Some participants revealed some instructors did not provide them with enough feedback on their nursing care plans. Although the students received some comments during pre-conferences, they only understood some of the problems of their cases. They did not know if their re-writes were right or wrong because they received no feedback after submitting the improved version of their nursing care plans. A third year participant said:

[About the case I had planned], I could understand some, but not all! ...If about doing my nursing care plan, instructors might not have time to check. They didn't comment much. ...I meant normally, when practising, in the morning, we [nursing students] could have conferences, couldn't we? So, they commented [nursing care plan] in some parts. Anyway, like others [other parts], we didn't present things

in the early few days, like pathology [part]. I mean the entire nursing care plan. They didn't comment. We just presented [after finishing case care], so we [students and instructor] didn't talk about that case any more. ...[slight laugh], so I couldn't [get any more comment at all]. If I already submitted my completed nursing care plan [laugh], I couldn't get it returned at all [speaking and shaking her head]. ...For the part I didn't understand, I had to read texts by myself [slight laugh]. (Hana, Interview 1, page 13)

Moreover, it was quite rare to see their instructors in the afternoon because they had to carry out many other functions to meet the missions of the institute (detailed in Chapter One). That meant the students who were placed in the regional hospital could learn with their instructors only during the morning of day shifts. If they did not understand some issues in the afternoons, they could not ask for more explanation. A fourth year participant said:

I didn't quite ask [for more explanations from] instructors [laugh]. ...They came to wards only in the morning, didn't they? In the afternoon, they were at the college. Sometimes, if they were at wards, I could ask, yes! But! I meant if they were at the college, sometimes, I went back there in a different time. Yes! Like, when I arrived there [the college], I couldn't see them, things like that. (Needa, Interview 2, page 25)

Getting late feedback was also unhelpful as students were working on new cases and could not go back to the earlier cases.

Furthermore, sometimes, their instructors only asked questions; they did not give their students any explanation in those issues or their explanations were incomplete. For example, when they tried to learn about the abnormal sounds of their patients, some instructors [as with some preceptors/nurses] only told them what abnormal sounds were. They did not teach them about how to identify those sounds from the real cases.

Apart from not providing enough feedback and/or teaching, the participants also reported that some of their instructors limited learning opportunities in their conferences.

Some instructors limited learning opportunities in conferences

Some participants reported that during pre-conferences, their instructors did not ask them about the pathologies of their patients, nor comment about the pathologies their students presented. Moreover, only some students, especially those presenting first in pre-conferences, were able to present some of what they planned. A third year participant disclosed:

Normally, pre-conferences just took a bit of time. ...Yes! Like nursing care activities, I mean sometimes, I still hadn't said what activities I planned to care. I mean I just presented the nursing diagnosis. Like, my instructor asked me, ah, "How about your patient today?" So, I told her [instructor], "My patient had this/that symptom", ah [my instructor said], "What nursing diagnoses do you specify today?" I mean sometimes, I only talked about the nursing diagnoses. For nursing care, sometimes, I couldn't [present] because many friends hadn't yet presented. Sometimes, we didn't have enough time because some wards had the shift round around 9am or 10am, things like that. ...Like, holding a pre-conference at the bedside, normally, there wasn't enough time. (Rhoba, Interview 2, page 40)

Also, students reported that their instructors did not give them enough time, for example, frequently postponing appointments for content conferences; thus students would forget the information about that case as they had moved on to another setting or back to class before that content conference was held. Some also confused information about new cases with the previous ones. Another third year participant said:

Instructors frequently had meetings. Sometimes, the time for supervision wasn't enough. Not enough! Yes! I felt oh! About time, I knew our instructors had lots of workload. Like, sometimes, they didn't finish [the supervision] [khang]³⁴, yes! Not really unfinished! Like a conference that belonged to that ward, but it was carried to this ward until we [students in group] forgot [the information] about the case. ...Too long! Perhaps for a month, yes! If so, we quite forgot the information. Sometimes, the information was faulty. We didn't blame instructors, but I felt they didn't give us enough time. That meant our work was late. We didn't get enough time. Instructors didn't give us enough time. ... (Hana, Interview 2, page 52)

Training with different supervisors also led to confusion about the use of language in nursing care plans.

Different supervisors applied different concepts

Some of the participants revealed that different supervisors guided them to specify nursing diagnoses in different ways. They sometimes reported this issue with positive aspects. Some thought different supervisors might have different points of view about the patients' problems, whereas others assumed that nursing diagnosis concepts might be flexible. These might lead them to have more opportunities to learn as they could set the problems of their cases in several manners such as "having a problem concerning/with", "at risk of", "promoting", and "preventing". However, they did not understand which nursing diagnoses should be specified for the present problems, or particular signs/symptoms their cases had at that time. They often had questions about why they could not set the diagnoses as they thought, but reported not having any opportunity to discuss this issue with their supervisors. A third year participant said:

³⁴ Khang means to be left unfinished or to remain stuck.

Yes! Like some instructors said I could set something [a nursing diagnosis] with “Promoting ...” Anyway others focused on “Risk of” or “Having problem about”, things like that. I mean, they didn’t quite have “Promoting”, so I doubted whether I could use “Promoting” or not. Moreover, sometimes they told me if the patients had signs/symptoms that showed they exactly had the problems or risked for another problem, I had to centre on the problems threatening the patients. But! If you would like to set something as “Promoting”, you could. (Araya, Interview 2, page 55-56)

During this early stage, besides the conditions reported, the participants thought that *learning environment* also much influenced their case learning.

LEARNING ENVIRONMENT

While the *learning environment* had not caused participants much difficulty in developing basic nursing skills, these students reported that it had more power in their case learning. This was particularly so for the practical study management and the settings where they were placed, which either facilitated or made them lose opportunities to understand their patients’ problems and the nursing care they needed. These influences are detailed in two sub-concepts.

Facilitative learning environment

Consistent with the stage of developing basic nursing skills, the participants reported that the learning supports their college provided encouraged them to understand the problems of their cases. However, in this stage, most of the students focused on how well the practical study management and settings for their practical studies facilitated their understanding of how to provide nursing care for their clients’ problems. These factors are described in two codes.

Appropriate practical study management

Second year participants reported that they were directly placed into clinical settings after finishing their theoretical sessions about the diseases and how to provide nursing care for particular patients. That arrangement of practical study aided their learning. The content they remembered formed the basis for their understanding of the problems, which made it easier to care for their cases. One of them said:

Well! Finishing two papers and then practising [about them] was appropriate because like, I could still remember [about what I had learned], yes! When I practised, it was easy to care for patients too. Like, I had studied about ‘Adult’, hadn’t I? I had studied about some nursing care activities, so I quite remembered that. It was like a continuation. I had basic knowledge from the content I had learned, and

then more was added [after the real experiences], so I could understand more. (Plyma, Interview 2, page 61-62)

Moreover, more than half of the participants reported they were allowed enough time for learning about most of their assigned cases. They also thought that their placement duration in most settings and/or fields was appropriate for learning what they had to practise. As well, they realised that to fully understand the problems, their requirements must be done together. They revealed the requirements of most subjects were appropriate for their practice duration. Their nursing care plan forms were good guidelines for them to correctly collect support data for patients' problems. Some also thought the management that provided them with different settings gave them more opportunity to learn about different diseases and/or conditions of their cases. For example, a third year participant described the impact of practice duration and setting rotations on learning:

Practice duration was around three weeks [per setting]. For the first week, I had to adapt myself first. The second week, I could care. During the third week, I was skilful [in caring for patients] of that ward. When I had to move to another ward, it was new experience there as each ward was totally different. ... It was the addition of different experiences and new techniques. ...If I had opportunities to practise in different wards, that made me have more knowledge. I mean I could have more knowledge about diverse diseases and different procedures. (Nirin, Interview 2, page 26)

Appropriate practical settings

Nearly half of the participants were fairly satisfied with most of their practical settings. They indicated that most practical settings they were placed in provided them with enough cases and equipment for their practising. As well, they had enough opportunities to learn about different cases, which meant some of them had complicated conditions, especially in the regional hospital. In some settings, they had another nurse who was willing to teach them, places to do their work or take a break. Furthermore, when going on community placements, they were also able to practice with very friendly clients who gave them more opportunities to learn. A fourth year participant said about the regional hospital setting:

Talking about the settings where I have practised, the [said the name of] regional hospital was the setting which facilitated me to learn about different cases. ...I thought the [said the name of] regional hospital provided me with different cases that helped me to learn quite a lot. I have talked to friends who practised at a [said the name of] provincial hospital, I asked them like, "Why do you not know this issue?", "You have practised ICU at [said the name of a provincial hospital], haven't you?", "Why do you not know?", things like that. I felt practising [at the regional hospital] did help me, no problem at all. (Areeda, Interview 2, page 33)

Although most of the participants were satisfied that most of learning environments facilitated their understanding of how to provide nursing care for their patients' problems, nearly all mentioned facing an *unsupportive learning environment* during this stage too.

Unsupportive learning environment

More than half of the participants found that some environments created difficulties at this early case learning stage just as they had during the previous stage. They focused on the gaps in the college's management of their practical learning and the settings that reduced their opportunities to learn about their cases. Two codes detail why these students were concerned about losing opportunities to learn and/or how the issues should be managed.

Inappropriate practical study management

Half of them thought that their practical duration in some fields and/or settings, especially in obstetrics, pediatric, critical care and community fields, was not long enough for learning about the problems of clients and how to provide nursing care for them. They thought that their practical time should be extended. A fourth year participant noted:

The field that allowed us to practise only one week was too short, I thought, because we had to spend at least one week for adaptation to the ward, preceptors/nurses, and the requirements I had to complete, including the references I had to cite, things like that. I thought two weeks was just perfect. Anyway, four weeks could make understanding stronger. (Areea, Interview 2, page 37)

Participants also reported they lost opportunities to learn for many reasons. For instance, some preceptors did not allow students to provide nursing care for patients who had diseases that involved systems they had not studied; in other situations, assigned cases and content conferences were too few; for others, if their instructors made pre-conferences within patients' sight, they could not talk and/or ask for more explanation about some issues; they had to do the project that was the main objective of the subject; sometimes they had to practise in a big group, which meant these were not enough opportunities to learn, or they missed out on having an opportunity to practise in some areas. They were also placed in different settings and/or times from their friends, so they could not together review what they had to know for the licence test.

Sometimes, they had to practise what they should learn out of sequence, which made it more difficult to clearly understand the problems of their patients and how to provide nursing care for them, as illustrated in the following extract.

...But! The obstetrics field was back to front. I felt confused. When practising at PP [a post partum ward], I was asked about labour, so how could I know about caring in labour? ...Ah! When I moved to labour, a preceptor there asked me about ANC that I had never experienced. How could I know that, things like that? I didn't understand, like it [my placement] was backwards. I thought it was strange! I started with PP! I was allowed to learn about post partum patients even though I didn't know how they delivered, or about their pregnancy and prenatal care.I was also blamed ah; a patient had uterus pain [that was my nursing diagnosis] and then what happened? How about her delivery? Or about episiotomy wound pain; how a nurse made an episiotomy wound and why she had that pain. I didn't know how to specify [nursing diagnoses] ...If possible, I would like to practise in sequence. (Hana, Interview 2, page 62)

Moreover, third and fourth year participants revealed that the practical study management in the third year decreased their learning, as they had to learn too many subjects and then practise for a long time. This meant that sometimes they forgot what they had learned earlier, and some reported they felt stressed and did not pay full attention to their practice because the long practice made them feel fatigued; they had to meet many requirements and did not have enough time to take a break, or to prepare for their practice before moving to the next setting. A third year participant with high GPA commented:

It [practising with no time to take a break] related more to practical preparation, I thought. I would prepare a little or sometimes it was quite rare to do that. I mean I would read at the night before submitting my nursing care plan. Like this ward, I was still on a shift on Saturday, then on Sunday evening, I had to do an observation [case] in the next ward. I didn't have time to read or understand about what I had to do in the next ward. Also, my work during practising at the previous ward wasn't completed because I had worked there until Saturday. That mean I had to do my nursing care plan or something [until Saturday]. When Sunday was coming, ah! Observe [a case] at the next ward! I couldn't prepare anything for that. ..., "Didn't have time, didn't have space for me to prepare before going to the next ward". (Hana, Interview 2, page 60)

Participants thought if they could study the theoretical contents together with practising, they would understand and remember what they had learned by making use of it to care for patients in the real settings. A second year participant said:

In my idea, I thought we [nursing students] should have some classes and some practices. Studying and practising together, yes! That should be of benefit. As we had learned for a long time, sometimes, we forgot things. I mean we couldn't remember all. So, we should study and after that we should have practices, things like that. Sometimes, I had to review what I had studied. That meant I had to work again and again. So, we should study and practice together, studied theoretical content and have a practical placement. Yes! ...We could see the real cases in the same time, things like that. "Try it!" In my idea, I mean supposing on one day, we should study in the morning, and practise in the afternoon. Do that

together, ...or maybe like, study for two days and practise for three days. ... (Nawin, Interview 2, page 54-55)

Furthermore, having to complete too many requirements did not help the participants to fully learn about their cases, particularly when the conditions were rather similar. They could not learn more by writing the same pathologies and nursing care activities. Moreover, they had to frequently leave their nursing care plans to do their group work.

Apart from inappropriate practical management reported, another *unsupportive learning environment* that could act together with the other barriers to case problem understanding of the participants was *inappropriate practical settings*.

Inappropriate practical settings

Although nearly half of the participants were fairly satisfied with most of their practical settings, some thought that in some settings, especially in community hospitals, they did not have enough cases. They revealed they sometimes rarely developed their skills because they had to share cases and had often heard their friends' case analysis at conferences, so it was not a new case for them. A third year participant noted:

...If I was at [said the ward name] where I had practised, they [cases] were quite rare. Sometimes, we [students in group] might be assigned the same case [as my friend]. I mean one friend had already cared for [that patient]. In the next few days, my other friend was assigned [that case] again. I thought our learning was stationary ... when my friend cared for that case, I listened to how to care for her/him and what nursing diagnoses my friend set, and then I used that to make my own. My learning wasn't happening. I mean that it didn't train me to do things by myself; it didn't train me to think about that by myself. So, it's like I wasn't progressing. Just making a copy! (Aunchana, Interview 2, page 29)

Meanwhile, other Buddhist students were also concerned about language barriers. They disclosed that sometimes they could not take some information from their cases and/or do some physical examination because they could not communicate with them (as they spoke a different language). A third year participant who was placed in the hospitals where most of the patients were Muslim talked about the difficulty she had to face at one setting that:

Yes! [laugh] ...Sometimes, I had to care for a Muslim patient. It was difficult to ask for a physical examination. Sometimes, I couldn't [do], yes! Like, I intended to ah, do this with that/this technique. But! I couldn't do it all. ...It was because I didn't know how to tell her/him [patient] [laugh], I thought. If I could communicate that I would like to do [a physical examination], s/he would allow it. (Mintra, Interview 1, page 22-23)

Starting learning cases' problems based on all of the conditions presented led the participants to develop particular strategies to provide nursing care for them.

STRATEGIES

In this early stage of case learning, the participants revealed that they tried to develop two main strategies. Being influenced by the powerful condition, *concern about not understanding case problems* and the other stimulating conditions that were facilitative in the previous stage, the participants attempted to learn by developing *strategies to improve case understanding*. When encountering conditions that inhibited/interrupted their learning development, they tried to apply *strategies to maintain learning* (see Figure 6.1). All of these strategies are presented in the following section.

STRATEGIES TO IMPROVE CASE UNDERSTANDING

The participants entered this stage feeling concerned about not understanding case problems and how to provide nursing care. They used a variety of strategies in this early stage of case learning which together brought some understanding of how to care for their cases. The strategies were relatively simple when compared to later stages. They applied the strategies back and forth repeatedly before making use of them to develop new advanced strategies for learning about the problems of their cases in the following stage(s). Five sub-concepts detail the strategies these students employed.

Building up self-confidence

As they were worried and afraid they would not know how to provide nursing care for their patients, the participants tried to prepare for their practice by building up their self-confidence through information. In this stage, these students revealed that they focused on learning about their cases by preparing how to care for them before going to practice, and then taking part in pre-conferences. They explained this strategy provided an overview, and reported others they applied to deal with the details of their practice during the stage. To build up their self-confidence, some of them reviewed the related theoretical content they thought they would have use for a few days before entering the field(s). Meanwhile, the majority attempted to do that after getting information about their cases. As previously mentioned, the questions from their supervisors were significant issues that concerned all of them. They were worried about what they would

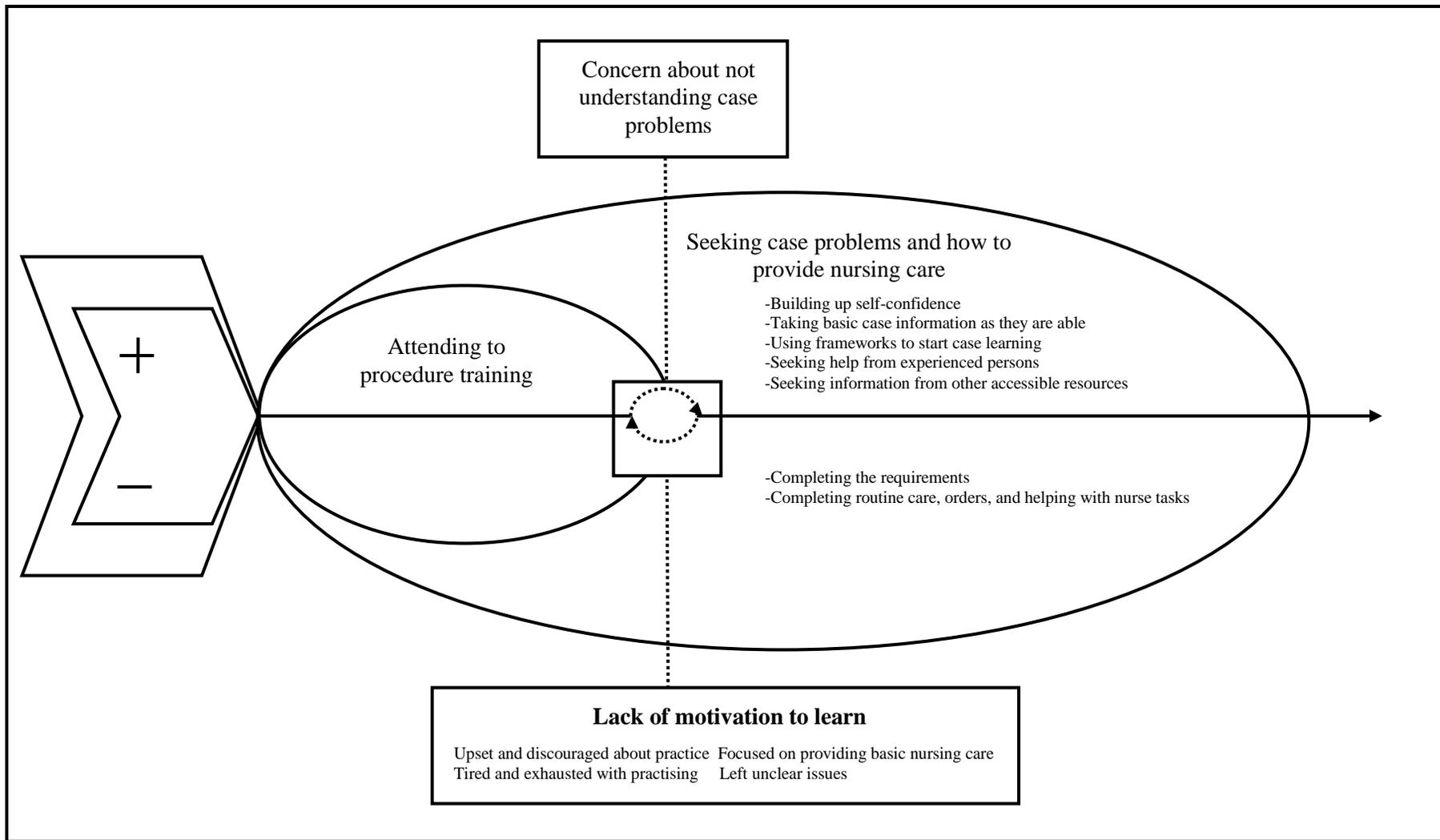


Figure 6.1 Learning strategies used for *seeking case problems and how to provide nursing care*

have to confer about on the following day(s), so they tried to apply many strategies that helped them learn about the problems of their cases and how to provide nursing care for them. Some students reported that during the early days of the stage, they focused on finding at least one problem of their cases to present to their instructors at pre-conferences. They were less interested to learn about the problems their patients had at that time. A fourth year participant recalled:

I was reprimanded, in my second year for the reason that, “[I was asked] how many nursing diagnoses have you done today?” I just responded, “Only one”, things like that. In the second year, like when I did my nursing care plan, I just thought, “Let me find one problem to confer tomorrow” [laugh]. Yes! You know? I wasn’t interested in what problems my patient had at that time. I meant I wrote only one problem [for taking part in a pre-conference]. ... (Areeda, Interview 2, page 19)

After practising for a period of time, others also reported that they tried to understand the diseases of their cases and related issues for responding to their supervisors’ questions and caring for their cases. Nearly all of them, however, accepted that they focused on what they had to know about their cases first. Some of them explained about how they prepared with the words “read only what I have to know and do first”. Not being concerned about preparing for the licence test in this stage, they were worried only about responding to the questions, having guidelines for caring for their patients each day, and completing their requirements. They revealed that they had to search for issues they did not know every day because their instructors questioned them frequently. Another fourth year participant disclosed:

...Like if my instructor asked me something, ok! I would search that. But! I didn’t try to find out more. That wasn’t good for a student. For example, my instructor asked [me something], aha! If you knew that, what did you plan to do [care for a patient]. Oh! I couldn’t further! I thought, “You [instructor] just asked me one thing, so I only have one answer”. Why did you ask me more? I knew only that [laugh]. Sometimes, I thought like that. I thought I already did my main job, doing my nursing care plan.If I tried to extend [about what I should know more], tomorrow, if she [instructor] asked me more, I could immediately respond, I thought. Anyway, I didn’t do that. I don’t know why [laugh]. ... (Siripat, Interview 1, page 10, 11)

The other strategies the participants applied to deal with their patients’ problems are reported in the remaining four following sub-concepts.

Taking basic case information as they are able

As novice case learners, the participants started their case learning with rather nervous and puzzled feelings. On the observation day, the data revealed that they searched for their patients’ problems in three main ways.

Taking as much patient information from the charts as they could

Most participants said that they attempted to take as much information as they could from the charts. More than half revealed that they did not understand how to do a nursing care plan, which resulted in a lack of direction for gathering information for case learning. They did not know what or how to collect the information on their cases. They tried to take notes from the information on charts, but they did not know what information on the chart they had to look for. Some of them did not know whether the data they took was related to their cases' problems or which information was important for understanding the problems. A third year participant said:

...The first time I observed my case, I didn't know what information I had to take notes. Yes! So, I took notes all from the chart. After coming back [to the college], I didn't know even what 'labs' [lab results] I record were. So, I went to see my senior. She [my senior] asked, "What do you take notes of? I said, "Everything". Anyway, I didn't know what it was I recorded. ... (Nirin, Interview 1, page 8)

In addition to taking information from the charts, in this stage, the participants also tried to find out their patients' problems by asking them and/or doing physical examination as they could.

Asking patients and/or doing physical examination

On observation days, the participants also had little idea about what and how to talk to their cases and relatives. Some participants only introduced themselves to their cases and took vital signs; they did not take any information from their patients. Meanwhile, others reported that they did not know what to ask their cases. They still could not analyse how the diseases of their cases affected them. They asked their cases only for the information they had to acquire to fill in the blanks on the nursing care plan forms, and some of it was not necessarily related to the problems. They felt they ended up talking about general topics and offering help, rather than dealing with patient's specific problems. A fourth year participant recalled:

...I remembered that the first time I saw her [my patient], I felt very confused. ...I introduced myself to her...I told her I cared for the patient in this bed. If you had to ask for help, you could tell me. I thought I focused more on general topics. ...In the early stage, I didn't quite think about how disease(s) affected them [patients]. What happened with my patients, at that time, I didn't know. I hadn't studied about diseases. ...I only thought what problem(s) they had at that time. I asked like, "How are you now?" If she said, "Stomach ache", I only remembered that she had stomach ache, thing like that. A patient came to see a doctor because of stomach ache. Or maybe, a patient had fever, things like that. Just that! I didn't think why s/he had fever or stomach ache or why something. ... (Areeda, Interview 1, page 2)

Furthermore, when trying to do a physical examination, these students were unable to identify the abnormal status of their cases. Although their supervisors had told them what the abnormal features were, they still could not clearly identify them. Students undertook few physical examinations and/or observations of the conditions/contexts of their patients as they were limited by their understanding at that time. A second year participant said:

Didn't do much! I just looked at skin and general appearances. ...I just looked at what I could see [laugh]. I mean if a patient had DM³⁵ with wound(s), I just looked at them; he [patient] had wound(s) in that area. Just saw skin or something! I didn't quite do a physical examination. ...On the observation day, I had to rush. But! In the second day [of my caring], I could do more. Anyway, I only examined in the part(s), he had problems [laugh]. ...If about others [other parts], I might investigate anemia. I mean I looked at his eyes, skin, or maybe tested skin turgor. ...Listen to lung sound(s), if the patient had a problem in the lung. If s/he had diarrhea, things like that, I tried to check bowel sounds too. But! I didn't do [a physical examination] in every system. (Raiya, Interview 1, page 24-25)

Even though the participants were trying to access what they had to do to care for their cases, they only focused on the present problems their cases told them about and/or the conditions/contexts they could see at that time.

Focusing on the signs and symptoms

Asking their patients about what symptoms they had and observing their conditions were the significant methods that led these students to know most about their patient problems. Some of them disclosed that although they did not understand the diseases or pathologies of their cases, they could plan how to provide nursing care for them because they found their problems from the symptoms their patients described and/or the conditions shown. A fourth year participant recalled:

In the early stage, [in my second and third years], I read a patient's history and then looked at her/his general appearance first, and then talked to her/him. ...Saw whether a patient had any tube/line or not. And then asked about ah! "Do you have any pain?" "How do you feel now?" "Can you eat or not?", things like that. (Chuntira, Interview 2, page 23)

To find out what problems their patients might have, the participants not only applied the strategies reported, but they also took their case information by using frameworks.

³⁵ DM: Diabetes Mellitus

Using frameworks to start case learning

When talking to their cases, all of the participants also applied frameworks to assist them to identify their problems. They explained that during their theoretical studies, they had learned about Gordon's 11 functional health patterns (1987) (Somantri, 2011) that provided them with a framework for what and how to take information about their cases. Also, before starting their practical placements, these students were orientated about how to complete the nursing care plans and/or the guidelines for their community learning (Boromarajonani College of Nursing, 2008a). For these reasons, concerned about completing their nursing care plans and their preparation for pre-conferences, they tried to take information from their patients by using these frameworks together with the strategies of *taking basic case information as they are able* to start learning about their patients. A second year participant said:

...After finishing [from taking notes on charts], I then talked to my patient and his relatives, yes! [I started with] asking [for his information] by applying the 11 patterns. At first, I couldn't remember [about what I had to ask] at all. You know? I had notes [laugh]. I started with those notes since the first pattern, the Health Perception and Health Management Pattern. ...I took notes in my note book. I had asked a patient until sometimes, he [patient] said, "What else [do you need]?"... I said, "Wait a minute please, I will look at [my notes] first" [show looking at note]. So, I read [about that note] and then asked him. ...I meant at the first time, I asked him one by one pattern. ... (Summana, Interview 1, page 30)

After using these frameworks for a period of time, these students became familiar with them and could use them more effectively for gathering relevant patient data. As they gained experience, they could make use of other frameworks that they had learned from being in practice settings and/or applying other learning strategies during this stage. They disclosed they could find and use the information on their patients' charts, such as diagnoses, patient information, progress notes, and nurse's notes as guidelines for gathering more information from their cases. Before starting their case learning, they tried to read these documents to get an idea about what problems their cases might have at that time, so they knew what related information they still needed to collect. A fourth year participant recalled:

[Observed information from charts], in my second year, ...sometimes, I also read nurse's notes to know about the symptoms of my patient first. Then I tried to find out what was similar to [the symptoms of my case]. I mean I asked her/him. ...I checked her/his present symptoms from nurse's notes first.I meant after I knew that, I would talk to my case [to find out whether] s/he still had those symptoms or not. ...Like, sometimes, I couldn't ask all issues from my case. If I knew that [the symptoms of my case on nurse's notes], I still didn't ask [her/him], so I could return back to ask [her/him] again, things like that. If my patient said, no! [s/he didn't have that symptom anymore], I could finish with that issue, things like that. (Kanda, Interview 2, page 30, 31)

Nearly half of them reported that when they knew the disease diagnoses of their patients, they could read about them and get direction on what to ask about the present symptoms and related data, especially during the following day(s). However, if they did not understand the diagnoses or miscopied them, they did not know how to ask for their cases' information. The data they got also did not correspond to their cases' illness as diagnosed. These problems led them to not understand the problems of their patients. A second year participant claimed:

[If knowing about a patient's diagnose(s)], yes! I could recall [what I should ask her/him] only some. Sometimes, like cirrhosis, for example, I couldn't recall [all of it]. So, I just remembered like my case had hepatomegaly or not, things like that. Yes! I just recalled [about that] a little bit to ask her/him. So, I tried to read [about that] when returning back to the college. I read about cirrhosis; what symptoms a patient might have or what complications s/he might risk. On Monday [the first day of my caring], I asked her/him again, so I could learn more [about that disease]. (Wana, Interview 2, page 24)

Meanwhile, others revealed they also made use of progress notes or doctors' records to stimulate relevant physical examinations of their cases. A second year participant said:

About some physical examinations I couldn't [do], ...sometimes about edema, for example. A doctor recorded like this/that level, so I tried to test that too. Anyway, maybe at different times, there were different levels, things like that [laugh]. ...I meant I had to check what a doctor did [physical examination]. What sounds s/he [a doctor] could listen to. Then I tried to do that too [laugh]. (Supat, Interview 1, page 21, 20)

To further find out what problems their patients might have and the nursing care they needed, these students also sought help from the persons they thought experienced and could help them.

Seeking help from experienced persons

When knowing little about their assigned cases, *seeking help from experienced persons*, seniors, friends, supervisors, and some nurses, was one significant strategy these students applied. How they learned by the help of these persons has been coded into two codes.

Asking help from seniors

Their seniors were the significant persons who assisted the participants to start their case learning. At the beginning of the stage, these students did not know how to make use of the information they had gathered to do their first nursing care plans. They brought the handbooks they used during their theoretical sessions to their seniors and

emphasised their need for help from them. Nearly half of them reported their seniors had taught them to do their nursing care plans. As well, the seniors gave them guides and/or recommended texts that might be useful for learning about their cases. The seniors also made suggestions about what information they had to gather, how to prepare for pre-conferences, and helped them search for relevant information to respond their supervisors' questions. Besides asking for help, these students also reported that their seniors told them about issues they might find in the licence test and how to prepare for it. A third year participant described the kinds of help received from her senior:

...She [my senior] taught me. She said this one [a lab result] was here, filled it here [in particular column of the nursing care plan form] and interpreted like this. She also said to me, "You should use this book". She told me she had it and allowed me to use. ...On the first day [I did my nursing care plan], she helped me to find out what nursing diagnoses I could use. Like, she told me, "You could use this/that" and also this/that nursing care activity. She helped me with my first one [nursing care plan]. I mean she underlined what I could use, and told me to read that if it corresponded to my case or not. That was my first one! I didn't know how to do it at all. In the first two nights, I had to be with her. ...She also suggested to me from the first night to take notes about nursing diagnoses and the care activities I had to tell my instructor during the conference. ... (Nirin, Interview 1, page 8, 9)

The participants reported that friends, supervisors, and some nurses were also sources they asked for help during this stage.

Asking help from friends, supervisors, and some nurses

Throughout the stage, nearly all of the participants accepted that asking help from friends, supervisors, and some nurses was a significant strategy they applied for learning about their cases. They employed this strategy in many situations and for many objectives. It was also related to their trust in the competence of persons they asked for help. Some disclosed that they asked for help when they did not know about how to provide nursing care for their cases or other patients, especially when they did not have enough time to prepare. Meanwhile, others revealed that they frequently asked the nurses and/or their supervisors to guide them about some issues they could not find or did not have enough time to search for when they had to respond to the questions of their supervisors and/or the nurses. A fourth year participant talked about asking for help when she had a problem:

...If a preceptor asked me and I couldn't respond, I recorded that question first. After that, I tried to search about it to answer her the next day. About some [issues] I couldn't really find anything, I would consult my friend(s) first. If they couldn't help, I would ask help from my senior(s) or maybe the nurse(s).

I mean other nurses. (Nutsaree, Interview 2, page 26)

These students also asked their supervisors for help and suggestions when they had to complete their requirements. If the questions related to what nursing care activities they planned to implement for their cases, these students emphasised asking help from their instructors. A fourth year participant confirmed:

...I focused on asking my instructors. ...About my case, such as nursing care, ...what nursing care activities I should provide her/him, things like that. How about the ones [nursing care activities] I had planned? Were they sufficient or not? (Jeena, Interview 1, page 33)

As well, these students asked for help to confirm their thoughts on issues they were not sure of. For example, when having to give some information to their cases, some revealed that they confirmed what they were going to suggest with the nurses first. When they were not sure about what information they had to ask from their cases, they sometimes asked help from preceptors/nurses. A second year participant said:

...If I couldn't recall [about what information I had to ask for my patient], I would ask help from my preceptor/the nurse. Like, "Do the patient with this/that disease have this/that symptom?" If I wasn't sure, before talking to my case, I would ask [that person] first. Like, whether the symptom(s) I thought about were right or not. If they said yes! ...So, I could make use of that to ask my case. Normally, they helped me. (Wana, Interview 2, page 24)

Applying these strategies allowed the participants to gain partial knowledge about their patients. To find out more precise information about problems of their patients and the nursing care they needed, these students sought out further accessible sources of information.

Seeking information from other accessible resources

This strategy was another important one that helped the participants learn how to provide nursing care for their patients. Overall, it provided them with more patient problems and how to care than other strategies of this stage, especially after the beginning of the stage. The students explained that they gained a partial understanding of the problems of their patients from many resources during the process of obtaining information. After that, they tried to find the accurate nursing diagnoses for these problems, and seek more problems their cases might have and how to care for them from any accessible resource they thought could help them. More than half of them found the nursing diagnoses and care activities to help their patients from texts,

printouts, nurses' notes, and/or the charts, especially treatment orders. Some also extracted the problems of their cases and how to care from the previous nursing care plans of seniors, friends, and themselves. They disclosed that during this stage, they took a very long time to find the nursing diagnoses of patients who had similar diseases as their cases from these many resources. After that, they chose the diagnoses and nursing care activities they thought they could use for their patients to do their own nursing care plans. A fourth year participant recalled:

... I used many textbooks to do [my nursing care plan], and sometimes I also had guideline from my seniors' nursing care plans too. I mean I used all of those together. ...[For nursing diagnoses], ah, I got them from both texts and the information I had observed on charts. On charts had the problem(s) of that patient too. I mean on the nurse's notes. So, I could also use that to do mine, ...but only some, not all of them.I compared mmm!, to see if my case still had this/that problem or not. Somethings from nurse's notes didn't correspond [to my case's problems], so I had to think about them by myself. ...[If from texts], in some texts something like if a patient had this/that symptom, a nursing diagnosis was specified for her/him there. Anyway, I had to know what symptoms my case had. I mean I had to choose the one that corresponded to her/him too. (Jeena, Interview 1, page 18-22)

As well, others got information about some of the problems and how to provide nursing care from supervisors, friends, seniors, and/or nurses, especially during shift rounds. Subsequently, when advising their cases, these students revealed they only referred to what they had learned and/or knew from their reading, instructors, friends, seniors and/or nurses. They accepted that they did not always know the reasons for what they recommended their patients to do. A fourth year participant said:

...In my second year, I got [suggestions] from preceptors/nurses. ...When practising, you know? I tried to protect myself. I meant I wasn't blamed/reprimanded by preceptors/nurses or my instructors. ... Like about disease(s), when preceptors/nurses talked to patients, I tried to follow them. So, I could hear if patients had this/that disease, we [nurses] should tell them about this/that. I frequently followed them. Then I talked about that to my case. When my instructor came to ward and asked, "Did this student [I] tell you something?" My case said, "Yes!", so I felt ok! I felt good. (Alfa, Interview 1, page 20)

Finding out cases' problems and how to care for them meant some of the students did their nursing care plans for the nursing diagnosis and care activity part first, and then came back to add the support data. They would then complete the nursing care plans by adding in further information such as the pathology and patient information sections (see Appendix A).

Yes! I had some information from talking to my patient, so I could set nursing diagnoses first. Then after finishing a nursing care part, I would fill [support data] in later. ...Sometimes, I didn't have some information. Like [the information from] the 11 patterns that I asked her/him later, I might use that to fill in [for some nursing diagnoses]. So, I waited for total information and then filled in [my nursing care plan] later to make it complete. Anyway, normally, I couldn't find all [support information]. I wrote a few

to “Ss”³⁶ and “Os”³⁷. [laugh]. ...Like a patient couldn't void for one day and s/he was retained Cath's [Foley Catheter], so, ah, s/he had the risk of infection. I set that first, “Risk of infection”. But! I didn't check “Ss” and “Os”. Then after finishing writing nursing care activities, I would check ‘labs’ [lab results]. If WBC³⁸ increased, I would put that [to support] later. ... (Supat, Interview 1, page 23)

Furthermore, because of not really understanding their case problems, three participants who had low GPA sometimes tried to add some additional problems into their cases. They explained that they got some support data from the texts that were not the real symptoms/conditions of their patients to use in plans for the nursing care activities and/or for pre-conferences. One of them who was in the fourth year said:

...Sometimes, I just got a few [support data]. Not all! Because, ah, like ‘labs’ [lab results], I wasn't quite concerned. ...Actually, specifying nursing diagnoses, you know? I looked at in texts. Opened books! What was listed in texts [laugh], I used that. Normally, texts didn't have [support data]. I mean, had!, but it didn't correspond to my case. ...[For support data], yes!, I got some from texts and others from the patient. Sometimes, my case didn't have the problem, but it was listed in texts, things like that. Sometimes, when I submitted [my nursing care plan], my instructor underlined. Like, she [instructor] said, “Have or not?” [laugh]. ... (Chuntira, Interview 2, page 29-30)

In this study, I found that, even when facing inhibiting/interrupting conditions, the participants tried to learn about their patients. The strategies they employed, however, were very different from those previously described in the early stage of development, as presented in the following section.

STRATEGIES TO MAINTAIN LEARNING

Throughout this stage, the participants continued to meet conditions that had a marked negative effect on their efforts to develop their case learning skills. This was especially so for the students whose understanding and competence was insufficient. These students only applied a few strategies to further their practice. They did not pay attention to their learning. They only tried to complete the requirements of the field(s). When going to settings, they provided their cases with routine care activities and completed the orders they were able to do, as well as doing the tasks the nurses requested. These two sub-concepts are detailed to show how these students diminished their learning during this stage.

³⁶ “S”: Subjective data

³⁷ “O”: Objective data

³⁸ WBC: White Blood Cells

Completing the requirements

More than half of the participants accepted that after encountering inhibiting condition(s), they did not pay attention to their practical studies. They only tried to complete the requirements their instructors assigned during their practical placements in each setting. Their greatest concern was that they would submit their assignments on time and/or complete all of them to pass the field(s). A clear example that indicates this strategy is the day before the due date of their nursing care plans, they would copy the part(s) they still had not done from textbooks to submit them. Even though they recognised that the pathology part could assist them in understanding how to properly respond to the problems that happened because of particular causes (as previously mentioned in the sub-concept of *lack of motivation to learn*, the code of *not interested in learning pathologies*), they revealed they did not try to understand it or write their own versions. They just copied information from textbooks and then put the symptoms they got from their patients on the other side of the pathology part of the form to complete the plans. Some also revealed they only wrote the pathologies from the textbooks but they did not relate these to their cases' symptoms. Others disclosed that they sometimes completed their nursing care plans by copying the comments of their instructors, and adding some issues they suggested focusing on to complete the plan. They did not search and read for more understanding beyond that. A second year participant said:

Yes! Sometimes, I didn't do that [a pathology] at all. I would do it when close to the time I had to submit, things like that. I meant that time I had to complete [all parts]. I wasn't quite concerned. ... and then I completed when...[before submitting my nursing care plan]... (Summana, Interview 2, page 44)

About group work, most of the participants raised the example of the content conferences. They reported that they sometimes could not clearly understand the main part(s). They only contributed to it to pass the requirements. The reason these students most frequently mentioned for only doing their own part was too many requirements overall. This meant they did not have enough time to discuss or work together. They just completed the part(s) their groups assigned them to do and then took part in the conferences. When making the conferences, they only presented what they had prepared to their placement groups. If they had to respond their supervisors' questions, they also frequently left this to their friends whose cases were under discussion and who were the group leaders. They were likely to answer only in the part(s) they were assigned to

prepare because they did not understand the other parts of the cases, especially during the beginning of this stage. A fourth year participant declared:

...Normally, when holding a [content] conference, we [students in group] focused more on texts or theoretical content. Not really connected to the case. ... For example, we copied all of pathologies from texts. We got nursing care activities from texts or a friend's [the own case] nursing care plan. Holding a content conference was something we had to do during our practising, wasn't it? ... We just did it to pass that hour [time for that requirement]. Just pass it, as any requirement was rush! We didn't pay attention to it. ...Some of us already had files [about the case]. When taking part in a [content] conference, they just put some patient's information. I mean just finished it as each of us had a nursing care plan [to complete too]. Ah! Didn't pay much attention to it. Just read what my friend assigned me because each group had a head person who understood [about the case] to help others in the team. (Chuntira, Interview 2, page 38)

Although they were in the stage of case learning, if encountering inhibiting/interrupting conditions when they were at settings, the participants implicitly reported that they only continued their patient learning by completing routine nursing care and doctor orders for them. For the most of their time there, they helped nurses with tasks.

Completing routine care, orders, and helping with nurses' tasks

When facing barrier(s) to learning at settings, especially *inattentive supervision*, the participants, although concerned about losing case learning opportunities, devoted most of their time there to helping nurses with tasks. Practising with nurses who frequently told them to help with their tasks meant they not only could not refuse, but also became involved in any routine work of settings they could do in this stage. More than half accepted that they did not have free time; they had to complete the tasks the nurses told them to do, especially in the afternoon of day shifts and during evening and night shifts. They could only provide their cases with routine care and complete the doctor's orders for them (detailed in the sub-concept of *inattentive supervision*, the code of *most preceptors/nurses did not have enough time to teach about cases*). A fourth year participant said:

...Normally, if it was about an evening shift, ah, [it was about] what a nurse had to care for that patient during the shift, like what time to give her/him medications, maybe, what time a nurse had to do 'labs' for her/him, things like that, so we [a nursing team] had to do the care activities like that. Normally, practising [in an evening shift], I wasn't assigned for one case. I mean I didn't have free time. I had to, ah, take V/S³⁹ for all of patients in a ward, things like that. So, the time for caring for my case was quite less. ...Like, I was assigned one case, but I had to work for all of the patients in that block, things like that, such as taking V/S for [the patients] in that block. And then if having a case needing a blood puncture, I had to do so. ... (Inee, Interview 2, page 41)

³⁹ V/S: Vital Signs

The consequences of the conditions under which participants practised and the strategies they developed in the stage of *seeking case problems and how to provide nursing care* are outlined in the following section.

CONSEQUENCES

Applying insufficiently advanced strategies in this stage did not help the participants to accomplish their case learning, but their attempts led them to some desirable results. However, encountering inhibiting/interrupting conditions also caused them many unwanted effects. These consequences are presented in the two following concepts.

DESIRABLE RESULTS

After trying to understand about case problems and seeking how to provide nursing care for a period of time, the participants became more familiar with case learning. Applying the *strategies to improve case understanding* assisted them mainly to learn how to care for particular problems, though learning from their supervisors and research helped more. Feeling they only partly understood about their patients encouraged some students' need to know more about their diseases and treatments. Three sub-concepts describe the desirable results that emerged.

Familiarity with case learning

During this stage the participants became familiar with case learning. They knew what and how to collect information about their patients, as well as learning how to prepare for caring for them. Towards the end of the stage, nearly half thought they only took data which related to their cases' problems, resulting in taking less time for observations and gathering more data than at the beginning of the stage. A third year participant reported:

...In my third year, I began to realise, ah, that [some information] didn't relate to [patient's problems], so it wasn't necessary to take notes, things like that. ...In my second year, I meant when I practised in the next ward or in 'Adult 1' field, things like that, I thought I began to know. ...When starting my late second year and in my third year, I felt I was quite skilful [in taking case information]. Sometimes, I wrote down the information through my nursing care plan, it saved my time [laugh]. Because if I took notes on scrap paper, I had to rewrite them again in my [nursing care] plan. ...In 'Adult' field, ah, I began to know which patterns affected [patient's problems], ah, an elimination pattern. If it was about a sleeping pattern that didn't relate to the patient, I didn't ask. I meant I would ask her/him [patient] on the following day(s). [On the observation day], I focused on the problems first. (Hana, Interview 1, page 20)

Although the participants made this advance in learning about case information, their learning about nursing care for cases took longer. In this stage, they understood how to care only for some problems.

Learned how to provide nursing care for some problems

Because most of strategies the participants applied did not effectively facilitate the students' ability to identify the problems of their patients when learning in this stage, nearly all of them accepted they only understood some aspects of the nursing care, especially the easy parts, but not necessarily the main parts. They still were not clear why their patients needed some aspects of their particular care. Knowing how to care for some conditions meant they could not plan to care for all the problems that their cases had. They still did not fully understand that some problems were more important than others. This meant that they felt they only planned for the symptoms they knew from their cases and what they could see at that time, and often omitted significant problems they were unaware of. Some problems they planned for did not match the ones shown by their cases, thus some planned activities could not be applied and others were not necessary. A third year participant recalled:

I focused on planning about the chief complaint symptom(s) of my case. ...I ask her/him [patient], "Do you still have that symptom?" If s/he said yes, and I thought it was obvious, I specified that. But! It [my nursing care plan] didn't correspond to all of my patient's problems.I didn't plan her/his present symptom(s). In my second year, I specified [the nursing diagnoses] based on her/his disease(s), not based on patient's [problems]. So, my instructor said, ah, "Rewrite it again", because although your patient had that disease, sometimes s/he might need another nursing care more, things like that. (Araya, Interview 2, page 43-44)

They sometimes only completed their nursing care plans without matching each part to the support data, the objectives, and some activities could not be put in the set order. That is, they felt they made use of only some of the content they had to remember from their theoretical sessions, but they could not adapt what they had learned to their practice. A second year participant said:

...Normally, I didn't put that [nursing care activities] on sequence. ...Like for a COPD patient, at first, if I had to do inhalation, I should do lung percussion first and then followed by inhalation, and maybe followed by something else. But! Sometimes, I just plan like doing inhalation, providing her/her with something, and ending with lung percussion. So, my instructor said, "You have to put nursing care activities in sequence". ...Yes! I frequently planned that [not necessary care activities] [laugh]. Sometimes, my instructor said, "Don't focus on getting all [nursing care activities] from the texts", "You have to consider your case". ...Didn't plan for something, yes, it happened often too. (Supat, Interview 2, page 39)

The best example from the data that reflects knowing some aspects of how to care is not being able to exactly respond to test items even though they had experienced those situations in clinical settings. They only recalled what they planned and/or done as care at that time as well as the nursing care their supervisors did and/or had highlighted to them, which was noticeable in especially the students with low GPA. A fourth year participant stated:

Oh! I could recall lots [nursing care situations]. If talking about [doing tests], I could make use of that more than something in texts.Anyway, sometimes, those didn't look quite right. What were they? I couldn't remember that. ...I didn't know whether the ward situations [I recalled] helped me or not. But! They made me choose the answer(s). I mean I could get the answer(s). ...But! Normally, they were wrong [laugh]. ...For example, in the case of DHF patient, at first, I had to do this/that, but I forgot to identify which stage s/he was. How many days the patient had fever, things like that. ... I just recalled what I did at that time. I recalled to the first thing that I did to care for that patient. I forgot! [about the stage] Like, I couldn't quite analyse the [test] question. ... (Siripat, Interview 2, page 38-39)

Nevertheless, after having opportunities to provide nursing care for their patients for a period of time and attaining some basic skills, participants were motivated to learn more about the diseases of their cases. They were interested in case learning.

Interested in case learning

Participants demonstrated *interest in case learning* in a number of ways. Some wanted to know how their cases' behaviours led to their illness. Meanwhile, others needed to know whether their cases' symptoms were similar to what they had learned in class. They had many questions about their cases' conditions such as why their cases had been treated in particular ways and how those treatments assisted them to get better. Since the Adult 1 field, they had paid more attention to the diseases of their patients. A third year participant said:

As I had learned about theoretical content [about diseases], so I needed to know, yes, what I had learned was similar to what happened in my case or not. I would like to know that, so I tried to read more. Like, that patient, ah, was investigated about this. Like a heart disease patient, sometimes, s/he was investigated for something special, so I was interested why a doctor had to do that,Sometimes, my instructor asked, ah, apart from routine 'labs' [laboratory], what might a heart patient be investigated for more. Well! So, I checked that in a chart. I checked like what more 'labs' a doctor had ordered. Ah! Yes! It was different [from the 'labs' I had ever seen], so I tried to find out why. (Leeya, Interview 1, page 28; Interview 2, page 33)

Interest in case learning became a significant base condition to learn about case problems and how to provide nursing care in the following stage(s).

Another consequence that emerged over the stage of *seeking case problems and how to provide nursing care* was a set of unwanted effects. Particularly, when encountering the inhibiting/interrupting conditions, the participants faced. The following concept describes all of these consequences.

UNWANTED EFFECTS

When encountering inhibiting and/or interrupting condition(s), the students who did not know enough about what to do to care for their patients often experienced learning difficulties. Four sub-concepts detail the consequences for these students.

Focused on providing basic nursing care

Nearly half of the participants revealed the nursing care they gave to their patients was no different from the BCPN subject where they had to develop basic skills, despite the Adult 1 subject where they had been taught how to care for persons with a range of diseases. In settings, they only took care of the physical aspects they could do at that time, under the management of their supervisors or the nurses who were focused on orders and completing tasks (as detailed in the sub-concept of *inattentive supervision*, the code of *most preceptors/nurses did not have enough time to teach about cases*).

Another reason that made these students focus on basic nursing care was although they had had practice in the Adult 1 course, they were also sometimes still concerned about the BCPN requirements. This influenced the students into putting some emphasis on performing BCPN procedures. A third year participant said:

...Yes! [quickly responding to the question]. I focused on procedures! Like, some couldn't complete the case requirements [of 'BCPN'], so they further did that in 'Person with Health Problem 1'. ...Like, now they were practising 'Person with Health Problem 1', but they had still experienced [some] case requirements, things like that. ...So, practising at that time wasn't quite different from 'BCPN' period. ... (Araya, Interview 1, page 24)

Focusing on basic nursing care also made the participants tired and exhausted with practising in this stage.

Tired and exhausted with practising

Some of the participants accepted they were tired and exhausted with practising in this stage because they had to do many nursing tasks. At some settings, because they had to

help with nurse tasks if the nurses were still busy, they could not sit down. Coming back from settings, feeling very tired meant that even if they wanted to review about some of the issues of their patients, they could not always do it. A second year participant said:

...But! I didn't quite review [about my notes I took about the cases I had cared for] because when coming back from a ward [practising], I felt I would like to take a rest. I was tired, yes! After finishing a morning shift, I felt fatigued. I wanted to lie down, yes! Because when practising at a ward, I paid full attention to doing [nursing care activities]. So, when coming back, in a break time, I needed to take a rest. (Klaiwit, Interview 2, page 46)

Moreover, many requirements they had to complete during their practical placements also made them feel too tired. They had to study harder than when attending classes. They took a very long time to find what the case's problems were and research the nursing care that was required. A fourth year participant said:

...In my second year, I didn't quite understand [about patient's problems]. You know? That night, I didn't sleep at all. I worked until morning and then went through to the ward. ...I did my nursing care plan [laugh]. ...Before that, I always went to bed late, but that night, I didn't sleep at all. ...Like, tomorrow I had to submit my completed [nursing care] plan. ...I practised with that instructor [didn't need to say the name of her instructor]. She told me, ah, "You observe today, tomorrow you have to complete your plan". So, I didn't sleep all night. ... (Noree, Interview 1, page 11)

For this reason, sometimes, some participants wished their cases were not discharged because they did not want to have to search more about a new case they were not familiar with. A fourth year participant disclosed:

...I wished a doctor didn't discharge my patient. [If so,] I had to search for information for a new assigned case. You know? Searching about a new case means I had to know diagnosis, medications including their side effects, or something. Like, I wasn't familiar with that [case learning]. ...As I was new to that, I had to take a long time to find out about each issue of a case, you know? ...That made me work harder and harder. (Siripat, Interview 1, page 7-8)

In addition to being tired and exhausted, when encountering inhibiting/interrupting factors, participants left unclear issues.

Left unclear issues

Sometimes, some of the participants did not search more about the issues they still did not understand. They just left the unclear issues. The most common reason that made these students leave unclear issues relating to their previous cases was moving to new assigned cases and/or new practical settings. A fourth year participant explained why she left her previous cases with unclear issues:

... Sometimes, [doing my nursing care plan], I didn't clearly understand [about case], but I had to change [to a new assigned case]. I tried to study, but I still wasn't clear [about a case]. ...I left that [previous] case. I had to study a new assigned case. I still didn't understand some about my previous case, did I? Anyway, I had to know about a new assigned case as tomorrow I had to do pre-conference with my instructor. I had to know the information [of a new assigned case] and report her/him [instructor]. Just finishing day by day! ...Normally, we [students in group] did like that. Just finished in time! ... (Chuntira, Interview 3, page 58)

These students also revealed other reasons for their inability to deal with unclear issues. For example, after trying to search for information, they could not find it, so they would not respond to their supervisor's questions, which again led them to not understanding what they needed to know. They did not have opportunity to ask for more explanation from their supervisors. They sometimes also did not get any comments from their supervisors so they had no direction for following up, or access to information, as a second year participant commented:

Sometimes, the Internet was a problem. Supposing, if I questioned about this/that, didn't I? And Internet had a problem, things like that, my thinking was stopped. Stopped at all! Sometimes that issue was new. I mean I couldn't find that in texts. If something happened like that, I felt not finished [questionable]! I wanted to know at that moment. If later, I might want to know but forgot that, I didn't search it anymore. (Klaiwit, Interview 2, page 58)

Meanwhile, some students accepted that they were unmotivated about finding some issues they had to know about their patients.

Furthermore, the participants raised one significant example that showed they had to leave unclear issues. During their content conferences, they still had questions about some issues. They felt confused with what their instructors said, but they did not know what to ask to get more explanation from them as they could not remember the case information they left for a long time because of the postponing by their instructors (detailed in the sub-concept of *inattentive supervision*, the code of *some instructors limited learning opportunities in conferences*). A third year participant declared:

...I couldn't really remember about the case. Eh! Whether that case was normal or not, I forgot! Even though I could read that [case information] from a report, sometimes, I forgot. I couldn't get the picture. I mean it was difficult to connect [between what we were talking about and the case I forgot]. My instructor tried to explain, but I still got confused. When I tried to connect that [the explanations] to the case, I couldn't remember which case. Forgot! As it was a long time [we left it]. (Hana, Interview 2, page 52)

Also, they were no longer interested in learning about the unclear issues. They just completed their requirements and left those unclear issues.

CONCLUSION

Not having sufficiently advanced strategies in this stage led the participants to not achieve how to provide nursing care for their patients. They were struggling to learn by using many strategies to find out what problems their cases might have and how they should care for them. Spending quite a long time moving back and forth among strategies throughout the stage, especially when influenced by inhibiting and/or interrupting factors only hampered their efforts from the many cases they experienced. They had to seek information about what they should provide for their patients any time they had to care for them, especially for responding to their supervisors' questions. When learning in this stage, more than half of the participants only did it for completing the requirements; they were not concerned that they had to know exactly what they had to do to care for their patients. Some of them had not progressed through the period of **learning how to provide nursing care**, or even the next stage. Many influences could play a significant role in blocking their development of skills in the process of **Developing Effective Strategies for Nursing Care**. Applying the strategies they had developed, however, made them familiar with how to learn about their patients and interested in case learning. Needing to know more about their cases, as well as having enough facilitating conditions, led most of these students to attempt to make use of the strategies employed in this stage to develop new one(s) for the following stage(s). This was one significant technique that facilitated them to understand the problems and how to care for their patients. The details of how they advanced their case learning skills are reported in the next chapter.

LEARNING HOW TO PROVIDE NURSING CARE

INTRODUCTION

The previous chapter detailed how the participants started their case learning in the stage of *seeking case problems and how to provide nursing care*. Although the strategies these students applied were not entirely adequate to facilitate their understanding of how to specifically respond to their patients' problems, they did form the basis for developing new strategies in the next phase of **learning how to provide nursing care**.

This chapter emphasises why and how the participants advanced their case learning skills to understand their patients' conditions during the next two stages (sub-categories), *modifying the strategies for case learning*, and *discovering how to understand case conditions*, which are represented by the third and fourth overlapping ovals of the process (Figure 4.1). These stages are the first and second sub-category of the second phase (category) of the students' learning development—**learning how to provide nursing care**. In this phase, students still found it difficult to attend to relevant aspects of case learning and focused on pre-conference preparation more than applying their understanding. However, data show that when practising, the majority of participants could reach the first stage of the phase. Additionally, only some of the participants, who had strong motivating conditions in this phase, overcame the inhibiting and/or interrupting factors. They could increasingly understand why they had to care for their cases in particular ways, so they could reach the stage of *discovering how to understand case conditions*, thus completing the process of **Developing Effective Strategies for Nursing Care**.

Table 7.1 summarises the conditions, strategies (actions/interactions), and consequences from *modifying the strategies for case learning*, and *discovering how to understand case conditions*.

Table 7.1 Learning how to provide nursing care: Conditions, strategies (actions/interactions), and consequences

Conditions	Strategies (actions/interactions)	Consequences
<p>Conditions for modifying the strategies for case learning</p> <p>1. Supervisors' expectations</p> <p>2. Motivation to learn</p>	<p>Strategies used to modify case learning</p> <p>1. Learning based on supervisors' and experienced persons' support</p> <p>2. Learning together with friends</p> <p>3. Applying learning experiences to analyse case problems and nursing care</p> <p>4. Comparing cases' symptoms with pathologies or normal health status to find the problems</p> <p>5. Applying accessible resources as guides to understand case problems and how to provide nursing care</p> <p>6. Taking more opportunities to learn</p>	<p>Consequences from modifying the strategies for case learning</p> <p>1. Better understanding and remembering more about cases</p> <p>2. Being more able to match problems and nursing care</p> <p>3. Using opportunities to apply plans to care for cases</p> <p>4. Becoming happier with case learning</p> <p>5. More confidence to provide nursing care</p> <p>6. Beginning preparations for the licence test</p>
<p>Condition for discovering how to understand case conditions</p> <p>1. Desire to learn</p>	<p>Strategies used to discover how to understand case conditions</p> <p>1. Analysing the roots of problems from case pathologies</p> <p>2. Using all information as a base for analysing patient problems and corresponding nursing care</p>	<p>Consequences from discovering how to understand case conditions</p> <p>1. Understanding case problems and how to provide nursing care</p> <ul style="list-style-type: none"> -knowing what nursing care the cases needed -knowing what additional information to find

CONDITIONS FOR MODIFYING THE STRATEGIES FOR CASE LEARNING

All of the conditions that motivated the participants to learn during the previous stage could further facilitate them to modify the strategies for case learning. In this stage, the significant condition that influenced their efforts to learn more about their patients' conditions was *supervisors' expectations*, whereas a new *motivation to learn* and one consequence of the previous stage, *interested in case learning*, were also important factors that encouraged the students to continue their case learning. All of these conditions facilitated these students to advance their learning throughout the stage as outlined in the following section.

SUPERVISORS' EXPECTATIONS

Supervisors' expectations, (which is represented by the middle rectangle above the third stage, *modifying the strategies for case learning*, Figure 4.1), was the significant condition of the stage. When influenced by this factor, the participants reached the second transitional point of the process (as symbolised by the rectangle frames on the middle part of the central arrow). They needed to further enhance their skills to progress through the next stage, (which is symbolised by the middle forward semicircle broken arrow line), by applying more advanced learning strategies when compared to the previous stage. This condition had also played an important role when they were in the stage of *attending to procedure training*. In the third stage, they explained this concept in terms relating to their self-esteem. Being more concerned about their self-esteem being affected, especially when they were seniors, led these students to strive to learn well. Half of these students accepted that *supervisors' expectations*, both from positive and negative comments, could affect their self-esteem. Some reported they felt ashamed if they were not able to respond to the questions of their supervisors, especially within patients' sight. A third year participant said:

...When my instructor or preceptor asked, "Why did a doctor treat the patient with this medication?", if I still couldn't respond, they said, "You are a third year student now", things like that [laugh]. I felt oh! I had to find that out. So, I told them, "Yes! I will give you the answer tomorrow". Things like that. Yes! I felt ashamed! If I couldn't [answer] within the patients' sight [laugh], [I felt] so ashamed! Anyway, I told them I would search for that. I then responded to their questions. (Araya, Interview 2, page 49)

Others revealed they felt unhappy and sometimes had low self-esteem because of the expectations of supervisors and/or the nurses. It made them feel like they had not prepared for their practice. That led them to study about what they did not know. Another third year participant said:

...Sometimes when reading [about cases] or doing my [nursing care] plans, I was concerned about what my instructor might ask tomorrow [laugh]. I thought, "What will she ask me?", "What will I respond to her?" I thought that because if I couldn't, I would feel terrible. I felt like I didn't prepare for [practising], things like that.Sometimes, I felt discouraged with reprimanding. Preceptors/nurses didn't understand me, things like that. That made me not want to practise [or learn anything]. Anyway, over time, I felt like, "Forget it!" and I tried to read more. I mean every time I was reprimanded, like they said, "Even this, do you still don't know?" So, I had to read. A few days later, she [the same preceptor] asked me again, so I could. Mmm! Because of your reprimanding, I could remember [laugh]. ... (Fatou, Interview 1, page 6, 13)

When thinking about the expectations of supervisors, the students were worried and stressed that they could not meet them, because they had to show they knew more than when they were juniors. Some who felt unhappy about not meeting expectations intensively searched for the issues so as to be skilful and/or able to respond to the supervisors who looked down on them. Others disclosed they tried to ask friends who finished particular settings about what the supervisors expected them to know about the cases. They then tried to search and read more about their cases' diseases to meet the expectations and to avoid the stress of not learning enough. A fourth year participant recalled:

I tried to ask friends, "How about the instructor [of the setting I would move to]?", "When holding pre-conferences, does s/he focus on nursing care activities or pathologies?" I mean I could prepare for that. Sometimes, this instructor focused on pathologies, so I prepared about them. If I couldn't respond to her/his questions, I felt bad. So, I asked friends who just finished that setting. ...as I had to meet what the instructor expected I should know. (Alfa, Validation Interview)

In addition to *supervisors' expectations* that influenced the participants to learn in this stage, some students with moderate-low GPA also developed more *motivation to learn*. These conditions together facilitated the participants to develop their previous learning strategies.

MOTIVATION TO LEARN

Twelve of the participants with moderate-high GPA had reported motivation to learn in previous stages; however during this stage, five participants with moderate GPA and four with low GPA began to have increased motivation to learn. The significant

influence that motivated them to learn was having to take the licence test in the near future. Some explained that in this stage, they made an effort to read about and analyse their cases more than in the previous one. A fourth year participant with moderate GPA recalled:

...When I was in the third year, ah, instructors began to tell us [nursing students] [about the licence test]. For example, they gave us the questions and told us that nursing care issue might be found in the licence test or maybe in other test items we had to take [the PBRI's or PSU's test items]⁴⁰. When knowing that was important and related to the test, I read and analysed cases more. ...I tried to analyse more, like, the abnormal 'labs' [lab results] were found because of what happened with the patient. I mean if I could analyse abnormal 'labs', I could learn more about the problems of that case. (Yarat, Interview 3, page 30)

Perceiving the difficulties in preparing and passing the test, as well as hearing about the effects of failing from seniors and instructors, made the participants try to learn more. They hoped practising would help them to have more knowledge. Two students were also aware of learning what their friends knew. Others attempted to answer the previous test items. When it was noticed that the test items addressed the same situations as their cases had experienced, one participant with moderate GPA realised that he should pay more attention to those cases. He said:

I hoped I could pass eight subjects in my first attempt. I didn't want to be a technician nurse. I felt I had to compete with friends who were studying at [mentioned a name of the college where his friends who got the same scholarship were studying]. ...If I didn't pay attention to my studies and if my friends could pass the licence test [in their first attempt], but I couldn't, it means they could be professional nurses, whereas I was just a technician [nurse].Sometimes, I saw ward cases and then found [those issues] in the [previous licence] test items again. That led me to know ah! I had to learn more about ward cases. I had to focus more on my practical studies in this period. Like, I experienced ward cases that could be found in the licence test, things like that. ...that made me feel well, next time, I would pay more attention to learn [about that]. I wouldn't let it [learning opportunity] to pass anymore. (Klaiwit, Interview 2, page 61-62)

Moreover, when entering this stage, some reported that different situations influenced them to pay more attention to learn about their patients than the previous stage. These were recognising that they had to do their best with their study because they had to be nurses, being placed with a new group where they did not have friends to support them, being more aware of being alive when practising in critical units, and needing to further their studies after graduating. A fourth year participant with low GPA said:

...In my first and second year, I tried to learn, but I didn't pay enough attention. When I was in the third and fourth year, I felt I hadn't done my best with my study, so I tried to learn more. I paid more attention

⁴⁰ The students who study in the Thai college programmes have to take PBRI's and Prince of Songkla University (PSU)'s comprehensive test as their college is affiliated to these institutes.

to my study. ...During the first period, I had to adapt myself as I didn't like [nursing]. I mean I still didn't adapt myself to nursing study. I couldn't read more. I didn't like to study nursing at that time. ...As I had to be a nurse, hadn't I?, I tried to do my best with what I chose. I mean I attempted to change my idea, like when I decided that [choosing to be a nurse], I had to do my best. (Nutsaree, Interview 2, page 49)

Influencing by the powerful condition of the stage, *supervisors' expectations*, as well as having increased *motivation to learn* led the participants to develop more advanced strategies to modify their case learning.

STRATEGIES USED TO MODIFY CASE LEARNING

Participants in this stage developed more systematic strategies, largely based on strategies they had developed in the previous stage, to learn about their cases. This also included some strategies that their supervisors suggested (Figure 7.1). If they could not always use the new strategies, however, they returned to make use of ones they had developed during the early stage to continue their case learning. Six concepts are detailed to describe how the participants learned the problems of their patients and how to provide nursing care for them after encountering the second transitional point.

LEARNING BASED ON SUPERVISORS' AND EXPERIENCED PERSONS' SUPPORT

Participants reported that they tried to understand more about the problems of their cases and how to provide nursing care for them by consulting supervisors and other experienced persons whom they thought could help them such as seniors, friends, medical students, doctors. Then they tried to make use of that help and/or experience to understand the problems of their cases and how to care for them. They also attempted to read more and/or do their requirements such as nursing care plans to link what they had learned to the nursing care of their cases.

When taking part in pre-conferences, these students learned how to set the diagnoses that are based on their cases' conditions. With the help of their supervisors, they learned how to find the data that indicated problems they had not thought about. When taking part in pre-conferences at bedsides, they could see the present conditions of their cases that their supervisors pointed out and/or assess them at that time. As well, they had opportunities to tell their supervisors what they knew about their cases and/or ask for

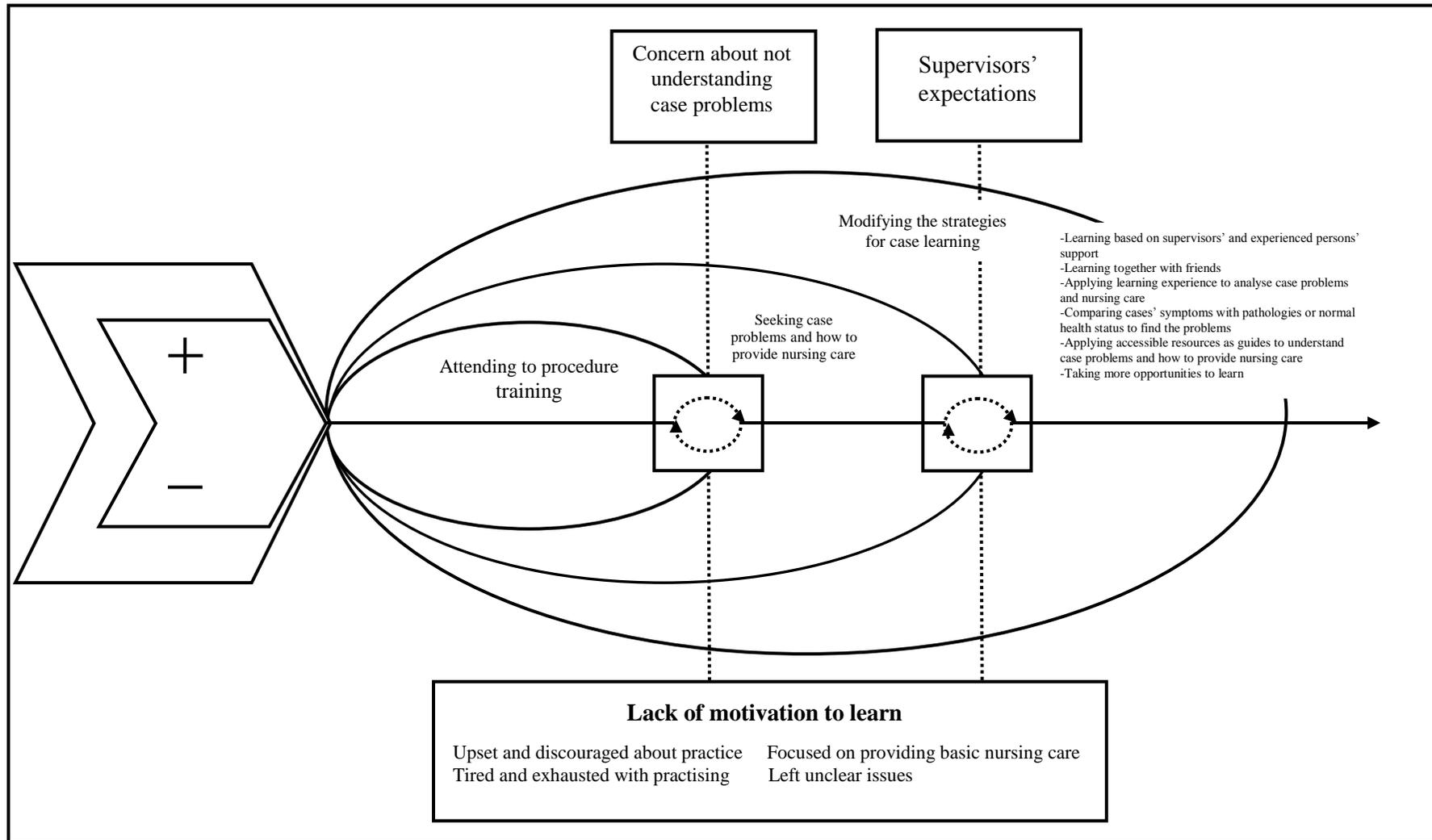


Figure 7.1 Learning strategies used for *modifying the strategies for case learning*

more explanation from them, so they could confirm what they had prepared as nursing care activities for their patients with their supervisors. Nearly half of them accepted that they could also learn by this strategy. It facilitated greater understanding about their present case problems and how to provide nursing care for them. A third year participant said:

When holding a pre-conference at bedsides, I could see [the present conditions of] my patient. Yes! Like, I could see those conditions/symptoms at the same time as my instructor talked about them, so I could learn more about the cases. (Araya, Interview 2, page 52)

When taking part in content conferences, students in groups of three to four had to discuss one interesting case in the presence of one instructor. More than half found this more useful for learning about the cases than participating in pre-conferences, especially for learning about the associated pathologies. They also had more opportunities to ask for explanation about the issues they still had questions on. The discussion of their groups about the abnormal data and/or the suggestions of their instructors about how to search for the problems that the pathologies showed led them to understand the present problems of the cases. After that they tried to discuss with their groups about what nursing diagnoses they had to specify and how they should care for the cases that showed those conditions. Another third year participant confirmed:

...Like, if I did my case report [nursing care plan], I wasn't interest in pathologies, was I? But when we [students in group] had to do a content conference, we had to do clearer comparison [of the case signs/symptoms with pathologies listed in texts], so we could understand. ...About content conference, I thought I could understand more as I had friends and my instructor who tried to add [explain] something at that time. ...Ah! Our case had things [signs/symptoms] like that as we knew from the pathologies, didn't we? So, our instructor needed us to use support data we had. Like, we already set [nursing diagnoses], but they didn't complete, so we had to add them at that time. We then discussed like what nursing care activities we had to provide for this nursing diagnosis. Normally, we did in that way. (Mintra, Interview 1, page 16)

Interestingly, some of the participants with low GPA, even those who were likely to remain in the first phase, emphasised that when participating in content conferences, they could better understand and remember the pathologies of the cases when their instructors tried to ask and/or give them more explanation to guide them to think about the connections of each issue. Also, they could learn more when their instructors summarised the significant issues of the cases for them. This meant that they could make good use of what they learned during content conferences to guide them and improve their nursing care plans, more so than from the discussions in pre-conferences,

especially for comparing the pathologies of their cases to ones in the texts. A fourth year participant said:

[Taking part in content] conferences made me learn. Yes! It made me understand more about diseases. For example, I didn't search some issues [about the cases]. When holding [content] conferences, our instructors tried to ask us more and more. I mean they stimulated our thoughts, ah, this one could affect that one too. Sometimes, I hadn't searched that yet, so instructors told us. I mean they added something [to make clear], things like that. ...Anyway, I could remember that afterwards. I felt ah! This disease had pathology like that, but if it was as clearly understood as the day we held [content] conferences, then maybe I couldn't, especially if I didn't review that frequently. Even the cases that we had already held [content] conferences about, a few weeks ago maybe, I forgot. I mean I forgot about the details, but I might remember what the instructors asked. Yes! I thought I could remember about what instructors asked. ...normally, I could get about what instructors asked; I could remember for a long term more. (Siripat, Interview 2, page 25)

In addition, asking for more explanation from supervisors, friends, seniors, nurses or doctors, also helped these participants to understand more about the problems of their cases and how to care for them in this stage. Half of them reported that they frequently applied this strategy. It was slightly different, however, between the group who had moderate-high GPA and those with low GPA. The first group was likely to ask for more explanation from their instructors, preceptors, nurses, medical students, or doctors; meanwhile, the latter one expected to gain a clearer understanding from their friends, seniors, or some nurses with whom they were familiar. When asking for more explanation from their instructors, even though both groups were likely to prepare for what they were going to ask, the students who had moderate-high GPA showed a greater awareness of what they were still not clear about than the others. Normally, these students only asked about the issues they still did not understand or the content of their cases they were unsure of. Some of the high GPA group, however, tried to get follow up explanations about the issues of other cases they heard about during taking part in pre-conferences and/or shift rounds, especially their friends' cases. A second year participant with a high GPA said:

Yes! [I didn't understand some issues]. Like, I had learned in a theoretical session, hadn't I? At practical settings, even the diseases I already studied, patients had different symptoms; they weren't the same as what I had learned. I meant the content I knew and patients' symptoms didn't match. ...So, I asked for more explanations from my instructors/preceptors.Normally, I asked for that about my cases. For my friends' cases, I tried to think about that too. ...Ah! About some [of my friends'] cases I had really doubted, so I asked instructors, "Why they had symptoms/signs like that?"... (Wana, Interview 2, page 19, 30)

Meanwhile, a fourth year participant who had a low GPA talked about her similar help seeking strategies when she had some questions about her assigned cases:

About some issues I couldn't find or didn't understand, I might ask the nurses. They could explain more to me. I mean if the cases I was assigned were the same as them. ...Anyway, you know, normally, I focused on asking help from friends. (Meena, Interview 1, page 21, 23)

Some participants reported that they also learned how to assess some problems of their cases to confirm their initial ideas by doing physical examinations and consulting with friends, supervisors, or nurses, or reading doctors' documents. Others also learned techniques for clients' information assessment by observing what their friends did during the earlier practice of their community field. A fourth year participant said:

...In the community field, I could make use of the conversations my friend did. Sometimes, I observed the conversations between him [friend] and his clients. He tried to make relationships by talking about general topics first. Like, "How about your doves? [as the area is famous about doves and many people rear them], which one could get the reward?", things like that. Nothing related to health that we [nursing students] focused on! ...sometimes, I couldn't, but it has to do... We have to make relationships first. ...That helped me learn community techniques. I could learn from friends. ... (Areeda, Interview 2, page 31)

The participants acknowledged that the help they obtained made them more confident about their knowledge and the nursing care they were going to provide. More than half of them accepted that *learning based on supervisors' and experienced persons' support* was one significant method they applied during this stage.

Participants also asked help from friends and helped each other to learn together about the problems of their patients and how to provide nursing care for them.

LEARNING TOGETHER WITH FRIENDS

Participants also discussed the problems of the cases and how to provide nursing care for them in many situations with friends. More than half revealed that they did this if there was enough time when they were preparing for their content conferences. They helped each other to collect related information about the cases they were interested in studying. After that, each of them in their groups was assigned to complete her/his part and then present it to all the groups. They indicated that all of them had to know all information of the cases. They also attempted to review the information and/or some nursing diagnoses that each of them prepared before participating with groups. They then tried to make use of that information when deciding the appropriate nursing diagnoses and finding the relevant nursing care for the cases together. If anyone in the group had some questions, she/he could ask for more information and/or help from their

group. A third year participant talked about how she prepared for her content conference that:

...Normally, we [students in group] did that [the part each of us was assigned] together. Like patient's information, [if somebody wasn't sure], s/he might ask the group, "Is this information right?" because if each of us only did our own part, maybe, the information might not correspond. ...[About patient's problems], normally, one who was assigned to do diagnosis part would present that to our group. Then we tried to discuss together again that the diagnoses were acceptable or we had to add some more. (Rhoba, Interview 2, page 44)

Moreover, the students reported that they also employed the strategy of learning together with friends when they were not sure about the problems of patients and how to provide nursing care for them. They raised many examples to show this discussion. When they had to re-write their community group work, they said it was very important to consult their group. After doing home visiting with their friends, they tried to think about and discuss with friends about what problems the cases might have and how to care for them. Sometimes, they also told their friends their case information and then asked for their ideas about the diagnoses they had developed as well as discussing some issues they did not understand with friends before going to take part in pre-conferences with their instructors. They also asked for ideas about the diagnoses they set from friends who took care of similar cases.

Some of them liked to exchange with each other some of the issues of their cases, especially if they knew the other students were likely to know the information. If they had different ideas when explaining about why the cases had particular symptoms, they would confirm those issues by comparing with the texts together. Sometimes, the groups assigned a task to each member to search for the issues they did not know about and/or had to answer their supervisors' or the nurses' questions. Each student then presented those issues to their group. When assessing some abnormal symptoms of their cases, they also tried to confirm them with friends before consulting about how to provide nursing care for those problems with instructors. A third year participant recalled:

Like, we did our own assignments in our space [in the same unit], things like that. Sometimes, we discussed [about cases]. Like, I asked my friends, ah, "What diagnoses could I set for that family?" So, they tried to think about that. ...[My friends] knew a little bit about my case's information. I mean I told them about my case. Then I asked, "How should I care for them?" So, my friends would discuss that. Sometimes, the case from a ward, if I specified [nursing diagnoses] alone, I felt they were quite awkward when I presented them to my instructor [during taking part in a pre-conference]. If my friends could screen them, they were more appropriate, I thought. ...I mean I told my friends about my case's

information and the nursing diagnoses I specified. So, they might tell me to add some, things like that, or maybe, they might say, "that's alright", things like that. (Kasaree, Interview 1, page 7)

Sometimes, these students reported this strategy with the words "help each other" as also found during the previous stage. These students described those situations, however, in the dimensions of facilitating them to learn about the problems of their case and how to provide nursing care. The students revealed many 'help and support' examples. For instance, when taking part in conferences, they tried to help each other respond their instructors' questions. They also helped each other to search for the issues that they had to respond to the questions they did not know at that time, and/or some interesting issues when they needed to know more. Moreover, during the time they worked in communities, their friends would remind them about the local people's beliefs that they should consider. Friends also helped them advise their clients and/or suggest what further information that they could gather from clients in case they forgot. Friends also frequently told them to assess abnormal health status from the cases they found. These students acknowledged that they were happy to practise together. A fourth year participant cited:

Yes! Like, we [nursing students in a small group] did home visiting together. If I asked for some information from my clients, sometimes my friend(s) tried to add something. Like, sometimes I forgot to ask something, so my friend(s) could help. When I visited the case(s) of my friend(s), I also helped them. Similarly, when giving suggestions, sometimes we went there [clients' home] together, like I advised something while my friend(s) showed them [how to do], things like that. Yes! We helped each other. (Suvadee, Interview 2, page 26)

Apart from the strategies presented, during this stage the participants also applied the experiences they had to analyse the problems of their cases and the nursing care they needed.

APPLYING LEARNING EXPERIENCES TO ANALYSE CASE PROBLEMS AND NURSING CARE

After studying about how to provide nursing care for patients in their theoretical session(s) and having experienced case learning during the previous stage, most of the participants tried to apply their learning experiences to analyse their cases' problems and the care for them. More than half reported that they now often made use of the experiences they had gained from earlier cases to do their present nursing care plans and/or provide nursing care for patients with the same condition(s)/disease(s), especially

when they did not have much time to prepare. They sought comments from their supervisors so that they could improve their nursing care plans and applied what many instructors had suggested about how to look for the significant issues of their previous cases. As well, when they had opportunities to do nursing care plans and/or care for patients with the same condition/disease frequently, they could remember how to specify their problems and how to provide nursing care for them. A third year participant said:

[I could understand more about case problems] when I was in the third year because many instructors suggested that I had to focus on the significant issues of each case. I mean my experiences, yes! If in my second year, I didn't quite know any more. In my third year, I could roughly specify this/that [nursing diagnosis] and then proved it with texts. It was quite right, yes! ...Like when coming back from observation, I thought about the case's problems I might set. ...and I checked that with texts again. If in my second year, I just came back with nothing. I didn't know what I had to set, so I just copied all [nursing diagnoses] from texts. In my third year, after I experienced practising many wards and many times, sometimes, I could specify, ah, I had to set this/that. Anyway, about the reasons [to explain why my case had this/that problem] I had to read texts. (Kasaree, Interview 1, page 15)

However, these students only provided their patients with the nursing care they could remember and sometimes found that at that time they did not know whether some issues they suggested correspond with any new patients' problems or not. A fourth year participant recalled:

[If I didn't have enough time to prepare for nursing care] Mmm! Maybe, [I gave the patient] some suggestions. Anyway, that was about [stopped for a minute]. For example, a heart patient needed to go to a toilet. I knew that disease had to take bed rest. So, I told the patient not to let her/him out of the bed. I mean the patient had to be on bed anytime, things like that. I mean I didn't know more; that was just the main issue [for that patient], yes! If about other details, I couldn't remember. ...Sometimes, they weren't the main issues, but they were the things I knew. ...maybe from class or from my previous cases and sometimes from discussions. When preceptors suggested [patients], I tried to remember that too. Ah! A heart patient, "Take bed rest". ...I remembered that. (Inee, Interview 2, page 42)

Only some, i.e. predominantly students who had moderate-high GPA, reported that they could recall the content they had learned from their theoretical studies to search for the associated conditions, information and/or symptoms, that might indicate the issues involved with their case problems and how to respond them, especially when they did not have enough time to prepare for the nursing care. A third year participant said:

...If about something quite easy, I could. Like today, I meant on Sunday [observation day], my patient didn't have that problem [UTI], but today she [patient] couldn't void and last night she had been cared for by Foley Cath's. So, this morning, I set [nursing diagnosis], "Risk of having infection in bladder", and nursing care for that. I told my instructor I started with assessment. ...Like, I had experienced that since my second year, so I could recall its nursing activities. I mean I recalled the steps [for caring that problem]. If about infection, what I had to do. ...I had studied about the disease in a urinary tract system

in 'Problem Person 1'. So, if [the patient] had full urinary bladder for quite a long time, she might have an infection, yes! I knew as I had ever learned that. I mean I had read and taken a test [about that]. (Sorphee, Interview 1, page 13, 14)

Besides the strategies revealed, the participants also tried to compare their patients' symptoms with the pathologies listed in texts or sometimes with their normal health status. This led them to better analyse the problems of their cases during this stage.

COMPARING CASES' SYMPTOMS WITH PATHOLOGIES OR NORMAL HEALTH STATUS TO FIND THE PROBLEMS

Because of the suggestions and expectations of their supervisors, more than half of the participants began to better understand the diseases and problems of their patients by learning their pathologies. In this stage, most of these students explained that before doing their nursing care plans, they tried to read the pathologies of their patients and compare their symptoms to them. If their cases had the similar symptoms/signs to the pathologies, it meant they had those problems, so they could search for corresponding nursing care from the texts. Applying this strategy made these students feel more confident that they could specify the problems their patients had. In making use of the comparison to understand the diseases of their cases, the entire group also reported that in this stage, they did the pathology part of their nursing care plans by putting the information of their patients into the relevant sections of their pathologies. This helped them to see more clearly what symptoms of their cases indicated their problems. However, normally, they still did this part after the nursing care part (see Appendix A). As such, learning pathologies in this stage only enabled these students to know what symptoms their patients who had particular diseases might have. A fourth year participant explained how she knew the problems of her patient:

...I had to know about my patient's information first, yes, from talking to her/him and her/his relatives, things like that, including from charts too. ...About the problem(s) related to pathologies, I had to read more. ...I mean I had to compare with theoretical content and then asked my patient [about that] again on the following day(s). Like, my patient ah, told me like this/that. So, that related to her/his disease(s) or not. I had to connect to the disease(s) too. ...I then asked my patient again. ...and compared with the information I observed or got from charts or asked the patient or her/his relatives, maybe. Then I compared what [the information] I knew with theoretical content. ...Analysed [the information], ah, whether it was the same thing that my patient had or not. If yes, ah, it meant s/he had that problem. I mean that problem [symptom/sign] occurred from the pathology s/he had. (Laina, Interview 2, page 22)

Moreover, some of the participants also found some of their cases' problems by comparing their symptoms with their normal health status. This helped them specify the

diagnoses for their patients and search for appropriate nursing care from the texts. A third year participant revealed:

I compared [my case's health information I had] with her/his normal daily living requirements. I mean I had to know her/his normal health. When the patient was admitted, s/he had problems like this/that. It was different from the things the patient had in her/his normal daily living, so it showed abnormal health. ...Like, normally, the patient had stool once a day, but during her/his admission, s/he couldn't produce stools for a few days. That meant the patient had a problem, constipation, things like that. (Sorphee, Interview 1, page 8)

Learning in this stage, therefore, these students did not analyse the pathologies to comprehensively learn about how they caused the symptoms in their patients; instead, the comparison only led them to get rough idea of patients' problems. They still could not link what they had learned from the pathologies to the nursing care. In other words, they could not explain how the care they provided helped their patients to get better.

To better understand the problems of their patients and how to provide nursing care for them, another strategy the participants employed during this stage was applying accessible resources as guides.

APPLYING ACCESSIBLE RESOURCES AS GUIDES TO UNDERSTAND CASE PROBLEMS AND HOW TO PROVIDE NURSING CARE

Nearly all of the participants tried to make use of accessible resources as guides for gathering case information and helping them diagnose the problems of their cases, and prepare corresponding nursing care for them. More than half revealed that the significant guides that they used to improve their nursing care plans, prepare for content conferences, and/or nursing care for their patients were textbooks and previous nursing care plans of themselves, their friends, seniors, and caring guidelines of settings, including nurses' notes. Some of these students also reported they could make use of the exemplar information as listed in textbooks to specify the questions for asking their case information. Students confirmed that they could also make use of their supervisors' comments on the previous nursing care plans to improve their new ones, especially when preparing and/or caring for patients with the same disease.

...I knew more what information should be used to support which nursing diagnoses. As in my second year, I couldn't do that, so my instructors said, "This/that information doesn't support". In my third year, I could do in some degrees, I thought. ...My instructors told me, yes! ...Like, if [a patient had a problem] about respiratory system, I had to use information related to respiratory to support, things like that. ...they told me to rewrite my nursing care plans, so I could use that to improve another, yes! ...I mean I

improved [my nursing care plans] based on what my instructors said. If they said that information couldn't support the diagnosis, I didn't use it [in the next time]. ... (Noree, Interview 1, page 22-23)

Meanwhile, some participants also reported that the information on their patients gained during shift rounds, the recommendations from their supervisors during pre-conferences, including some symptoms their cases reported, provided important frameworks for them when studying about and/or caring for their cases. Moreover, nearly half of the participants disclosed that the treatments of their patients could be a guide for them to understand about their problems. A fourth year participant disclosed:

...Sometimes, if I couldn't clearly assess [my case's problem(s)], I might check on a doctor's treatments. I mean about medication the patient was treated with. I might return back and read about her/his disease(s), what the medications could treat, and then I read about the disease(s) again. (Meena, Interview 1, page 3)

These students explained that all of these guides could stimulate them to think about what problems their cases might have at that time based on the information they had. They also knew what nursing care activities they could apply to help their patients who had such problems. They stressed, however, that they had to understand the information in the guides before they could do the plans and/or provide the care. Most of the participants explained this strategy with the words “searching for compatible problems and nursing care”. They reported that in this stage, they focused on the present problems of their patients. They compared their patients' symptoms/conditions with the support data of the diagnoses in the texts and/or other documents they could access, such as the previous nursing care plans of their friends, and nurse's notes. They then chose only the diagnoses that had similar support data to their patient symptoms/conditions. Some also explained that they sometimes tried to ignore some information of the diagnoses in the texts that did not relate to their case data, but they still employed them. They also searched for nursing care activities they could use to care for their patients from the texts and/or other documents. Sometimes, they added more details in the ‘care activities’ of the nursing care plans to be compatible with their cases. Some clarified that the activities had to correspond to their cases' contexts. A fourth year participant confirmed:

...The exemplars of nursing diagnoses were in texts. So, I read that first. I mean I had to roughly know what nursing care activities my case might need, hadn't I? Then I considered whether I had enough case information to diagnose as the texts guided or not, things like that. If the patient had dyspnea, lung crepitation and pink frothy, I could specify like: “Risk of cell hypoxia because her/his heart decreased the effective work”, things like that. ...So, the [nursing care] activities for her/him, I had to solve the

problem. If s/he risk of cell hypoxia, how could I protect that? The texts had guidelines for me to do.They provided how to care for my case who had the disease(s). I made use of the nursing problems [nursing diagnoses] and nursing care activities only for the ones that my case had or needed. ... (Areeda, Interview 1, page 8-9)

In addition to the strategies reported, to enhance their case learning during this stage, the participants applied the strategy of *taking more opportunities to learn*.

TAKING MORE OPPORTUNITIES TO LEARN

In this stage, nearly all of the participants tried to take more opportunities to learn about the problems of their cases and how to provide nursing care for them. More than half of them, especially the students with moderate-high GPA, tried to ask to care for different cases and/or chose the cases they thought would be interesting for their content conferences to learn about many issues and/or diseases. Some participants tried to confer on cases that did not belong to anyone in the group, while others consulted their instructors whether particular cases had enough interesting conditions to confer on or not. They revealed that normally, they tried to confer on cases that had complicated conditions, multiple system problems, or the cases that they did not quite understand during their theoretical studies. A fourth year participant with high GPA talked about how her group chose cases for content conferences:

...We would choose the case that was interesting. I mean the case that could give us an opportunity to learn more. ...The case we chose must be quite critical and had problems in multiple systems. I mean we could learn many things. ...Sometimes, we asked for the ideas of preceptors too. If they suggested [particular] cases, we also chose the cases followed their ideas as they might see something [we could learn from the cases] more than us. ...Normally, we didn't choose the same disease cases. I mean we were placed in the same group, so we tried to choose the case that didn't have the same disease(s). Like, we had conferred about this disease at a medical ward. Next time, if we were placed at a medical ward again, we would select another disease. (Noree, Interview 1, page 42)

Nearly half of the students, however, reported they could also have more opportunities to learn when they were assigned to provide nursing care for cases with the same disease. The students who had moderate-high GPA explained that paying more attention to the different issues of the same disease could lead them to more thoroughly understand about patients with that condition. They could analyse similar and different conditions between the previous cases and the ones they were studying, so they could extend what they knew and/or fill in missing information from previous cases. A fourth year participant with high GPA talked about a different issue he could learn from caring for cases who had the same disease:

...Such as a DHF patient, that day I practised at a male medical ward, I could see the case had hepatomegaly. With my preceptor's question, "Why some cases are treated with Paracetamol, but others don't?" even though they had the same disease, DHF. After that, I tried to find out from texts and ask for more explanation from an Extern [medical student]...So, I knew that case had a pathology of the liver. Treating with Paracetamol could affect a patient's liver, maybe caused her/him to have a severe condition. Or in some cases, even they didn't have hepatomegaly, but doctors didn't treat them with Paracetamol, so we [nurses] had to check their 'labs'[lab results], SGOT⁴¹, for example. If their 'labs' were abnormal, they were also canceled this medication. We had to be concerned about this for each patient too. ... (Arun, Interview 3, page 30-31)

Meanwhile, the students who had low GPA reported that they could learn more when studying cases with the same disease many times. Another fourth year participant with low GPA explained:

Caring for the same disease cases led me to learn about that disease. I mean I know in-depth about the disease, like about its symptoms, pathologies, and causes. ...Like, when I read [about that disease] many times, I tried to do mind mapping. Then when I cared for the case again, I could make use of that. ... Normally, I summarised about the theoretical content of the disease first, yes! But! About the later cases, I tried to compare with my patients too. I mean I tried to search about the differences between that patient and previous cases. That made me read [about the disease] many times. Like, I could review that content too. I mean that helped me learn more about the disease. (Nutsaree, Interview 2, page 25, 26)

More than half of these participants, especially the students who had moderate-high GPA, indicated that they had to search for and read more about the issues they did not understand. They read more about the pathologies and how to care for the interesting cases they found during shift rounds, evening and/or night shifts. Sometimes, they also helped their friends to find some issues to answer their supervisors' questions. Some of this group also tried to understand the issues that their instructors and friends would likely want to talk about. Others attempted to review some aspects of some patients that were different from what they had learned. They also searched for more understanding about the issues they had been taught at settings. A fourth year participant with high GPA talked about how she increased her learning opportunity:

[Caring for a crisis DHF patient] made me learn more. I mean that helped me to definitely remember about DHF, you know? I mean about DHF, I could remember how many stages it had. What [nursing] care I had to provide for each stage. Also, how it changed to stage one to stage two or stage three. ...At that time, I still didn't understand about its pathologies. But! Like after caring for that case, I tried to read more. ...I reviewed about its pathologies and the care I had to provide during each stage. What were they? Like, I could refresh [my knowledge] too. I mean was it right or not in case of what care I gave and the theoretical content listed. (Suvadee, Interview 1, page 12)

⁴¹SGOT: Serum Glutamic Oxaloacetic Transaminase means an enzyme that is normally present in liver and heart cells. SGOT is released into blood when the liver or heart is damaged. This means that if the blood SGOT levels are elevated, these organs are damaged (MedicineNet.com, 2013).

Furthermore, some of these students tried to apply many strategies to have more opportunities to learn. They made use of the time given for their case learning to find as much information about their case problems as they could. They attempted to do physical examinations on some of the other bodily systems the patients might have problems with other than their chief complaints or the presenting problems which had been treated. They asked their patients and/or relatives for more details about their related health problem information to better investigate the problems they might face. The students who had moderate-high GPA also made their patients trust in their competence to get correct information from them, especially in community fields. During shift rounds and pre-conferences, they tried to learn about other cases to understand why the cases had those symptoms and get guidelines for how to provide nursing care for particular cases. They revealed that they developed some ideas to care for their cases from the care information their friends presented during pre-conferences. Others with moderate-high GPA also asked to care for cases that they had learned about during their theoretical studies to have opportunities to review these. Sometimes, they also tried to extend the time for case learning and/or asked for their preceptors to allow them to practise during their leisure time to get more experience. Meanwhile, some participants also took notes about the significant caring issues they had learned during their practical studies. They acknowledged that this was their important way to understand how to provide nursing care for their patients and prepare for the licence test they had to do. A fourth year participant noted:

When I was assigned cases, I tried to summarise [what I had learned] about them. ...Supposing, I found some problems, so I wrote those in my note book. The cases I had cared for had problems like this. I summarised like if they [my patients] had this problem, I had to provide them with nursing care activities like that. Like my patient had low K [potassium], what the doctor did to treat him, so I recorded that. ...If I tried to take notes about my cases, I might understand more and when my next practice, I might have to care for that problem again, so I could use it. (Meena, Interview 1, page 5)

After modifying the strategies for their case learning, the participants found they could attain many desirable results. The following section details the consequences emerging from their effort to learn about the problems of their patients and how to care for them through more advanced strategies.

CONSEQUENCES FROM MODIFYING THE STRATEGIES FOR CASE LEARNING

Although most strategies applied during this stage were mainly to meet *supervisors' expectations*, the participants thought this led them to focus on starting to analyse their cases' problems and how to provide nursing care. They reported that they could understand more about what problems their patients had and what nursing care they needed. Using this combination of strategies helped them develop a bigger picture and remember more about their cases. They also felt they had more opportunities to apply what they had planned to care for their cases, even though they had to help the nurses with tasks as in the previous stage. Finally, they confirmed that learning in this stage made them happy as they learned more from their cases and felt more confident to provide nursing care to them. Some also implicitly mentioned that practising could now lead them to have some opportunities to prepare for the licence test. All of the consequences emerging from this stage are coded into six concepts.

BETTER UNDERSTANDING AND REMEMBERING MORE ABOUT CASES

More than half of the participants could now get a better understanding and remember more about their cases, especially when their supervisors guided their thinking. When seeing cases, they could review what they had studied and then compare their symptoms with their pathologies, so they could get a better understanding of the diseases of their patients that they could not imagine during their theoretical studies. They could see whether or not their cases had the symptoms and consider the progress of their diseases as listed in the texts, and could remember what nursing care activities they had to provide them because they were related to the symptoms at that time. A third year participant declared:

...I tried to review about my case's disease(s) and then compared whether s/he had symptoms/signs as listed in texts or not. ...I did that to remember! I thought it helped me to memorise more than if only read texts. Like, I had cared for a DHF patient, for example, and a patient had fever for six days. I mean on day six, s/he had lower fever and began to have bleeding and rash, so I began to know a patient initiated into shock stage, things like that. If I only read about DHF had three stages; in the first stage, a patient had... It was harder for me to remember than learning from my case. As at first, a patient had fever for six days. When her/his fever decreased for 24-48 hours, my preceptor told me to read about what I had to caution, things like that. I had to care for her/him like this/that. After that a patient moved to the period of recovery. When my patient was in recovery period, I had to care for her/him like this/that. That helped me to remember more. (Nirin, Interview 1, page 13-14)

Moreover, half of the participants revealed that they could remember about the patients they had cared for in various settings, even though they had never learned about their conditions in classes. When returning to study about those patients' conditions in their theoretical sessions, they could make use of this experience to understand what their instructors taught more quickly than learning about conditions they had never experienced. Another third year participant confirmed:

[Caring for the case before studying about it was good for me]. Like, even not too much, I could understand some [about the disease]. When my instructor taught in my third year class, I could recall back when I practised in my second year. Well! That symptom occurred when a patient had this/that condition, things like that. It made me recall about the case [I had cared for]; like, normally, a heart patient had symptoms/signs like this/that. It could be a foundation for learning in my third year. ...When my instructor drew a picture about the heart and connect if it had failure in this/that 'room' [atrium or ventricle], what symptoms/signs it might show. So, it was easier for me to understand. ...I mean I could understand about the disease quite quickly. ...and remember more about it. (Araya, Interview 2, page 61)

When getting a better understanding and remembering more about their cases, the participants reported that they could better specify the problems of their patients and knew more about how to care for them.

BEING MORE ABLE TO MATCH PROBLEMS AND NURSING CARE

More than half of the participants acknowledged that they could understand more about the problems of their patients and how to provide nursing care for them. With more skill in assessing the problems, as well as more experience in completing nursing care plans, they could specifically match patients' problems and corresponding nursing care better than in the previous stage. A fourth year participant noted:

..Like, in my second year, I just did [a nursing care plan] by copying texts without understanding, ah, what problems that patient had! The care I provided was right or not? I mean did it correspond with a patient or not? But! When I did [nursing care plans] many times, like, I could see the significant problems of a patient more. ...I understood about the disease of my case more. ...so, I could see support data clearer. I mean I knew this/that support data would cause which problems [in my case], things like that. It was clearer! ...Like, a patient had electrolyte imbalance because s/he had diarrhea. ... [In my following years], I felt I could provide my patient with more corresponding [nursing care]. ...I mean I focused more on the present problems of my case. ...I tried to find what problems s/he had and my nursing care was focused more on that, I thought. (Needa, Interview 1, page 15-17)

Moreover, because participants could complete their nursing care plans more quickly in this stage, they had more time to read what they wanted to know about their patients, even though those details were not required for their nursing care plans. They also knew more about the reasons for doing some treatments and/or other nursing care activities. They felt able to apply some of what they had planned to care for their patients.

USING OPPORTUNITIES TO APPLY PLANS TO CARE FOR CASES

In this stage, nearly half of the participants felt they had opportunities to apply their plans to care for their cases to a much greater extent. They explained that applying the previously noted strategies of this stage allowed them to start case learning from the conditions of their cases which led them to learn more about their problems. Understanding more about the reasons for doing some treatments and/or other nursing care activities they had planned gave these students more direction in caring for their patients. In addition to completing procedures their supervisors and/or the nurses told them to do, they were able to deliver nursing care that corresponded to their patients' problems and conditions. A fourth year participant commented:

...When I was in year three-four, I mean I had an opportunity to practise in many wards, so I began to apply [my nursing care plan] ...Normally, [I] merged [my nursing care plan] with a doctor's order. I applied like, ah, in the order, what medications I had to give my patient. Then what nursing care activities in my plan I could do for her/him. I mixed that. ...I felt I made use of [my nursing care plan] more, yes, because like when participating in a pre-conference, we [nursing students and supervisors] talked about a patient's problems. If I omitted some [problems] or something, my instructor/preceptor tried to add that. So, I took notes about them, ah, tomorrow, I would add and apply them later. (Needa, Interview 2, page 22)

When getting more understanding, remembering more about their cases, doing better nursing care plans, and perceiving they could better apply what they had planned, the participants felt happier with their case learning in this stage.

BECOMING HAPPIER WITH CASE LEARNING

More than half of the participants confirmed that they were happy with their practice. They liked practising because they could understand more about what they had learned during their theoretical studies from the cases they had cared for. They could see the symptoms of different diseases in patients and then review and/or ask for more explanation about some issues they did not understand. Some revealed they liked practising more than studying in class because they could find out how to help their patients who had particular problems, especially when practising with supervisors who were willing to teach. They wanted to understand about what they could do next as part of nursing care for their patients. This made them need to study more and more as they were pleased with their greater understanding about the particular problems of their patients and the nursing care activities they should give them. A third year participant expressed:

...I practised at [said the name of the setting]. I really liked this ward. I felt really good with this ward. Today was the last day for me. Unfortunately! I mean I felt I really wanted to train myself at this ward. ...I got so many things there, not only about [nursing] knowledge I had to know, but I also understood about nursing processes. ...Practising at this ward, I felt I really wanted to train myself. I wanted to study and read. I mean I thought that tomorrow what could I do to care for my patient? I read about that first, things like that. I was happy like waking up with a feeling that I wanted to go to practice. Even if preceptors there were quite reprimanding, I felt good as they tried to teach me. I felt every preceptor/nurse there was sincere, yes! Preceptors/nurses at this ward were kind and so skilful. I meant they had the teaching strategies that were different from other wards. ... (Fatou, Interview 1, page 1)

Understanding more about the significant problems of their patients and the care they needed also made the participants feel more confident to provide the nursing care.

MORE CONFIDENCE TO PROVIDE NURSING CARE

Understanding more about the problems of their patients and how to provide nursing care for them made some of the participants feel more confident that they could respond to the questions of their instructors and give more nursing care to their cases. In this stage, they could give more advice to their patients and felt more confident to explain their recommendations. They acknowledged that having practised in many fields and/or moving through the successive years of study contributed to their confidence in giving nursing care to their patients at this stage. A third year participant said:

...In my third year, if my instructor questioned me, if I could respond that, I felt more confident. When my patient asked me [something], if I could respond or suggest her/him more; I meant I could explain more about the reasons of that nursing care [why I cared for her/him in a particular way], I felt that made me proud, yes!, I was able to make her/him understand some [issues that s/he had to know]. ... (Araya, Interview 1, page 21)

During this stage, the participants were more aware of preparing for the licence test and began to prepare for it.

BEGINNING PREPARATIONS FOR THE LICENCE TEST

Although more than half of the participants confirmed that they could make use of their practical experience to do their tests, only some with moderate-high GPA stated that they had to understand about the problems of their patients and how to provide nursing care because of their concern about the licence test. During practical studies, however, the students reported that they rarely had opportunities to prepare for this test because they spent most of their time meeting their current requirements. The time to start and the strategies to prepare for the test were quite different between the students who were seniors that would take the test in the near future and the juniors. A second year

participant talked about his early preparation for the test:

I tried to remember about the cases I had cared for, yes! I told myself to remember that experience. When close to the test, I should be able to recall about it. That would help me to do the test easier. As when I practised, I could study more about cases, so that would help me to remember more. When closer to the test, I might not read too much. ...I took notes about the cases [I had cared for]. I mean when I observed, I recorded details [about a case]. ...Yes! I took notes [on that] more every day. I mean I tried to record [every thing I knew about it]. When finishing the week, I mean when I could complete my [nursing care] plan, I would complete that case and kept it [for the test]. (Nawin, Interview 1, page 21)

Sometimes, some of the participants, especially those with low GPA did not pay enough attention to the test. They accepted that they still were not preparing for the test early enough. They only collected all of the related documents they acquired, but they still had not related this to the cases to study later. A third year participant with low GPA said:

I thought [about the test] for a long time. I felt stressed, yes! I'm worried I couldn't pass it [laugh]. ...Well! I began to summarise, and kept my nursing care plans. I summarised about the diseases I had learned. I tried to make short notes about them to read [to prepare for the test]. (Aunchana, Interview 1, page 18)

However, when perceiving that they had to know many things more and/or had failed comprehensive tests, some fourth year participants disclosed that they began to concentrate on the licence test. One of them with moderate GPA said:

*Recently, I tried to read [slightly smile]. In the past, I hadn't prepared [for the licence test] at all. When I started my first year, instructors frequently told us [nursing students in my class] like, in the future we had to take it [licence test] as our seniors. In my first year, I wasn't aware anything; I just studied [followed my study schedules]. In my second year, I had still studied in the same style. In my third year, I had to practise frequently, so I didn't have enough time to read [for the test], things like that. When I was in the fourth year, ...when I took the first [comprehensive] test, I already knew that I couldn't [do that] at all. ...I couldn't finish it in time. Some things in the test items, I had never seen, yes! That made me so worried. I concentrated to read when I was in the fourth year, yes! ...In my fourth year, I **read everything** I could access. ...And during my elective field, when I talked to friends from another college [the Project students from different colleges were placed together in the settings located in the unrest area], I knew that I didn't know things enough. I didn't know many things, so I had to prepare. (Alfa, Interview 2, page 47- 48)*

Meanwhile, other seniors, especially those with low-moderate GPA said during practical studies, they could do little more than complete their requirements and/or read about what their supervisors asked. As such, they started to prepare for the licence test only after finishing all of their practical studies. That was at the same time as their comprehensive tests. A fourth year participant with low GPA said:

...I concentrated on reading after finishing my practical placements.During my practising, I read some, but didn't cover all issues. I just read what I had to use for conferences tomorrow, things like that. About preparing for the licence test, I just gathered and read many things after finishing my practising. During practising, I had never thought about the licence test at all [slight laugh]. Absolutely not! Just thought about it right now! ...I focused on what I had to submit; I didn't read for the licence test, no! Only for the requirements I had to do every day. ... (Chuntira, Interview 1, page 4-5; Interview 3, page 60)

When reaching the end of this stage, some participants developed a significant internal drive, *desire to learn*. This condition led them to discover significant strategies to achieve their case learning. Thus, for these students, there was one more learning stage to explain why and how they accomplished the full process of **Developing Effective Strategies for Nursing Care**.

CONDITION FOR DISCOVERING HOW TO UNDERSTAND CASE PROBLEMS

Desire to learn emerged at this stage as the most powerful factor that encouraged some participants to discover how to understand their patients' conditions. Because of this important factor, some significant questions need to be asked at this point. For example, where did the factor come from? Why could it drive them to make a greater effort to achieve their case learning? This section focuses on the contribution of this condition to the last stage of the learning process.

DESIRE TO LEARN

Desire to learn is represented by the right rectangle above the process (Figure 4.1) of the final stage, *discovering how to understand case conditions*. When influenced by this factor, the participants were able to negotiate the last transitional point of the process symbolised by the rectangle frames on the right part of the central arrow. They needed to further enhance their skills by applying the learning strategies that led them to clearly understand cases' problems and why they had to provide nursing care for them in particular ways. *Desire to learn* was a significant internal driver that enabled some participants, especially those with high-moderate GPA, to discover how to understand case conditions and thus to develop effective strategies for nursing care. While *interest in case learning* was the basis of this condition, the *desire to learn* of the students came from many factors. Some reported that, as seniors in the fourth year, they had to be able to respond to the questions of the juniors who practised in the same settings. As well,

supervisors' expectations were an important influence that continued from the previous stage, *modifying the strategies for case learning*. In this stage, supervisors focused on the students' knowledge of the pathology of their cases. Participants' self-esteem as seniors was affected by successfully managing these expectations. Moreover, increasing responsibilities required them to clearly know what they had to do to care for patients. Because of the desire to be good nurses in the near future, they paid more attention to finding out about the pathologies of their patients. A fourth year participant with high GPA noted:

...In my third year, my instructor focused on pathology more and more. Like, when that pathology occurred, what symptoms/signs a patient might have.During my third and fourth year, like [my instructor] asked, "Why, and why?", "How did it [a pathology] happen?": "Explain that right now", things like that.Sometimes, I got angry myself, "Why don't I know?", "Why can't I respond?", "Really stupid", things like that. ...No! No! I had to know. I had to understand that, things like that. ...so, I tried to summarise [making mind maps] until I could clearly understand.If about a pathology, if my instructors/preceptors said, "You are a fourth year student, why do you still not know?" that made me so stressed. ...I mean I thought why I still didn't know that because I nearly graduated. ...So, I had to know as much as possible. (Areeda, Interview 2, page 21, 24; Interview 3, page 46)

Some second and third year participants, especially those with moderate-high GPA, also showed a *desire to learn*, although they were not yet seniors. Before doing their nursing care plans, these particular students needed to understand the pathologies to explain their patients' problems and why they had to care for them in particular ways. This led them to know how they could care for their patients. A second year participant with high GPA commented:

After I had [my patient's] information by observation, for me, I had to read about her/his pathologies first because I had to do my [nursing care] plan, hadn't I? So I had to understand about pathologies first. I read pathologies and the symptoms of her/his disease(s). I had to know when my patient had the disease(s), how I could care for her/him. (Wana, Interview 2, page 25)

Driven by the powerful condition of the stage, *desire to learn*, participants developed superior strategies to discover how to understand case conditions.

STRATEGIES USED TO DISCOVER HOW TO UNDERSTAND CASE CONDITIONS

Based on the previous strategies that enabled participants to begin to analyse the significant problems of their patients and how to provide nursing care for them, some participants further developed the strategies that led them to achieve their case learning.

This section outlines two main strategies (Figure 7.2) that enabled those participants to reach a clear understanding of the problems of their cases, leading to the design of relevant nursing care.

ANALYSING THE ROOTS OF PROBLEMS FROM CASE PATHOLOGIES

Some of the participants with moderate-high GPA (eight from the fourth year and three from the third year) reported that they could identify the significant problems of their patients after gaining a clear understanding their pathologies. They explained that after trying to compare their cases' symptoms with the pathologies to find their problems during the previous stage, they had extended their understanding by analysing how the pathologies caused the problems in their patients. Sometimes, they also tried to make mind maps and/or diagrams about the pathologies of their patients to find out how their symptoms happened; how the pathologies affected them; if the patients had particular pathologies, what signs/symptoms and/or problems they might have. The students then took into account their cases' information to connect to the problems they might be at risk of in the future, so they could understand why they had the signs/symptoms that they did. This led them to clearly know what problems their patients had and how they happened. A fourth year participant with high GPA clarified this by stating:

...For me, if I didn't understand, I had to read. ... While reading, I had to do mind mapping. ...If a patient had a heart problem, what conditions could happen with her/him? ...Like, in a CHF patient, texts listed she might have pink frothy sputum ...maybe she had dyspnea, and had to rest in a high fowler's position, and had orthopnea, things like that. So, I brought my case's information to compare with that. ... I tried to compare [my case's information with what the texts explained]. When doing that, I could understand more, ah, the reason(s), "Why did my patient have pink frothy sputum, why she has dyspnea" even she had a heart disease, not a lung problem. ...I knew, well, because of this/that [pathology]. The pathology could cause them [symptoms/signs], things like that. That led me to know the reason(s) why my patient had those symptoms/signs. ... (Areeda, Interview 1, page 7, 8)

Meanwhile, others tried to work backwards from case information, such as abnormal laboratory results, signs/symptoms shown, to identify what problems their patients had. These students acknowledged that clear understanding of pathologies led them to know the causes of their patients' problems. They could explain back and forth between what signs/symptoms and/or problems their cases might have and what problems they had when showing particular signs/symptoms, even if a patient had problems from multiple systems. A third year participant with moderate GPA clarified:

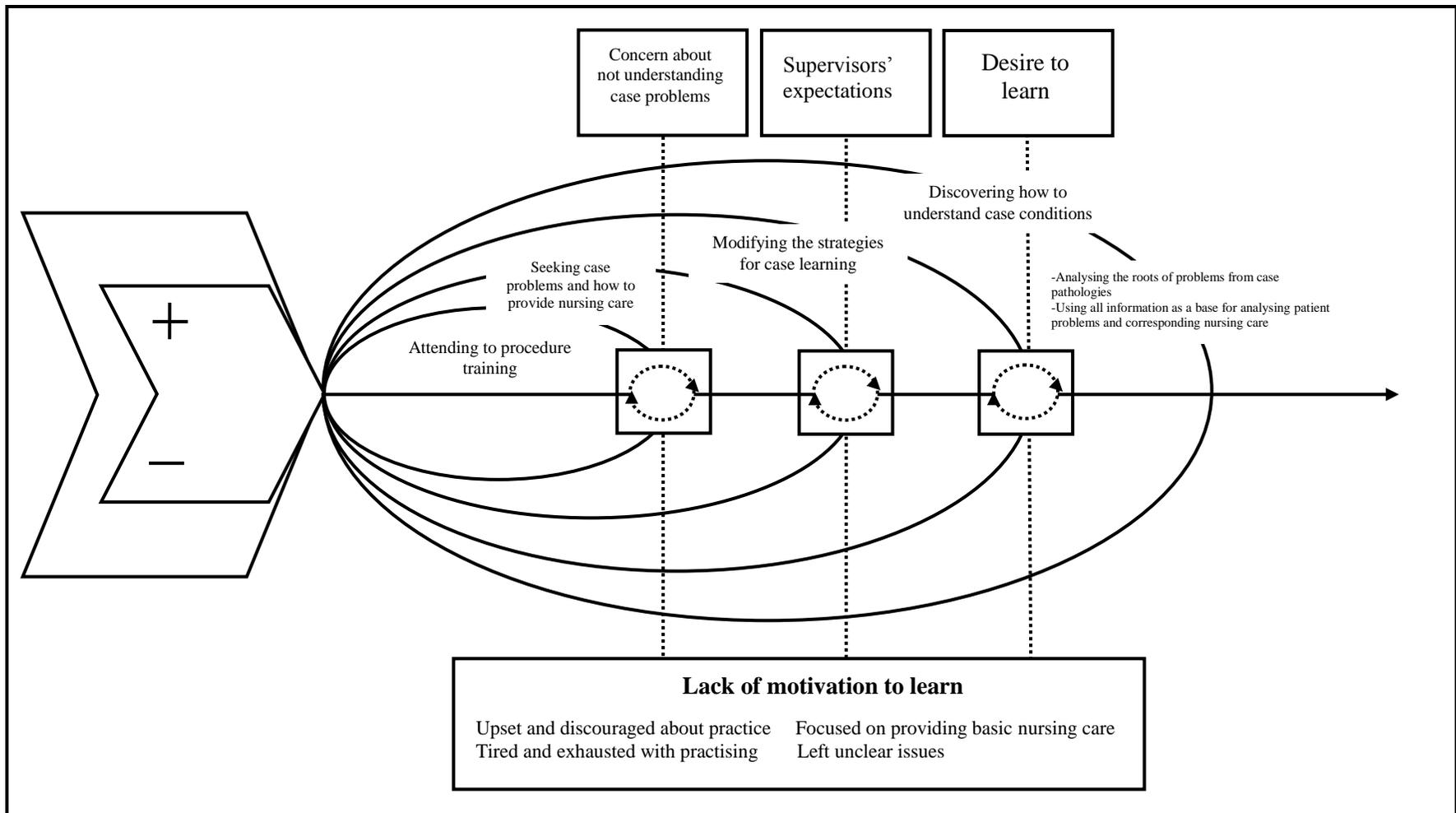


Figure 7.2 Learning strategies used for *discovering how to understand case conditions*

...When I read, I had to think about [this/that disease] might cause another. Like, finally, COPD could lead to a heart disease too, so I had to find out more how it caused a heart problem. ... How about my case? It had [information] that could indicate that or not. If my patient had a heart problem, how it affected her/him? About the symptom like edema, or less urine, what caused them? So I had to search more.Sometimes, I listed a problem first. Like, I saw one patient had dyspnea, so I thought about, "Hypoxia". Anyway, I had to find out why s/he had that problem. Maybe because of COPD, pulmonary edema, so I wrote something in my language first. Then I considered the data I had such as lung sound(s), x-ray results, and maybe dropped O₂ 'sat' [Oxygen saturation], or past health histories, to support. ...Sometimes, when filling in support data, I could think about, ah, what they came from, so I got a picture. ...I mean I understood the causes of the problems. The support data led me to understand what the problems came from. ... (Fatou, Interview 1, page 5, 8)

With regards to analysing the roots of problems from case pathologies, in this study, I found that some of the second year students, especially those with moderate-high GPA, tried to apply this strategy after it was recommended by their instructors as a way to understand the problems of their patients. These students, however, started from the pathologies in texts about what sign/symptoms and/or problems their cases might have. They tried to learn how the signs/symptoms and/or problems happened. They could roughly explain why their patients had the signs/symptoms shown by relating them to the information they had. They thought this led them to more exactly specify the causes of the problems of their cases, especially in the areas that they had studied, although it did not indicate that they could clearly understand the problems. Also, the study did not find the information that showed they could convert back to what problems their cases had when showing particular signs/symptoms. A second year participant with high GPA talked about how she analysed her patient's problems:

...[I had to explain about] the pathologies [from texts] that indicated symptoms/signs the patient might have and then connected to my case's information. ...I explained [why my case had this/that symptom/sign], yes! Texts had information like confusion in a cirrhosis patient, occurred from being full of ammonia⁴², things like that. I reported my patient's information like, she had constipation for four days, so she couldn't drain any ammonia. Too much ammonia could affect her brain, things like that. I mean I connected that to her information. If I read, I could understand and explain that. ...So, [the nursing diagnosis] I specified like, "Risk of confusion as she was full of ammonia" ... (Wana, Interview 2, page 25)

Based on clear understanding about how the pathologies caused the problems in their patients, the participants in the fourth stage then tried to analyse all of the case information they had to find the problems of their patients. This method was another significant strategy led them to fully understand the problems of their cases and what

⁴² Ammonia is a toxic substance that can form in the body when protein is broken down by bacteria in the intestines. Normally, the liver converts ammonia into urea, which is then eliminated in urine. (Alchemistlab, 2012; WebMD: Digestive Disorders Health Center, 2011).

nursing care activities matched their contexts and/or life-styles.

USING ALL INFORMATION AS A BASE FOR ANALYSING PATIENT PROBLEMS AND CORRESPONDING NURSING CARE

Some participants, eight of the fourth year and three of the third year students who had moderate-high GPA, revealed that they could provide corresponding nursing care to their patients by analysing all case information. This strategy was the next process of finding their patients' problems from their pathologies and/or conditions. They had to clearly understand textbook information about what could cause the problems in their patients. They then tried to analyse all of their case information, including patients' contexts and/or life-styles. After precisely analysing the problems, these students could also make use of the information about those contexts and/or life-styles to think about how to provide nursing care that corresponded. A fourth year participant with high GPA noted:

...About diseases, I had to understand about pathologies and related information to how they occurred. What factors might relate to them. ...Sometimes, the clients had severe complication(s). But! They confirmed they continued medication(s), strictly controlled diet. Anyway, their diseases were getting worse, maybe they had to admit or had shock too. That struck me to think they might have other [related factors] more than that, but they didn't tell me yet. ... (Suvadee, Interview 1, page 4-5)

Furthermore, these students were concerned more about the psychological problems of their patients and/or caregivers, especially when they had cared for patients who had severe problems. When going into the communities, they were very careful to think about whether the suggestions they gave or nursing care activities they designed for them matched their patients' contexts and/or life-styles, as Suvadee further stated:

...One more thing, [in that case], her daughter was the one person who cared for her. ...I had to focus on giving the suggestions to her daughter. ...Also, my patient had crisis hypertension and had to be admitted at an ICU after around a month. That caused her daughter to leave her work. Yes! That was another connected problem. ...Yes! I had to care for her daughter too. I had to help her to adapt herself to the change occurring in her life too. ... (Suvadee, Interview 1, page 8)

After applying these strategies to clearly understand case conditions, the participants reported that they could understand case conditions and provide effective nursing care.

CONSEQUENCE FROM DISCOVERING HOW TO UNDERSTAND CASE CONDITIONS

After trying to analyse the problems of their patients and developing corresponding nursing care based on the content they understood and all of their information, some of the fourth and third year participants who had moderate-high GPA acknowledged that they could understand their patients' significant problems and how to care. Hence, learning in this stage led them to accomplish the process of **Developing Effective Strategies for Nursing Care**. This section highlights the consequence that emerged from their efforts in case learning.

UNDERSTANDING CASE PROBLEMS AND HOW TO PROVIDE NURSING CARE

The strategies applied during this last stage led the participants to achieve their case learning. They clearly understand about what happened with their patients and what nursing care corresponds to those who had particular contexts and/or life-styles. They detailed the significance of what they had attained during the stage in two sub-concepts.

Knowing what nursing care the cases needed

When understanding how the pathologies caused problems in their patients, the participants knew what nursing diagnoses they should specify and what nursing care they needed. They reported that during pre-conferences, they could explain to their instructors why they had set the nursing diagnoses and care for their cases in the ways they presented. They could give the reasons showing why their nursing care activities could solve the significant problems of their cases even though they had not had time to fully prepare. They also revealed that because they could now link signs/symptoms and/or problems, they realised why some of their previous efforts at diagnoses did not match the patients' conditions. In this stage, they could do their nursing care plans more quickly than in the previous ones. They knew what data should support which nursing diagnoses, and what problems should be solved by what nursing care. Moreover, in clinical settings, the students reported that they could successfully assess patients' problems. They knew what they should do for them when finding that their signs and/or symptoms had changed. A fourth year participant with high GPA claimed:

...If I assessed myself, at this time, I was in the fourth year, I was nearly graduated in a few months, as I practised in an elective field, I felt I could do patients' assessments clearer than other previous fields I had experienced. Like, my thinking processes were more systematic. ...Like, when I saw a patient had a crackly voice, I knew what care I should give her/him, things like that. If in the past, I might do [some nursing care activities] as preceptors told me. ...But now! When seeing like that, I knew I had to do suction, things like that. I would tell the preceptor/nurse there I would do that. ...I felt I could provide more good care for patients.[At present], I could tell my instructors/preceptors because my patients had those pathologies, that caused the patients had these problems, so I had to set [nursing] diagnoses like these and gave them that care. ... (Areeda, Interview 1, page 1, 7)

When advising their cases, they could explain why the patients should do their self-care as they recommended. They also confirmed that their suggestions corresponded with the contexts and life-styles of their clients. Another fourth year participant with moderate GPA verified:

...In my fourth year, I could respond to [patients' questions] and discuss [regarding talking about care issues] at that time. Also, I could give them the advantages and disadvantages too.Like, about foods, I thought maybe they could only adapt some, we [nurses] shouldn't tell them to change [all of their life-styles]. ...I mean we couldn't prohibit them, but we should suggest them to have less. ...Like, I liked this one, if I was told not to eat it. I mean I thought like I was a patient. So, I could only suggest them to decrease [that food], not changing all of what they were eating. (Laina, Interview 3, page 39, 45)

Furthermore, they could good make use of their practical experiences to do their tests. They disclosed that when understanding about the cases, they could get most answers right on the tests. They could recall about the concepts they had cared for in their patients and then analysed them when doing the test questions so as to choose the right answers. This implied that they could integrate their practising into preparing for the licence test. A fourth year participant with moderate GPA confirmed:

Yes! [I made use of ward experience to do tests]. Like the case I had cared for, what were the significant issues I had to be cautious, I could connect [the test item to my previous case], so I could recall that. ...Anyway, I had to consider the information in test questions too. Like, ah! That 'lab' [lab result] was abnormal, for example, so I had to check it. If about the cases I had cared for, I could recall that. Well! If about that disease, a patient might have this/those problems, things like that. ... (Needa, Interview 2, page 47)

Moreover, some of the fourth year participants with moderate GPA who could pass the PSU's comprehensive test in their first attempt also reported that they only reviewed the understanding they got from their practical studies to pass it. One of them said:

[Practising and preparing for the licence test was the same thing] for me, yes! I thought during practising, I read much because I had to do my [nursing] care plans and conferences or something, hadn't I? That seemed to be the same as test items. During clinical practice, I tried to understand [what I had experienced]. I mean I could definitely remember that. If about the cases I had cared for, I could remember what I read like, pathologies, nursing care activities, things like that. When doing tests [stopped for a minute]. I mean before taking the test, I just review that, not reading much. I just read the

issues I wasn't sure because when doing tests, sometimes I found the situations as I had cared for other cases. The [patients who had] diseases I had been assigned. I mean I had done conferences, so I could [get the right answers of tests]. I could make use of that, yes! (Laina, Interview 4, page 58)

This implies that not only knowing what nursing care their patients needed, if the participants thought they did not have enough data to indicate the problems, they also knew what additional information they had to find.

Knowing what additional information to find

Some of the fourth year participants who had moderate-high GPA reported that after understanding what problems their patients might have, they knew what information from various sources indicated which problems. If they thought they did not have enough data to support their conclusions, they knew what else to find it. When noticing that cases had signs and/or symptoms that had changed, they knew what other physical examination(s) they should do. The understanding about how the pathologies caused the problems in their patients led these students to assess any data indicating them, before providing the corresponding nursing care. A fourth year participant with moderate GPA said:

About the problems, I had to analyse. Like, the present problems, I had to find out how about the symptoms of that patient now? So, I could link them to [nursing] diagnoses.I mean I had to read about her/his disease(s) in text(s) first. ...If I hadn't enough information; I didn't have some, I had to look for them more in the chart. ...How about it? I had to analyse whether it was normal or not. (Inee, Interview 1, page 4)

The strategies the participants used in this stage were efficient as they could lead them to clearly understand how their cases' problems developed, what factors could influence them and the nursing care their patients needed. If they were not sure whether or not their patients had certain problems, they knew what information they had to find.

CONCLUSION

Although the external condition, *supervisors' expectation*, could strongly motivate the nursing students in the third stage to learn about their patients, it was not enough to facilitate them to fully achieve their case learning. In this study, when driven by the internal condition, *desire to learn*, the students in the fourth stage developed advanced learning strategies to clearly understand about their patients. Moreover, being interested in learning about pathologies that could cause the problems in patients also led these

students to understand the problems of their cases and how to provide nursing care for them. Even though this factor did not help them clearly learn about their patients during the beginning stage, it evolved as a foundation for developing effective strategies for case learning. Therefore, when having both the *desire to learn* and enough advanced learning strategies, the students could reach the full process of **Developing Effective Strategies for Nursing Care**. How internal motivation plays a significant role in developing these learning strategies so that they achieve their learning goals is depicted and then discussed in Chapter Eight.

DEVELOPING EFFECTIVE STRATEGIES FOR NURSING CARE

INTRODUCTION

In this study, I aimed to understand how Thai undergraduate nursing students, enrolled in the College BNS programme on one campus setting, developed their learning in the process of caring for patients in clinical practice settings. The study was undertaken at a time in which pass rates in the external licence exams of graduates across the 29 campuses of the College had been low for nearly a decade; and in the context of a government initiative (the *Project*) to address chronic nursing shortages in the southern provinces of Thailand that were exacerbated by political unrest. The study question arose from expressed concern as to why students could not integrate theoretical knowledge into clinical nursing care, which was the basis of the licence test items (Thailand Nursing and Midwifery Council, 2010b).

A Straussian grounded theory approach was used to develop a substantive theory: **Developing Effective Strategies for Nursing Care**, that is structured in terms of the paradigm model of conditions, actions/interactions and consequences outlined by Strauss and Corbin (1990; 1998) and illustrated in Figure 4.1. A substantive theory aids understanding and action in the context in which it is generated. However, when elements of that context change, some conditions may change with the possibility of alteration in some actions/interactions and consequences. The implications of contextual change on the findings of this study will be addressed later in this chapter.

The previous three chapters provided detailed description of the four stages (sub-categories) and the two phases (categories) that comprise the developmental learning process of participants as they discover how to clearly understand case conditions and provide patients with appropriate nursing care. The core category that best represented this process was identified as **Developing Effective Strategies for Nursing Care**.

In this chapter, an overview of the substantive theory is provided, outlining key propositions that can be drawn from the findings and supporting these with recent literature where appropriate. Similarities and differences between the findings of this study and comparable research are also identified. The limitations of the study are discussed and recommendations for education, practice, and further research are proposed. A concluding statement completes the chapter.

DEVELOPING EFFECTIVE STRATEGIES FOR NURSING CARE

The substantive theory **Developing Effective Strategies for Nursing Care** is composed of two main categories: **continuing practical studies** and **learning how to provide nursing care**. There are also four sub-categories: *attending to procedure training*, *seeking case problems and how to provide nursing care*, *modifying the strategies for case learning* and *discovering how to understand case conditions*. Each sub-category consists of the relevant concepts that are assigned to “conditions”, “actions/interactions (strategies)” and “consequences”, which are summarised in Table 8.1. All together, the concepts have the ability to describe the developmental learning process of Thai College nursing students in clinical practice as they strive to develop effective strategies for nursing care.

The substantive theory is congruent with adult learning theories. According to Illeris (2009), a learning process takes place when the psychological process of persons is initiated by any input from the external environment, or by an interaction dimension such as perception, transmission, experience, imitation, activity, or participation. The internal process is then integrated by the interplay between the function of managing content and the incentive function that provides and directs the mental energy for learning such as emotion and motivation to run the process. When concerned about their skill development (perception), and influenced by conditions in the external teaching and learning environment, the participants evolved strategies in relation to those conditions and their *motivation to learn* in order to further their learning based on their thoughts, beliefs, attitudes, and values. Therefore, they could determine what, when, and how they learn within the constraints of that context. Most of the participants in this study could show a degree of competence as adult learners in accordance with the key

assumptions of Lindeman (1926, as summarised in Knowles, Holton, & Swanson, 2011), about adult learners; that is:

1. Adults are motivated to learn as they experience needs and interests that learning will satisfy
2. Adults' orientation to learning is life centered
3. Experience is the richest source for adults' learning
4. Adults have a deep need to be self-directing
5. Individual differences among people increase with age

(Lindeman (1926), as summaried in Knowles et al., 2011, p. 38)

These assumptions have implications for the ways that learning is organised and managed. In the following sections a series of propositions will be drawn from the substantive theory and the findings compared with recent literature.

CLINICAL TEACHING AND LEARNING ENVIRONMENT

The clinical teaching and learning environment strongly influences student learning opportunities. While some aspects of the clinical teaching and learning environment in this study facilitated the participants to develop their nursing skills, others demotivated their learning, sometimes contributing to conflicted thoughts and feelings. For example, supervision styles greatly influenced participants' learning opportunities. In this study, I found that learning with caring supervisors who were interested in what the students had to learn and the adaptations they had to make led them to develop more self-confidence, which then furthered their practice and their satisfaction with it. These findings are in accordance with those of Sivadamrongpong et al. (2003), who found that students rated the teaching and learning relating to supervision at a high level. The positive effect from the attention of supervisors is in accordance with a recent cross-sectional survey of Swedish nursing students (Kristofferzon, Mårtensson, Mamhidir, & Löfmark, 2013).

An interesting comparison can be made with the earlier qualitative work of Gillespie (2002) in Canada, whose findings highlighted the importance of a "connected student-teacher relationship" (p. 569) in supervision, where-in students felt accepted as mutual persons, valued, respected, and experienced positive self-regard. Feeling that they were in a safe environment that affirmed them as individuals, learners, and nurses, and

Table 8.1 The process of “Developing Effective Strategies for Nursing Care”

Conditions	Actions/interactions (strategies)	Consequences	Sub-categories	Categories	Core-category
-Worried and afraid about practising -Motivation to learn -Supervision -Learning environment	Strategies used to improve nursing skill -building up self-confidence -beginning procedures with help and support -becoming familiar through performing procedures Strategies used to maintain learning -avoiding trouble -completing assigned tasks -seeking opportunities to learn	Desirable results -more skilled, confident and happy to practise -getting more trust from supervisors/nurses Unwanted effects -fear to contact and work with some nurses/preceptors -incomplete skill development -confused and conflict over technique differences -upset and discouraged about practice	Attending to procedure training	Continuing Practical Studies	Developing Effective Strategies for Nursing Care
-Concern about not understanding case problems -Motivation to learn -Supervision -Learning environment	Strategies used to improve case understanding -building up self-confidence -taking basic case information as they are able -using frameworks to start case learning -seeking help from experienced persons -seeking information from other accessible resources Strategies used to maintain learning -completing the requirements -completing routine care, orders, and helping with nurse tasks	Desirable results -familiarity with case learning -learned how to provide nursing care for some problems -interested in case learning Unwanted effects -focused on providing basic nursing care -tired and exhausted with practising -left unclear issues	Seeking case problems and how to provide nursing care		
-Supervisors' expectations -Motivation to learn	Strategies used to modify case learning -learning based on supervisors' and experienced persons' support -learning together with friends -applying learning experiences to analyse case problems and nursing care -comparing cases' symptoms with pathologies or normal health status to find the problems -applying accessible resources as guides to understand case problems and how to provide nursing care -taking more opportunities to learn	Consequences from modifying the strategies for case learning -better understanding and remembering more about cases -being more able to match problems and nursing care -using opportunities to apply plans to care for cases -becoming happier with case learning -more confidence to provide nursing care -beginning preparations for the licence test	Modifying the strategies for case learning	Learning How to Provide Nursing Care	
-Desire to learn	Strategies used to discover how to understand case conditions -analysing the roots of problems from case pathologies -using all information as a base for analysing patient problems and corresponding nursing care	Consequences from discovering how to understand case conditions -understanding case problems and how to provide nursing care	Discovering how to understand case conditions		

supported their active participation in learning process, was directly linked to the learning outcomes of those students, increasing their self-confidence and motivation to learn and their abilities to synthesise their nursing knowledge, to recognise and respond to patients' needs, and to develop an increased level of clinical judgment.

In contrast, the findings of the current study demonstrated that while Thai supervisors were also interested in helping their students to develop nursing skills and were aware of what their students had to learn, the interpersonal relationships between supervisors were hierarchical, rather than egalitarian and the students often did not feel they were in a safe environment. The hierarchy in interpersonal relationships of Thais was introduced in Chapter One. Although Thai supervisors as superiors are expected to fulfil their students' needs or give them support as inferiors, they would not relate to the students in the way that Gillespie suggests, and neither would Thai students expect their supervisors to create such a connected relationship; thus Thai students would not expect supervisors to know much about their personal life or to respect their privacy and opinions. In the current study, learning with caring supervisors was an insufficient condition to enable students to synthesise nursing knowledge into their practice. Other factors, however, also influenced their learning, including *supervisors' expectations* and the *desire to learn* of students, discussed later in this chapter.

On the other hand, *inattentive supervision* plays a crucial role in creating an inappropriate clinical learning environment for nursing students leading to a loss of learning opportunities. The findings of this study are supported by previous studies, in both Thai (Naosuwan et al., 2006) and international (Brammer, 2006; Hsu, 2006; Sharif & Masoumi, 2005) literature. In particular, a recent review paper on students' perceptions of learning in the clinical environment reported that over the last decade, nursing students from different countries perceived that nursing was focused on performing tasks; i.e. they were trained by fitting into ward work to complete tasks (Henderson, Cooke, Creedy, & Walker, 2012), a finding that is consistent with the current study.

Inattentive supervision, including reprimanding/scolding, diverting students' learning by asking for help with tasks, or showing bias, resulted in internal conflict for participants in this study. Participants were unable to argue or show any opposing

reaction, refuse, request, or even express their thoughts to these persons as Thai cultural norms require them to give respect to preceptors/nurses as they are the inferiors of these persons. Thais value preserving social relationships by avoiding confrontation and are less likely to impose on others, “krenjai” (showing deference and respect as detailed in Chapter One), especially in a Thai nursing culture that values the junior-senior system (Naiyapatana, Burnard, & Edwards, 2008). When facing inattentive responses of preceptors or nurses, Thai nursing students are expected to accept what their preceptors/nurses said and hide their feelings, especially the emotions that destroy interpersonal relationships, otherwise, they might not be supported. Attempting to prevent/mitigate difficulties with these persons led them to feel conflicted during their practical placement. Such situations were also found in a qualitative study by Naiyapatana et al. (2008) that revealed most of the students thought that being a first year and adapting to the nursing hierarchy was one of their main stressors. Similarly, another study (Kamdee et al., 2007) reported that nursing students thought their preceptors had lowest caring behaviour in respect to both positive and negative student feelings. Conflict arising from preceptor relationships is not unique to Asian countries with a social hierarchy. A mixed method study that explored the nature of conflict in the preceptorship experience of Canadian undergraduate students and preceptors during their final clinical placement (Mamchur & Myrick, 2003) revealed that the incidence of nursing preceptor conflict was significant and was reported by 24% of students and 17% of preceptors.

Moreover, internal conflict of participants in this study arose over differences in techniques of some nurses/preceptors; participants felt unable to ask for reasons or more explanation from their superiors and were thus left with questions and uncertainty. This finding is consistent with the findings of an Australian grounded theory study (Reid-Searl, Moxham, Walker, & Happell, 2009) that explored the internal conflict of Australian final year nursing students facing inadequate supervision while administering medication in the clinical settings. Their internal conflict occurred from their desire to meet the expectations of the university and of the clinical settings in order to be successfully assessed and able to proceed through the programme, as their grades in the final year were assessed by registered nurses. Their pressure was intensified by the probability of harming patients and their own future employment in the clinical organisation if what was written on their clinical assessment showed insecure practice.

These students also reported little power to question the nurses' techniques (Reid-Searl et al., 2009). In the present study, experienced students tried to adhere to the concepts they had learned, but adapted their performance to practices of the particular setting. However, when encountering differences of nursing diagnosis concepts (see page 1), the participants did not report any strategy to deal with or opportunities to discuss this issue with their supervisors, thus inhibiting the development of assertiveness and critical thinking skills which are desired attributes of nurses.

It could therefore be argued that currently the hierarchical culture of Thai Nursing contributes to lost learning opportunities and inhibits the development of critical thinking and assertiveness skills of nursing students more than it helps and supports them to learn.

Preceptorships are an essential part of learning success in professional education, especially in nursing (Billay & Myrick, 2008). However, consistent with other research (Arkal & Chutchavarat, 2004; Corlett, 2000), preceptors in the present study were limited in their ability to fully support student learning due to workload pressures consequent upon the chronic nursing shortage, the number of students requiring supervision and inadequate communication between practical settings and educational institutes about student learning requirements. As a result some teaching techniques used by preceptors did not correspond with what students had to learn (Arkal & Chutchavarat, 2004). Thus, insufficient preparation for effective preceptorship before practical placement is another important factor that influences the skill development of nursing students. This issue is one of a number of issues that can be addressed by the teaching and learning management of the College.

TEACHING AND LEARNING MANAGEMENT OF THE COLLEGE

The teaching and learning management of the College strongly influences student learning opportunities. While much of the teaching and learning management facilitated the participants developing their nursing skills as detailed in Chapters Five and Six, other aspects discouraged their learning, especially when compounded by *inattentive supervision*. Four aspects warrant further discussion: practical study management, learning facilities, accommodation rules and assessment in the integrated curriculum.

Practical study management

In line with other Thai studies (e.g. Glynara, 2007; Sivadamrongpong et al., 2003), participants in this study thought most of the management and settings for their practical studies facilitated their learning. They had appropriate arrangements about the timing of placements, practical duration, requirements and settings. Such management, when it works well, leads to enough learning opportunities for nursing students to develop their nursing skills. However, there were issues such as short placements and out of sequence practical placements, that the participants thought made them lose opportunities to learn. These problems arose from the attempt to rotate students through multiple settings to ensure they experienced each subject (as detailed in Chapter One). It can be argued that this approach to clinical experience is not congruent with an integrated curriculum.

Of particular concern for the participants was that shorter placements made it harder for the students to adapt themselves to the staff, the patients, and even the routines of the settings, as well as developing enough skills. These findings are supported by many studies (Gabb & Keating, 2005; Levett-Jones, Lathlean, Higgins, & McMillan, 2008; Nolan, 1998; Warne et al., 2010) that confirmed shorter placements are a major issue that reduces nursing students' opportunities to develop their nursing skills. For example, a mixed method study undertaken in Australia and the United Kingdom revealed that such rotations kept nursing students from the continuity (and maybe ordered structure) of clinical practice (Levett-Jones et al., 2008) and therefore of their learning. It is seen as a key influence on their experience of belongingness through "settling in" and "becoming a part of the team". At the start of each placement, students needed to settle in to gain understanding of the routines, terminology, language, values and practices of the settings and to become familiar and comfortable with the staff. This takes at least two to four weeks. With a lack of strong collegial relationships with nursing staff, it was more difficult for students to feel secure and at ease with them. They were unable to confidently engage with learning opportunities through, active and participative learning until they felt settled and comfortable in the clinical environment (Levett-Jones et al., 2008), so it is hard for them to fully develop their nursing skills.

Moreover, in clinical settings, students need time for the building of therapeutic relationships with patients and knowledgeable supervisors. This allows greater access to learning opportunities with effective and regular supervisory discussion. Also, it is possible that students who see the whole episode of nursing care of individuals will have gained a clearer understanding of nurse roles than those who had only a particular time to provide them with segments of nursing care during short placements (Warne et al., 2010). Longer periods of placement in the one setting, rather than a succession of short-term placements are also supported in *The National Review of Nursing Education in Australia* (discussed in Gabb & Keating, 2005).

In addition, opportunities to learn for the participants in this study were impacted by inappropriate practical settings, shortage of access to some procedures, equipment, learning support, and/or cases and by being placed at the same time as other students/groups. All of these issues reduced opportunities to work with patients which is a core element of professional development in nursing (Warne et al., 2010). As well, students have fewer opportunities for learning both through group participation and supervisory interactions (Croxon & Maginnis, 2009). A number of studies conducted on cohorts of nursing and health science students (Allan, 2011; Curran, Sharpe, Forristall, & Flynn, 2008; Cusack & O'Donoghue, 2012) confirmed that small group teaching and learning facilitated the clinical skill development of these students. Therefore, opportunities to interact with patients, groups, and supervisors are important factors that facilitate student learning.

It can be argued that self-confidence and motivation to learn in nursing students can be supported by their sense of “belongingness” to practical settings, feeling accepted as individuals and learners, with sufficient help and support.

Learning facilities

Consistent with the findings of Puttiwanit et al. (2006), in this study, I found that most participants were generally satisfied with learning supports such as the library, laboratory rooms, the Internet, and their dormitories. More than half of the participants, however, thought some aspects of their learning environment should be improved. In particular, the *Project* students (who were many in number) reported that their library

did not have enough textbooks when students were using them for both their practical studies and preparing for the licence test. Others in the normal intake also reported they faced many difficulties in using learning resources of their college. For example, some of the books were out of date, and other learning supports such as the retrieval system of the library and demonstration rooms, demonstration equipment, computers, and the Internet did not fully facilitate their learning. The issue is confirmed in other studies (Glynara et al., 2008; Sivadamrongpong et al., 2003; Sottipolanun et al., 2007). This finding is not surprising, given the major impact of the introduction of a large cohort of *Project* students, additional to the normal intake, with short lead-in time for increasing resources. The one-off nature of the large intake must also have impacted resourcing decisions.

In summary, in relation to teaching and learning management, it can be argued that nursing students take more opportunities to learn when having enough communication between educational institutes and practical settings, enough opportunities to work with patients over a longer period, to participate and interact with supervisors/groups, having good relationship with clinical staff, and sufficient facilitating resources.

Accommodation rules and learning styles

In this study, the participants tried to convey that the rules of living in the College dormitories (outlined in Chapter One) contradicted their learning styles. While some of these rules were put in place to ensure the safety of students in an area of unrest and to encourage learning, perversely the rules may cut across the need of young adults to be self-directing (Lindeman (1926), as summarised in Knowles et al., 2011). In a review of the literature, O'Shea (2003) suggested that not being able to direct their own learning can influence self-directed learning readiness, an essential attribute for developing the skills for lifelong learning.

A descriptive correlational study in Korea revealed that the learning style of nursing students was positively related to their critical thinking ability (Ju An & Sook Yoo, 2008), a desirable attribute of nurses that was evidenced in participants in the current study who reached the fourth stage of the learning process. Moreover, Rassool and Rawaf (2007), reported that when a mismatch between teaching and learning styles has

been found, students demonstrated serious affects such as lack of interest in learning, doing poorly on tests, and becoming discouraged about the course. These might lead them to conclude that they are not good at the subject before giving up. A mismatch between College rules and learning styles might also contribute to those effects. However, descriptive research in Jordan (AlKhasawneh, 2013) and a longitudinal study in Ireland (Fleming, McKee, & Huntley-Moore, 2011) reported that students' learning styles are not stable; they may change when the nursing curriculum shifts from mainly lectures in the early years to more clinical training in the later years; similarly, teaching methods introduced during their course may make nursing students aware of applying learning preferences that enabled them to master the learning objectives of the course (AlKhasawneh, 2013). In reviewing College rules and teaching styles, consideration of the needs of students as adult learners is warranted. A related issue is the relationship between assessment and student learning in the integrated curriculum.

Assessment and the integrated curriculum

Issues around assessment and its impact on student learning arise throughout the findings chapters. To reiterate, in Chapter Five, mention is made of the many requirements to be met and of the impact of pre and post-conferences on availability of time to carry out patient care and practice procedures; in Chapter Six participants reported that completing many requirements did not necessarily facilitate their understanding of the problems of cases when the conditions were rather similar, that it was difficult to learn from other cases presented in pre-conferences when preoccupied with what they were to present, that there was limited time to present their cases, and that the many requirements left them tired and exhausted; while in Chapter Seven participants linked being able to complete their nursing care plans more quickly to having more time to read what they wanted to know about their patients and to apply what they had planned to care. The common thread in these concerns is a preoccupation with completing requirements rather than self-directed learning. Lindeman (1926, as summarised in Knowles et al., 2011) argued that adults are motivated to learn as they experience needs and interests that learning will satisfy. Excessive requirements for evidence of learning may perversely inhibit rather than facilitate learning. It can be argued that the integrated curriculum offers opportunities to review the amount and type of assessment required to demonstrate competence and a focus on the transferability of

knowledge and skills across conditions.

There is some support for this viewpoint in the literature. It is noted that “clinical assignments provide opportunities for nursing students to develop thinking skills vital to the effective delivery of patient care” (Marchigiano, Eduljee, & Harvey, 2011, p. 143). However, in a pilot project that surveyed 51 third year American nursing students, those authors found interesting results. When implementing a journal format of assessment that required responses to 10 situated patients care-related questions the students perceived that they were more able to use their thinking skills compared to using the full format of a nursing care plan when analysing information, determining relevance, making connection, selecting appropriate information, applying relevant knowledge and evaluating outcomes. They also indicated that completing the clinical journal required less than half the reported time required to complete the care plan (Marchigiano et al., 2011).

In another study, Montgomery (2011) implemented a system for student self-selection of clinical client assignments, based on the help and support of instructors, with 57 American nursing students who enrolled in the second half of a four semester course. Most of the students felt their learning needs were better met. They could seek patients who met their criteria while the course objectives were still met. Students expressed increased satisfaction with the clinical experience and an increased sense of responsibility for their own learning process. These studies support a review of the type and amount of assessment in the integrated programme.

In addition to the contextual factors discussed in the previous sections that influenced learning opportunities, *motivation to learn* was a significant condition that influenced the participants’ nursing skill development throughout their course.

MOTIVATION TO LEARN

In this study, I found many internal and external factors associated with the participants’ motivation to learn. Some arose from existing contextual influences, and together facilitated the students throughout their learning process; whereas others arose as a result of specific stage conditions, which helped the students move from one stage to the next. However, sometimes the students felt exhausted and had no motivation to learn.

The following six concepts summarise and discuss with supporting literature why the factors stimulated/interrupted the students learning during their practical studies.

Individual goals and values

In this study, most of the participants' learning was activated by individual goals and values from both internal and external factors. The findings are in accordance with previous research conducted about learning motivation. To exemplify, the finding that students could be encouraged by wanting to be nurses/or hoping they could be nurses, to fulfil their families' wishes is similar to the research findings of Nilsson and Stomberg (2008). Their mixed method study found that wanting to become a nurse was the main motivation for Swedish nursing students to further their studies. Meanwhile, the finding that getting trust or admiration and/or caring from their supervisors facilitated the learning of students in the current study is supported by the work of Bengtsson and Ohlsson (2010) and Chesser-Smyth and Long (2013). They confirmed that learning approaches such as committed teachers giving performance feedback enhanced enthusiasm and learning of Swedish nursing and medical students.

Furthermore, in this study, I found that some participants (seven with high GPA and five with moderate GPA), who hoped to clearly understand about the problems of their patients and how to care for them, paid full attention to their clinical studies. This factor formed the basis of being *interested in case learning*, leading to *desire to learn* (discussed in the next concept). This result is similar to the findings of Bengtsson and Ohlsson (2010) who reported that Swedish nursing and medical students were motivated by focusing on their learning as they had to help and care for clients. They applied two concepts—cursory learning and learning in depth—to clearly understand what they had learned. This finding is consistent with Lindeman's (1926) assumption that adults are motivated to learn as they experience needs and interests that learning will satisfy (summarised in Knowles et al., 2011).

A sense of professional responsibility

Participants in this study were motivated by a sense of professional responsibility toward their patients to learn in detail about the diseases of their patients and appropriate nursing care. These findings strongly concur with an earlier ethnographic

study of Lundberg and Boonprasabhai (2001) that investigated final year undergraduate Thai nursing students studying in a College programme; they found that students recognised they had to provide nursing care based on compassion and wanted to have enough knowledge, skill, and experience to provide the care according to each patient's problems in order to always promote good quality of nursing care. Moreover, the result of the current study also showed the participants respected their patients' rights. This finding is supported by a longitudinal study that found Turkish nursing students believed that patients should have the right to participate in the decision-making process about their treatment. These attitudes reflected that the students recognised and carried out the duty of patient advocacy as they were influenced by nursing values of protecting other persons' autonomy and human dignity (Altun & Ersoy, 2003). Including nursing ethics within nursing courses, therefore, can facilitate nursing students' development of the role of advocate for patients' health and safety which can also be a significant motivation for nursing students to learn in depth.

Feelings of worry and fear

In this study, I found that entering practical placements when *worried and afraid about practising* and *concerned about not understanding case problems* led the participants to make much effort to be ready for their practice and to increase their patients' trust in their competence. These feelings became another significant influence that motivated the students to learn. Phelps (2006, as cited in Schunk, 2012) suggests that emotions can help persons to direct their attention, which is necessary for their learning, a notion supported by an earlier study (Ofori & Charlton, 2002) that found that increasing levels of academic worry led to higher support-seeking and this in turn resulted in the better performance of British undergraduate nursing students. Another possibility is that the development of learning strategies by the novices in the current study occurred to mitigate their worry and fear. As new members of clinical teams and new staff to patients/relatives, they anticipated they might face possible undesirable situations during their practice. Consequently, they tried to adapt themselves to be ready for such conditions. Similar motivational effects have been noted in a Singapore study that reported that Singapore undergraduate students used negative-expectation strategies to prepare themselves for possible failure; thus they planned to direct efforts to prevent possible undesired outcomes of the upcoming events (Lim, 2009). Being worried and

afraid, therefore, motivated the students in the current study to apply many learning strategies to prepare themselves to be able to start and further their practice.

This finding is supported by a United Kingdom study that found fear raised by a certain frequency of reminders about an examination could have a positive relationship with examination performance through a mastery-approach with final year school students. However, if the fear was perceived through threats of test failure, it was inversely related to examination performance because of performance-avoidance and the worry and tension components of test anxiety (Putwain & Symes, 2011). Worry and fear then can lead to both positive and negative outcomes. It is possible that only an appropriate level of worry and fear can motivate learning.

It could therefore be argued that worry and fear about practising motivates nursing students to prepare themselves for their practice and earn their patients' trust, whereas too much worry and fear diminishes their learning motivation.

Supervisors' expectations

In this study, *supervisors' expectations* are a very important influence that motivates further nursing skill development of the participants. This factor affected their self-esteem; i.e. they felt ashamed, unhappy and sometimes low in self-esteem if they were not able to respond to the questions of their supervisors, especially the seniors. They were intensely worried about reprimands/blame and/or punishments by their supervisors and/or the nurses if they could not complete procedures. When moving to the first stage of case learning, not understanding case problems made them stressed about doing pre-conferences. They were not only very worried and afraid that they might not be able to respond to their supervisors' questions, but they were also concerned that patients and relatives were not confident in their competence.

Although this study did not examine self-esteem levels of the participants, a previous cross-cultural study comparing self-esteem of Thai and British nursing students reported that undergraduate nursing students perceived their levels of self-esteem were in the normal range (Sasat et al., 2002). Furthermore, a grounded theory study by Randle (2001) indicated that British nursing students' self-esteem became fragmented during

the process of becoming nurses. She confirmed her results with quantitative data and found that students left the nursing programme with below average self-esteem, even though the majority began the courses with normal self-esteem (Randle, 2003). Also, a recent phenomenological study revealed that when American undergraduate nursing students experienced nursing faculty incivility, it hindered their professionalism interfering in the developing of their self-esteem (Del Prato, 2013). These studies make it possible to believe that the participants, as undergraduate nursing students, would not have high self-esteem, and might have quite low self-esteem, especially when they are in the higher years.

As people monitor their general acceptability to others, self-esteem, across situations and over time, their particular responses and patterns of their behaviours, are dependent on real, imagined, or anticipated acceptance or rejection (MacDonald & Leary, 2012). Being trained under conditions of low self-esteem, it is possible that the participants were motivated to learn by self-esteem concerns. They focused on presenting the learning strategies that met *supervisors' expectations* (discussed in the next section) to protect their self-esteem. This finding is in line with the work of many scholars who have investigated patterns/styles of self-presentation (Baumeister, Tice, & Hutton, 1989; Hermann & Arkin, 2013). They reported that individuals with a high self-esteem scores make use of self-presentation strategies to maximise the favourable impression they might make (self-enhancing self-presentation), but those with a low self-esteem scores behave in cautious or conservative ways (self-protective orientation). Furthermore, a recent survey reported that Chinese students use less enhancement-oriented strategies, but higher protection-oriented ones—a defensiveness strategy. Collectivistic contexts, such as East Asian cultures which emphasise fitting in and not going against social norms and obligations, therefore could affect the motives by which individuals protect themselves by minimising negative self-views or maintaining positive self-views without thwarting other motives (Hepper, Sedikides, & Cai, 2013). This is relevant as the participants of the current study emphasised learning to meet *supervisors' expectations* to avoid their self-esteem being further affected.

In addition, as the results of this study have shown, most of the participants attempted to improve their nursing skills because they needed to meet what their supervisors required them to understand. Thus, another way to understand why *supervisors' expectations*

motivated the students in this study to learn is to utilise the concept of external locus of control. This explains that people who believe anticipated outcomes are more influenced by extenuating circumstances beyond individual control than by the results of how they behave are more likely to conform to external manipulation (Schunk, 2012; Wood, Saylor, & Cohen, 2009). In this study, participants' attempts to learn were motivated in part by not wanting their supervisors who they respected to feel unhappy if they still did not improve their nursing skills, and because they thought they should understand what their supervisors wanted them to learn because it would be useful for them, especially a clear understanding of case problems. This result is in line with a mixed method study that revealed that Filipinos and other Asian students reported higher external locus of control than Whites, and other Asians rated higher external locus of control than Hispanics (Wood et al., 2009). Therefore, it is possible that external locus of control is a significant factor that is linked to the motivation of the nursing students in the present study.

The impact of *supervisors' expectations* on the motivation to learn of participants in this study, on the other hand, can be construed as a positive effect of Thai hierarchical culture. That is, when the students value respecting the supervisor (as they do not want their supervisors to feel upset about their lack of progress in their case learning) (Klausner, 2000), and supervisors' support (because they believe that is good for them) (Klausner, 2000), they make increased effort to learn. It could be argued that these values make it possible for Thai students to continue learning despite encountering the episodes of *inattentive supervision* found in this study.

Supervisors' expectations, therefore, are a powerful influence that facilitates the learning process of Thai nursing students. Supervisor's expectations motivate the students to learn until some are able to develop internally motivated, *desire to learn*, and increased self-confidence. This mechanism differs from that identified in international literature (Gillespie, 2002) where the learning process of Canadian nursing students was facilitated by a "connected student-teacher relationship" (p. 569) in supervision, where-in students felt accepted as mutual persons, valued, respected, and experienced positive self-regard (previously discussed in the section of clinical teaching and learning environment).

Desire to learn

In this study, I discovered that *desire to learn* is formed based on *interest in case learning* together with other factors that concerned the participants, such as high expectations of their supervisors. These motivators led the students to develop specific learning strategies, and to intensify those strategies during the last stage, *discovering how to understand case conditions* (discussed in the next section). The strong desire to learn described by participants in the fourth stage of the learning process is more reflective of an internal locus of control. When the students believed that they have control over their success by the strategies they develop, they are more inclined to engage, expend effort, and persist on tasks to promote achievement (Schunk, 2012). However, at differing times throughout the learning process students encountered internal or conditions that induced a lack of motivation to learn.

Lack of motivation to learn

Several conditions contributed to feelings of exhaustion and lack of motivation to learn at differing times in the participants' course of study. These included participants' feelings that they did not want to study nursing and their responses to encountering inhibiting and/or interrupting conditions during their practical placement. In particular, facing inattentive responses of some nurses/preceptors affected their motivation to learn throughout their nursing course. The students felt *upset and discouraged about practice, tired and exhausted with practising. They left unclear issues and still focused on providing basic nursing care.* These effects occurred in each stage of the learning process and thus *lack of motivation to learn* arose in a cyclic way throughout their learning processes.

The findings are comparable with those of a cross-sectional study that revealed 47.2% of first year Italian university students did not choose a nursing degree because they lacked interest in nursing (Dante, Rizzi, Ianderca, & Palese, 2013). Some of the participants in the current study were not interested in learning because they perceived the content as difficult, a finding in line with an open-ended response survey in United States that linked lack of interest in learning to poor results in assignments and failures in Pathophysiology (identified as a difficult subject in the literature) (Dunn, Osborne, & Rakes, 2013). Feelings of fatigue expressed by participants when undertaking lengthy

placements and completing many case requirements is a finding shared with the qualitative work of Gibbons, Dempster, and Moutray (2008), who reported fatigue from the demands of a nursing programme in the final year of British nursing students.

Participants' feelings caused by them encountering inhibiting and/or interrupting conditions that influenced them during their practical placement are similar to the results of a study by Hanifi, Parvizy, and Joolae (2013). They also disclosed that inappropriate communication or unfriendly behaviours that happened with students in settings, nurses' inattention, lack of learning opportunities, or just performing routine nursing activities could decrease students' motivation. In addition, enduring disrespect, insult, or humiliation from nurses damaged students' professional identity and in some instances made them think about leaving the nursing field (Hanifi et al., 2013). From these results and the present findings, it is to be noted that although inappropriate clinical learning environments can be caused by other health professional staff, it is nurses and especially the nurse-student relationships, that can be strongly demotivating and have much influence on the quality of clinical learning of nursing students.

Furthermore, the findings of the current study also revealed that being very worried and afraid led the participants to have no motivation to learn. For example, they did not want to try procedures and/or were not motivated to further their skill development (detailed in the code of *very nervous and worried to try procedures*, Chapter Five). It is possible that in some instances, the participants felt learned helplessness. This means that when these students felt they had no control in situations, they might do nothing, or learn more slowly than those not exposed to uncontrollability (Schunk, 2012). Thus, when nursing students become too stressed, motivation rapidly declines. This was also revealed in a review study where unpleasant clinical experiences was a significant factor that led to international nursing students leaving their nursing course (Eick, Williamson, & Heath, 2012).

In point of fact, the findings of this study clearly show that low motivation could be altered by the factors that positively influenced the participants to learn and so they were able to continue. When advancing through the next stage(s), the factors that made the students less motivated to learn seemed to be less influential on their skill development. Their ability to adjust to the programme demands with decreasing stress

levels contrasts with the results of a mixed method study which found that, living with stress, especially during clinical practice badly affected undergraduate American nursing students, who had moderate levels of emotional exhaustion and burnout, low levels of depersonalisation and secondary traumatic stress (Michalec, Diefenbeck, & Mahoney, 2013).

Even though attentive supervisors could enhance enthusiasm and learning in nursing education to some degree, they could not make the final learning goal possible. The current study showed that participants who were motivated by *supervisors' expectations* paid more attention to their clinical practice, but did not accomplish the full process of learning reflected in the fourth stage of the substantive theory. Instead, intrinsic motivation had to be developed continuously; the previous motive(s) could form the basis for the next one(s). Motivation occurs and exists as a significant influence, especially the *desire to learn*, to drive the students to reach their learning goals.

It can therefore be argued that motivation to learn (particularly, developed when nursing students have self-confidence in practising) encourages them to think critically and contributes to their academic success. Whereas, lack of motivation to learn is a significant condition that contributes to nursing students' failure to progress or slows the accomplishment of their clinical learning.

In this study, I found that all of the conditions discussed so far lead to the learning strategies used for the two different skill development phases of the participants, **continuing practical studies**, and **learning how to provide nursing care**.

LEARNING STRATEGIES USED FOR CONTINUING PRACTICAL STUDIES

During the **continuing practical studies** phase, the participants applied several learning strategies to develop their nursing skills, but they only focused on improving basic nursing skills and seeking out what they should do to care for their patients. Four concepts are used to discuss why the strategies employed helped them to begin learning to be nurses.

Building up self-confidence

Building up self-confidence was the first strategy that the participants who were very worried and afraid used to prepare themselves to be ready for their practice. For basic skill development, the students applied many strategies to control their nervous feelings and make themselves more confident to try. To care for their cases, the students tried to seek out as much information about their cases as they could in order to respond to the questions of their supervisors during pre-conferences.

The findings of the current study are consistent with research projects undertaken with health science students. For instance, one mixed method study revealed that even though Netherland medical students' learning goals and self-reported learning outcomes during their early clinical placements closely matched the formal educational goals set by the medical school, their main learning outcomes were different. The students emphasised gaining the skills of communication, empathy, and reflection on performance, professional behaviour, teamwork and future professional development. Some of them also formulated learning to deal with emotions and difficult situations as an extra learning goal and learning outcome (Esther, Sanneke, Roland, & Raymond, 2011). This implies that the students need to prepare themselves to be ready for their practice before paying attention to developing their skills. Therefore, nursing students who start their clinical studies in such environments need to know how to prepare.

Moreover, the participants in the present study focused on applying strategies relating to their learning styles to build up self-confidence. These findings are supported by studies that investigated cohorts of nursing and medical students (Kolovelonis, Goudas, & Dermitzaki, 2012; Roberts, 2010). To exemplify, a literature review study revealed that British nursing students could learn by being able to observe or listen to other's or peer's experiences, which is known as vicarious learning (Roberts, 2010). An experimental study found that fifth and sixth-grade Greek medical students who combined self-talk with either process goals or performance goals did better on a new motor (dart-throwing) skill than students in the goal only and control group conditions (Kolovelonis et al., 2012).

The build up self-confidence strategies the participants employed also emphasised wanting to experience what they had to practise at settings; they wished to be familiar with it first, especially by having opportunities to observe how to perform particular procedures as well as knowing how to provide nursing care for their clients. According to Lundberg (2008), clinical confidence cannot be learned in a classroom, rather mastery of newly learned skills and experiencing success takes place in clinical settings and one strategy to build self-confidence of clinical nursing students is clinical simulation. It could be argued that experiencing nursing care activities in clinical simulation allows them to practice new nursing skills with opportunities for repetition, feedback, evaluation and reflection until they achieve familiarity (Bland et al., 2011). This is confirmed by many previous studies (Bambini et al., 2009; Blum, Borglund, & Parcells, 2010; Foronda, Liu, & Bauman, 2013) assessing the effectiveness of clinical simulation in educating undergraduate nursing students. However, a survey study found that only approximately half of American undergraduate nursing students agreed that the simulated learning experiences would transfer to a real clinical setting (Feingold, Calaluce, & Kallen, 2004). Therefore, not all confidence built in a simulation unit is transferred to the real clinical settings. Also, a systemic review of the contribution of high-fidelity simulation (HFS) to nursing students' confidence by Yuan, Williams, and Fang (2012) found that there was insufficient evidence to support the notion that HFS enhanced nursing students' confidence and that more quantitative research is required. Nevertheless, clinical simulation warrants further consideration by nursing instructors as a strategy to assist build student confidence.

Although, some studies indicated that nursing students who were prepared for clinical placements felt reduced anxiety and increased self-confidence to practice (Bennett, Jones, Brown, & Barlow, 2013; Haskvitz & Koop, 2004), there is no clear evidence that the supervisors were interested in the strategies nursing students might use to build their self-confidence. The Thai college nursing students are prepared before their clinical placement (detailed in Chapter One), but the programme may not deliver what the students really need, and there has been no review of the outcomes of the preparation. Hence, it is to be noted that the students might gain full advantage if their strategies are integrated to the programme operated for their clinical study preparations.

Beginning practice with help and support

In this study, the participants needed a lot of help and support to facilitate their initial learning of nursing skills during both the early stage of procedure training and case learning. The people they could ask for help and who were most responsive with help and encouragement were friends, supervisors, and seniors. In particular, the students helped and supported each other, especially friends placed in the same group.

The help and support from friends and seniors found in this study is supported by studies on peer learning (both between friends and junior-senior matching) between nursing students (Goldsmith et al., 2006; Loke & Chow, 2007; Paenkaew et al., 2002; Roberts, 2009) and studies relating to learning processes (Christiansen & Bell, 2010). They revealed peers facilitated nursing students' learning as they provided a non-threatening learning context in which to learn and rehearse before working with their supervisors. With the empathy and friendship of a peer relationship, the students felt safe to ask questions and disclose their areas of uncertainty (Christiansen & Bell, 2010; Roberts, 2009). This initiated a pursuit of what they wanted to learn, resulting in development of their nursing skills (Christiansen & Bell, 2010). Thus help and support from friends and peers was a significant resource that facilitated nursing students' learning, and this parallels the supportive experiences reported by the Thai participants.

Applying basic case learning skills

In this study, I also found that being concerned about completing their nursing care plans and being prepared for pre-conferences forced the participants (novice case learners) to seek out as much information about the problems of their cases and how to care for them as they could (the strategies listed in Table 6.1). However, because they were not able to analyse how the diseases of their cases affected their patients, the students did not know whether the data they took from sources related to their problems or not. Similarly, they did not know which information was more important for their cases.

Applying basic case learning skills was a significant strategy for the novice case learners in this study. However they could not organise relevant information to identify the main features of the problems. Schunk (2012) states that novice learners try to

translate the information they access into lists but it is usually too much for them to manage and so they can only apply elements superficially. They then attempt to apply rules to guide themselves (Benner, 2001). The findings are also in line with a hermeneutical study by Orland-Barak and Wilhelem (2005). Through analysing novice Israeli nursing students' stories of practice to explore their perspectives towards learning to become nurses, they revealed that the students focused on reflecting on their performances of nursing procedures provided for their patients or the events related to them they could remember, especially their successful or unsuccessful performances. They almost completely excluded patients' reactions towards their caring. Students also detailed clinical findings by replicating the report of patient conditions such as patient's medical history, physical examination, and maybe laboratory results. When students apply strategies that are inappropriate, they do not achieve relevant caring for patients. This is because the basics/rules used to guide the performance cannot tell them the most relevant nursing care they need to provide in the real situations (Benner, 2001).

Facilitating psychomotor skills by frequent rehearsal and ongoing practise

This study revealed the participants attempted to gain experience on basic nursing skills by *becoming familiar through performing procedures*, and *seeking opportunities to learn* even when they encountered difficulties from inattentive preceptors/nurses.

The effectiveness of frequent rehearsal of psychomotor skills was demonstrated in an experimental study that found that American undergraduate nursing students who had brief monthly practices on CPR psychomotor skill performance for six months showed adequate volume ventilation. They also maintained their performances with monthly practice over the experimental (12 month) period. In comparison, the control group (no practice beyond their initial training experience) had a significant loss of compression skills after nine months (Oermann, Kardong-Edgren, & Odom-Maryon, 2011). Moreover, the present results are supported by a quasi-experimental study of the effects of integrating psychomotor skills through out a Nursing curriculum, which reported that situated authentic contexts with opportunities for immediate application, feedback and formative rehearsal developed procedure competence (DeBourgh, 2011). This concurs with the concept of clinical simulation as a learning strategy for undergraduate nursing

students (previously discussed in the concept of *building up self-confidence*) (Bland et al., 2011) that could certainly develop their psychomotor skills (Bambini et al., 2009; Stroup, 2014). Therefore, frequent and ongoing practice, especially in clinical settings, maintains or improves the basic nursing skills of nursing students. Furthermore, with complex care situations in the present that call for nurses who are competent in multiple nursing skills (Lee, Lee, Wong, Tsang, & Li, 2010), and where there are less opportunities to practise, and negative feelings of nursing students related to practical placement as found in this study, clinical simulation could be one option applied as teaching and learning strategy for nursing students.

When further motivated by positive learning motivation, especially *supervisors' expectations* and *desire to learn*, the participants in this study made use all of the strategies employed during the first phase to develop more advanced strategies for learning how to provide nursing care.

STRATEGIES USED FOR LEARNING HOW TO PROVIDE NURSING CARE

When moving to the phase of **learning how to provide nursing care**, the participants applied two main learning strategies—*modifying learning experience* and *paying attention to root problem analysis based on all information*—to develop their nursing skills. The strategies led them to advance their nursing skills by beginning to analyse the significant problems of their patients to gain a clear understanding of them and how to care for the patients. Two concepts summarise these strategies and discuss why they are effective.

Modifying learning experience

Because of focusing on meeting their *supervisors' expectations*, participants attempted to modify their learning experience to learn about their cases during the stage, *modifying the strategies for case learning* (the strategies listed in Table 7.1). This was especially the case for those with moderate-high GPA who were motivated to clearly understand from the outset of their studies. By changing some learning behaviours, most of them were able to analyse the significant problems of their patients more competently and to provide them with corresponding nursing care.

However, their self-reports show a change in the thinking skills they brought to their approach to care with scope development of evaluation as well as rule application. The development of critical thinking skills is very important for nursing. Critical thinking has been studied and categorised based on two instruments, California Critical Thinking Skills Test (CCTST) of Colucciello (1997) and Facione and Facione (1997) and the California Critical Thinking Dispositions Inventory (CCTDI) of Colucciello (1997), Facione and Facione (1997) and Facione, Sanchez, Facione, and Gainen (1995), show that the critical strategies most of the participants used are initial analysis and truth-seeking. This means the student showed partial connections from the evidence they could observe from their patients to their theoretical knowledge base to provide them with corresponding nursing care.

These findings are in line with literature that reported overall the critical thinking ability of nursing students is reported as a weakness (Shin et al., 2006; Suliman & Halabi, 2007; Zhang & Lambert, 2008). One possibility is participants enter programmes with rather low learning competencies (Ariyanon et al., 2008) and/or have quite low GPA during their nursing course (Thepworachai et al., 2008). Particularly, their critical thinking and problem solving skills are lower than other skills (Glynara et al., 2008). A second possibility is that the participants improve their skills during the stage of *modifying the strategies for case learning* because of *supervisors' expectations*, as according to Dag (1997) and Abaan, Bulut, and Cihangir (2003) (as cited in Yılmaz & Kaya, 2010), externally controlled persons have less motivation and/or are less capable of problem solving, so these students' nursing skills developed less. It is possible though that attempting to meet their *supervisors' expectations* (external control) means the students pay more attention to what their supervisors wanted and make some improvement. This was limited though as Gillespie (2002) found that when students focused on "getting it right" and pleasing their supervisors, the possibility of synthesising knowledge related to what they had to learn during their clinical practice did not increase. All of these explanations could be relevant to why most students in the present study did not fully develop the strategies to clearly understand the problems of their patients and how to provide nursing care for them in this stage.

The findings on having fewer learning opportunities are also supported by the work of Chan (2013) (as previously discussed in the concept of *clinical teaching and learning*

environment). By applying a systematic review of 17 studies (one from Thailand), during 2002-2011, Chan found that students who tried to avoid conflicts, were aware of tradition seniority systems, and were afraid of making mistakes were less likely to speak out and think critically. *Avoiding trouble* (or developing difficulties with nurses/preceptors) also prevented the students in the current study from attempting to think critically. In particular, they feared to ask for more explanations about unclear issues. Chan (2013) too revealed that the nursing educators who did not value and trust students' opinions enough were not open to their challenges. They were inflexible, unsupportive, unapproachable, not open-minded teachers due to holding their own strong hierarchical beliefs and could not facilitate students' critical thinking. However, the Thai instructors did not seem to always be aware of their lack of acceptance of students as mutual persons which Gillespie (2002) reported was fundamental to a connected student-teacher relationship. The result was *inattentive supervision* which not only lowered self-confidence and motivation to learn, but also did not facilitate critical thinking as the participants explored possibilities about how relevant information explains the problems of their patients which then led to corresponding nursing care activities.

Nevertheless, according to the key assumptions about adult learners of Lindeman (1926, as summarised in Knowles et al., 2011), this study showed that the students began to be adult learners as they attempted to make use of their learning experience as the richest resources to develop their nursing skills. With unsupportive learning environments for adult learning as discussed above and lack of other adult learner characteristics (discussed in the next concept), however, their nursing skill development is limited.

Paying attention to root problem analysis based on all information

The present study revealed that some participants with moderate-high GPA who had *desire to learn* did develop effective strategies (listed in Table 7.1) over the stage of *discovering how to understand case conditions* to clearly understand the problems of their patients and what nursing care they needed or what additional information they had to find in order to identify the problems. Based on *desire to learn*, and perceiving they could understand the problems of their patients and how to provide nursing care for them by understanding the pathologies, the participants tried to analyse these to find out

the roots of their problems. According to Bandura (1991), “when people make self-satisfaction or tangible benefits conditional upon certain accomplishments, they motivate themselves to expend the effort needed to attain the requisite performances” (p. 256), so self motivators contribute to performance accomplishment, especially “on complex tasks that make heavy attentional and cognitive demands, self-satisfaction with personal progress toward challenging standards provides a positive motivational orientation for performance accomplishments” (p. 263). Consequently, the student success promotes their motivation to learn, resulting in contributions to their future self-regulation of learning. Motivation is closely linked with self-regulation and these influence one another. Persons will try to engage in self-regulatory activities because they believe that this will help them. More highly competent persons will sustain their motivation and self-regulation to attain new goals, so self-regulation can promote learning (Schunk, 2012). The success the students in this study perceived, in turn, led them to make more and more self-regulated effort to improve their nursing skills to achieve their ultimate goals. The development of this is, therefore, very important for student learning in clinical settings.

The learning style of these participants can also be partly explained by the characteristics of adult learners. Besides, making use of their learning experience as the richest resources for their learning (as previously mentioned), Lindeman (1926, as summarised in Knowles et al., 2011) also postulated that adults are motivated to learn what they most need or are interested in. They focus on learning what can develop their competence to achieve their full potential in life, and then take responsibility for their own learning. Moreover, just as affective self-reaction enacts behaviour change, skill acquisition is necessary for self-regulation (Burke & Mancuso, 2012). Needing to clearly understand the problems of their patients and hoping to achieve the nursing care led the students in this study to develop a range of strategies to accomplish their goals.

Apart from analysing the pathologies to find out the roots of their patients’ problems, *desire to learn* led the participants to attempt to consider all information that might cause or be related to the problems. According to Facione et al. (1995), this reflects that they thought about the problems based on the critical thinking dispositions of systematicity and maturity. It means they searched for the significant problems systematically by their critical thinking, and they then made their decision based on

standards, context and evidence, which precluded uncertainty. On another aspect, as experienced nursing students, they could identify the main features of the problems based on their knowledge. They were more careful to analyse the problems at a deeper level, leading to an increased value on strategies they applied (Schunk, 2012). The strategies the experienced students used as critical thinkers in the current study contributed to their success. Even the second year participants, if they had *desire to learn* or applied critical thinking strategies were more likely to be able to specify the right nursing diagnoses for their cases and the nursing care activities they should provide. The findings are supported by the work of Chan (2013) that revealed the components of critical thinkers: gathering and seeking information from a wide range of sources before analysing the situation and determining a solution; considering all aspects of the information and context; understanding and discriminating data; and linking information together to synthesise appropriate decisions or solve problems. Finally, critical thinkers are able to put knowledge/theory into practice; they can understand the big picture situations and predict upcoming events and know what to do next.

If considering the findings of the current study in relation to the concept of simulation as a learning strategy in the education of undergraduate nursing students (Bland et al., 2011, p. 668), the findings showed the participants tried to make use of all information found in appropriate scenarios (incorporating an authentic representation of reality) to integrate the complexities of practical and theoretical learning. With opportunities for repetition, feedback, evaluation and reflection offered by simulation (consistent with participants' attempts to analyse the roots of their patients' problems and consider all information that might cause or be related to the problems), they could clearly understand the problems of their patients and what nursing care they needed. It is confirmed that the concept of simulation matches all attributes of adult learners (Bland et al., 2011), so nursing students could improve knowledge acquisition and critical thinking (Lapkin et al., 2010; Stroup, 2014). Therefore, developing nursing skills through the critical thinking of students, based on the aspects of adult learners, can lead them to academic success. However, according to Lapkin et al. (2010), there is insufficient research evidence about the effectiveness of using high-fidelity human patient simulation manikins (HPSMs) in the teaching of clinical reasoning skills to undergraduate nursing students. Consequently, it could be an option to facilitate nursing

students to develop *some* required nursing skills for professional nursing and would require additional educational development for instructors.

THE CONTRIBUTION OF THE SUBSTANTIVE THEORY TO AN UNDERSTANDING OF PASS RATES

As stated earlier in the chapter, a substantive theory aids understanding and action in the context in which it was developed. The study arose from expressed concern as to why nursing students could not integrate theoretical knowledge into clinical nursing care, which was the basis of the licence test items; it was undertaken at a time in which pass rates in the external licence exams of graduates across the 29 campuses of the College had been low for nearly a decade; and in the context of a government initiative (the *Project*) to address chronic nursing shortages in the southern provinces of Thailand that were exacerbated by political unrest.

Through the students' perspectives on how they learned to provide nursing care for patients in practical settings, in this study, I discovered significant findings. Having enough learning opportunities and *willing supervision* develops the nursing students' self-confidence in practising and learning motivation. Feelings of worry and fear, a sense of professional responsibility and *supervisors' expectations* are important influences that motivate nursing skill development of the participants. The ability of some students to transition from learning in order to meet *supervisors' expectations* to an internal *desire to learn* marked those students as successful adult learners who demonstrated critical thinking skills, the ability to integrate theoretical knowledge into the care planning for their patients, and to transfer their knowledge to other nursing care situations. Thus seven of the eight 4th year participants who had strong internal learning motivation and accomplished the full process of **Developing Effective Strategies for Nursing Care**, passed all eight exams for the licence test, while the remaining student passed seven exams in a year in which the overall pass rate in the licence test for the College across its multiple campuses was 36.42%. Table 3.1 details the pass rates of all participants on their first attempt at the licence test. Those participants in the third year of study who, at the time of data collection, had reached the fourth stage of the learning process also passed the licence test when they sat for the first time in the following year.

Interestingly the pass rate for the College over all its campuses that year (2012) was

75.56% (Thailand Nursing and Midwifery Council, 2012b) and 92% in 2013 –the year that the 2nd year participants first sat the licence examinations (Thailand Nursing and Midwifery Council, 2013a). The latter group sat only six examinations as a result of merging of knowledge fields by the Nursing Council; Elderly Nursing was combined with Adult Nursing, and Obstetrics Nursing was combined with Mother-child Nursing (Thailand Nursing and Midwifery Council, 2013b). It seems likely that external factors such as possible refinement of the test-bank of items for the licence examinations in 2012 and reducing the number of knowledge fields tested in 2013 contributed to the higher pass rates in those years. However in 2014, the pass rates for the College again fell to 46.15% (Thailand Nursing and Midwifery Council, 2014), for reasons that are not currently understood.

It is understandable that the findings in this study revealed the students who had high-moderate GPA had stronger motivation to learn than those with low GPA. This important condition leads to differences in the licence pass rate. That is, 100% of the students with high GPA passed, whereas the students with moderate GPA were more likely to pass than those with low GPA. Some participants with low GPA did pass and a few passed the majority of subjects in their first attempt at the licence exam, especially the students in the normal programme (detailed in Chapter Three). While the cut-off level for GPA of the *Project* group was lower than that of the normal intake, their achievement was also affected by the size of that intake which resulted in loss of learning opportunities compared to those in the normal programme once the *Project* intake had completed the programme.

STUDY LIMITATIONS

In this study, I explored the learning processes of undergraduate nursing students who studied within one setting of the Thai college programmes. However, as is the case in all such qualitative studies, there are some methodological and other limitations that need to be taken into account. For instance, it is not possible (though not desirable either) to be highly specific or even concerned about the external validity of the study. That is, this qualitative and grounded study does not lead to generalised or causal inferences in the way that a quantitative study might. Instead, it offers theoretical propositions within a substantive theory that sufficiently reflects the occurring realities

and a range of conceptual explanations that frames these realities. In this way, the participants, i.e. Thai student nurses across a number of different year groups in one setting, have provided a significant amount of rich and extensive data that has enabled a comprehensive explanation of their realities and the strategies that they used to resolve their concerns.

The thesis's generalisability is therefore reflected in the argument that the findings are unique to the particular cohorts of Thais students used in the study, their circumstances, and their cultural backgrounds. Furthermore, although theoretical sampling was applied to capture the multiple aspects encompassing the experience being researched, it must be noted that the participants were recruited from only one particular location. Transferability, therefore, is possible to the degree that other contexts have similarity to the setting represented by findings.

Other limitations include a variety of everyday restrictions or boundaries that are commonly experienced in any study where the culture and language of the researcher and the research participants is different than the written language used in the study. Henceforth, data gathering and analysis was done in the Thai language, and then carefully converted into English. This difficult process involved a great deal of effort because, as previously noted in the thesis, some Thai words do not always easily convey their 'true' contextual and cultural meaning in English. In addition, at the time data were collected, the setting area had severe unrest. Due to this security issue, I could not observe the clinical practice of some participants and was thus unable to compare the interview data of those participants with observations in clinical practice. Consequently, the triangulation process of data collection was not able to be completed for these participants.

RECOMMENDATIONS

To promote nursing students to develop their full competency as early as possible, nursing teaching and learning management should be arranged based on the improvement of the four following aspects.

NURSING EDUCATION

1. Because feeling worried and afraid about practising drives nursing students to make increased effort to prepare themselves to be ready for their practice, before each clinical placement, practical study management should enhance their theoretical knowledge with an authentic simulation programme based on the concept of simulation as a learning strategy in the education of undergraduate nursing students (Bland et al., 2011). It should include enough constructive feedback, as well as encouraging them to rehearse enough nursing skills, based on the strategies they apply to build up both their level of skill competence and self-confidence.
2. Because good two way communication between educational institutes and practical settings will help nursing students to take more opportunities to learn, practical study management should promote an effective liaison system about what the students have been taught and what they need to develop during their practical training.
3. Because nursing students take more opportunities to learn when they have enough opportunities to work with patients and to participate and interact with supervisors/groups, clinical placement should be introduced earlier so students have enough time for training and development of their learning strategies, leading to improved nursing skills.
4. Because the sense of “belongingness to practical settings” develops self-confidence in practising and motivation to learn, nursing students should be placed for longer periods to have enough time to adapt themselves to settings, to establish good relationships with clinical staff, and be accepted as a part of a nursing care team.
5. Because the critical thinking skills of nursing students can be better developed when they have self-confidence and motivation to learn, supervisors should educate them through relationships that show acceptance of the students as individuals and learners and provide them with enough help and support.
6. Because the value of respecting their superiors/supervisors and their support can be one influence that made nursing students’ learning possible in difficult circumstances, nursing educational institutes need to reinforce these values as their core culture and encourage their students to preserve it in order to make their learning effort as successful as possible.
7. Because help and support, especially from friends and seniors can be significant resources that facilitate nursing students to develop nursing students’ self-confidence in practising and motivation to learn, nursing educational institutes should encourage the

developing of a formal system of junior-senior support/peer learning. In particular, students with good GPA who achieve well should have opportunities to help the students with lesser competence.

8. Because preparing well is a strategy used by senior students to maintain their self-esteem, placing senior and junior nursing students together would bring benefit to both groups. The seniors would increase their learning by following up on any gap in their knowledge/skills (based on their self-concept) and the juniors would have seniors who facilitate their adaptation to practical studies with less difficulty, especially case learning, and then advance to the next stage(s) as early as possible.

9. Because having sufficient facilitating resources is an important condition for nursing students being able to take more opportunities to learn, nursing educational institutes should encourage such self-directed learning as adult learners by providing them with excellent learning resources and environments.

10. Because a sense of professional responsibility is one source of motivation to learn for nursing students, nursing teaching and learning management should include nursing ethics in the nursing curriculum from first year onwards in undergraduate nursing programmes.

11. Because being tired and exhausted with practising influences lack of motivation to learn, leading to failure to progress or delayed accomplishment of learning, nursing teaching and learning management should be concerned about balancing clinical requirements to maximise learning without over assessment.

12. Because high GPA nursing students are successful in developing nursing skills and pass the licence test whereas moderate GPA nursing students are more likely to achieve the full process of developing nursing skills and pass the exam, PBRI institute should change the policy for nursing student recruitment by increasing GPA cut off point for entry.

NURSING PRACTICE

1. Because the hierarchical culture of nursing influences students' opportunities to learn and develop their assertiveness skills, clinical staff should be aware of what the students have to learn and promote the development of a sense of "belongingness". These strategies increase students' self-confidence in practising and their motivation to learn.

2. Because having enough opportunities to work with patients facilitates effective practical learning, clinical teaching environments should be managed to provide them

with enough opportunities to learn.

3. Because having opportunities to provide their patients with the best care they could supports self-confidence in practising and their motivation to learn, clinical teaching environments should encourage nursing students to do holistic care, based on the support of good models of patient care of supervisors/clinical staff.

NURSING RESEARCH

1. Because having enough learning opportunities based on being accepted as individuals and learners develops nursing students' self-confidence in practising and learning motivation, leading to critical thinking and academic success, further nursing research should investigate how to facilitate nursing students to progress through the last stage of the learning process as early as possible. The research should be an action study to test the key propositions postulated in this study based on the Thai college integrated nursing programmes.

2. Because self-confidence in abilities to care for patients is the significant attribute of nursing students to be ready for their practice and develop nursing skills, further nursing research should examine their self-confidence both after experiencing clinical simulations and during the early stage of each practical placement in order to provide them with appropriate help, which leads to a foundation for knowledge acquisition and successful implementation of newly acquired skills.

3. Because lack of motivation to learn is a significant condition that slows nursing students' progress through the full process of their skill development, further nursing research should develop learning motivation diagnosis instruments for students studying in the Thai college integrated nursing programmes. The instruments should identify the student motivation levels and determine when they need this particular support during their learning process.

CONCLUDING REMARKS

A substantive theory that is structured in terms of conditions, actions/interactions and consequences is open to change when there are changes in conditions. The impact of the *Project* has had far-reaching consequences both on the participants in this study and potentially on those who follow them. For the cohort of students in the *Project* and those in the normal intakes who studied at the same time as the project students, the

learning environment was heavily impacted by the large student numbers; in particular, on the availability of learning resources, the availability and workload of instructors, and an overload of students in clinical practice settings where staff were already under pressure due to nursing shortages. All of these conditions impacted on opportunities for student learning and their motivation to learn as detailed in Chapters Five and Six.

Once the project students completed their study and were employed in the Southern border provinces of Thailand, the conditions under which future cohorts of students in normal intakes would study could be predicted to improve, as there would be increased learning resources, reduced workload burden for instructors and fewer students in clinical settings. The staffing shortage in clinical settings in that region will have been addressed, although it will be heavily weighted with newly graduated nurses. However the “culture” of preceptors is unlikely to have changed. It would be interesting to explore the experiences of a new cohort of students with respect to their learning conditions and the impact on their motivation to learn.

In this study, I found unique findings strongly related to the concept of *motivation to learn* that emerged from the Thai hierarchical culture. Although most learning in the cohort of Thai nursing students is facilitated by *supervisors’ expectations* (as students value their support and try to please these persons they respect), they cannot achieve their ultimate learning goals. There are many aspects of the culture that limit students opportunities to learn. The nursing culture that has evolved within the Thai hierarchical culture has a strong influence on the learning processes of Thai nursing students. It is very difficult to develop/maintain high learning motivation in the learning environment of this culture. The students do not feel accepted as individuals and learners because Thai culture does not respect inferiors; in contrast, they have to know how to conduct themselves when working/contacting with supervisors/nurses who are their superiors so as to show respect to them. In regards to this issue, the students had to face many situations that made them upset and discouraged to learn. This also led them to feel less confident in practising in settings they perceived as unsafe. When they felt uncomfortable about participating, their motivation to learn and their learning declined. Learning within the Thai nursing culture, therefore, made it more difficult for the nursing students to develop the critical thinking and assertiveness skills that are necessary for their profession. As the culture values respecting superiors and avoidance

of confrontation, the students were very worried and afraid of thinking/doing things differently because they believe their superiors/supervisors gave them the right and good direction. Also, they were reluctant to develop the skills and capacity of interpersonal communication relating to refusing, requesting, and expressing their thoughts as they did not wish to upset others. However, *supervisors' expectations* could motivate the students to learn until some students were able to develop internally motivated, *desire to learn*. This facilitated the learning process of the students, so they achieved their academic success.

The challenge for the future is to find ways of building on the strengths of the hierarchical structure of Thai culture to further support student learning and motivation in this context.

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Appendices

Boromarajonani College of Nursing, [REDACTED]
Nursing Care Plan Form

Student's name.....
ID Number..... Programme..... Year of study.....
Paper's name.....
Instructor's name.....
Ward..... Hospital.....

Section A: Personal Information

Client's name..... Age..... Marital status.....
Nationality..... Citizen..... Religion..... Career.....
Level of education..... Family's income/month.....
Address.....
Date of admission..... Ward..... Bed.....
Duration of student's assignment.....
*Father's name..... Level of education.....
Career..... Family's income/month.....
*Mother's name..... Level of education.....
Career..... Family's income/month.....
*Only for the pediatric client

Section B: Information related to the client's health

Chief complain.....
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Present illness history.....
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History related to labour/ Growth and Development (applied only for pediatric nursing)

Growth and development (theories)	Growth and development of the client	Immunisation history	Nutrition history	Summaries

Information related to the 11 Gordon's functional health patterns

Admission V/S:

Temp.....C Pulses...../min Rhythm.....
Respiratory Rates...../min BP.....mmHg
Body Weight...../Kg Height.....cm

(In the following section, please include the information related to history taking, physical examinations and laboratory results according to each pattern)

1. Health Perception Health Management Pattern

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2. Nutritional Metabolic Pattern

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3. Elimination Pattern

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4. Activity Exercise Pattern

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5. Sleep Rest Pattern

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6. Cognitive-Perceptual Pattern

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7. Self-Perception-Self-Concept Pattern

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8. Role-Relationship Pattern

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9. Sexuality-Reproductive

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10. Coping-Stress Tolerance Pattern

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11. Value-Belief Pattern

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Physical examinations of each system

Body weight.....kg Height.....cm

Vital signs.....

General appearance

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Skin

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Head

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Eyes

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Ears

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Nose

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Oral cavity, neck, teeth

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Cardiovascular and circulatory system

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Respiratory system

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Digestive system

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Neurological system

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Elimination system

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Musculoskeletal system

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Reproductive system

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Laboratory result investigations

Date	Laboratory types	Laboratory results	Mean ranges	Result interpretation

Section C: Analysis of case pathologies compared to theories

Client's diagnosis.....

Disease's Definition.....

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Client (the information related to sign(s)and symptom(s)/client's problem(s))	Theories (the explanations of client's problems)

Section D: Doctor's treatments

Date	Order for one-day	Reason explanations	Date	Order for continuous	Reason explanations

The explanations of treatments during student's caring for the case

Date	Treatments/medications/dose and drug administrations	Drug actions	Side effects and cautions	Nursing care

Section E: Present sign(s)/symptom(s) during student's caring

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Summaries of nursing diagnoses

Nursing diagnoses	Sequence of client's problems/nursing diagnoses		
	Date.....	Date.....	Date.....

Section F: Nursing care plan (date).....

Assessments		Objectives/Evaluation criteria	Nursing care activities	Rationale for nursing care	Evaluation
Support data	Nursing diagnoses				

Client's self-regulations

Client	Relatives

References:

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MASSEY UNIVERSITY
COLLEGE OF HEALTH
TE KURA HAUORA TANGATA

July 20, 2010

Director of Boromarajonani College of Nursing, [REDACTED]

[REDACTED]
THAILAND

Dear Madam,

I am currently a Doctoral student of Nursing at Massey University, New Zealand, conducting research on a nursing skill development topic under Professor Julie Boddy supervision. I am going to collect my thesis data in Thailand from October 2010 to May 2011 and process the validation of preliminary findings in February 2012. In particular, my research emphasizes gaining the broadest possible spectrum of the phenomenon of nursing skill development. This study proposes to comprehend the learning process of undergraduate nursing students of Praboromarajchanok Institute (PBRI) in developing nursing skills to become professional nurses. It will be conducted under two main questions: 1) what is going on in the practical studies of PBRI nursing students? and 2) during practical placement, how do the PBRI nursing students learn about and deal with their clients' problems? Concurrently, the study will identify the key concepts in nursing skill development. Then, I will construct the theory of developing nursing skills in undergraduate nursing students who study in the college programmes supported by the institute. In order to do this, I need to research this learning process in Boromarajonani College of Nursing, [REDACTED]. Also, if necessary, I would like to access your databases related to my study. I would greatly appreciate it if you allow me to visit, access the databases, and collect my data in your setting.

I thank you for your consideration and look forward to hearing from you.

Yours Sincerely,

Handwritten signature of Miss Chittinan Pongsuwan.

(Miss Chittinan Pongsuwan)

Ph.D student

Handwritten signature of Professor Julie Boddy.

(Professor Julie Boddy)

Professor of Nursing

Appendix C



Boromarajonani College of Nursing, [REDACTED]

THAILAND

Ref: No. 0203.0930/0792

August 10, 2010

School of Health and Social Services
Massey University
Private Bag 11 222
Palmerston North 4442
NEW ZEALAND

Dear Miss Chittinan Pongsuwan

Regarding your letter asking for permission to carry out the research related the learning process for developing nursing skills in undergraduate nursing students of PBRI at Boromarajonani College of Nursing [REDACTED] we would like to inform you that we are happy to give you permission to gather your thesis data in our setting. We also allow you to access our any database related to your study and look forward to welcome you soon.

Yours sincerely,

[REDACTED]

Director of Boromarajonani College of Nursing [REDACTED]



MASSEY UNIVERSITY

28 September 2010

Miss Chittinan Pongsuwan
8 Mountain View Road
PALMERSTON NORTH 4410

Dear Chittinan

Re: HEC: Southern A Application – 10/63
The learning processes of undergraduate nursing students in developing nursing skills to become professional nurses

Thank you for your letter dated 27 September 2010.

On behalf of the Massey University Human Ethics Committee: Southern A, I am pleased to advise you that the ethics of your application are now approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

A/Prof Hugh Morton, Acting Chair
Massey University Human Ethics Committee: Southern A

cc Prof Julie Boddy & Prof Steve LaGrow, HoS
A/Prof Annette Huntington School of Health & Social Services
School of Health & Social Services PN371
PN371/WELLINGTON

Te Kunenga
ki Pūrehuroa

Massey University Human Ethics Committee
Accredited by the Health Research Council

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E humanethics@massey.ac.nz animalethics@massey.ac.nz gtc@massey.ac.nz
www.massey.ac.nz

***The Learning Processes of Undergraduate Nursing Students in
Developing Nursing Skills to Become Professional Nurses***

PARTICIPANT INFORMATION SHEET

Researcher Introduction

My name is Chittinan Pongsuwan. I worked as an instructor of Boromarajonani College of Nursing, [REDACTED] for 10 years. I am currently studying for a Doctoral degree in Nursing at the School of Health Science, Massey University, Palmerston North, New Zealand. To achieve the degree, I have to complete my research entitled *Learning Process of Undergraduate Nursing Students in Developing Nursing Skills to Become Professional Nurses* in Boromarajonani College of Nursing, [REDACTED]. I have conducted this research to construct a theory for developing the nursing skills of the students who study in the Thai college programmes supported by Praboromarajchanok Institute, Ministry of Public Health. This project is under the supervision of three supervisors. Two of them are in New Zealand, Professor Julie Boddy and Assistant Professor Annette Huntington and one fieldwork supervisor is in Thailand, Assistant Professor Quantar Balhip.

Project Description and Invitation

Thai nursing students studying within the college programmes supported by an institute of the Thai Ministry of Public Health have encountered learning problems. Some have found it is difficult to pass their nursing licence test on the first attempt. Previous studies about teaching and learning of nursing students have not investigated students' perspectives as to how they learn to develop their nursing skills. This study aims to explore how undergraduate nursing students learn to be professional nurses. It will be conducted by using in-depth audio-taped interviews, observations and field notes, and I would also like to look at some students' learning documents. This research will contribute to new guidelines for nursing education of the nursing colleges affiliated to the institute.

I would like to invite you to take part in this project. If you are interested in taking part, you can directly tell me or your instructor advisors of your class. Then, I will meet you, explain further information, and gain your informed consent.

Participant Identification and Recruitment

I would like to interview 30-35 nursing students of the setting who: 1) are over the age of 19; 2) have experienced practical studies; and 3) are willing to participate in the project. For the first stage, I would like to interview 10 students—two groups of five persons from the fourth and then third year of nursing students. In the second stage, I would like to interview 20-25 more students so that I can clarify the emerging hypotheses. This will involve students at all levels of their studies, so I may ask for more students to participate at this time by communicating with instructor advisors of classes or previous participants.

Project Procedures

1. In this nursing student meeting, I will inform you the details of this project, ethical considerations, and participants' involvement, as well as give you this information sheet.
2. You still have time to learn more about this project. If you have some questions about it, please feel free to ask for more information from me. **Please note that** you are under no obligation to accept this invitation and independently make your decision to participate in this study or not.
3. Whenever you are willing to participate in this study, you will be asked to sign the participant consent form.
4. Each interview will be started after you feel comfortable to be an informant. I plan to interview you around two to three times. The place and time for each interview and observation will be arranged by you to ensure your convenience.
5. You will be asked to respond to the two main questions: 1) what is going on in your practical studies? and 2) during practical placement, how do you learn about and deal with your clients' problems?
6. During the interview, I will ask your permission to record the conversation on a tape recorder, or to take some notes when I am performing observations.
7. I also would like to observe you doing some of your practical activities and social interactions with other persons during your practical studies around one to two times.

Then, I sometimes ask for your permission to record your activity or interaction images when I recognise that they are very important.

8. If convenient, I may like to look at some of your previously assessed learning documents such as nursing care plans, case studies, and community projects.

9. Data collection with each informant will stop when no new information is emerging. The research will be carried out from October 2010 to May 2011.

10. Most of the participants will be asked to validate my preliminary findings in February 2012.

Participation or non-participation in the research will not affect your study or any of your academic subject scores

Data Management

Each of your interviews will be transcribed and a copy shown to you to check for accuracy. Then, all of the information will be analysed by the researcher. The preliminary findings will be presented to you to validate. Then, the final findings will be written in the thesis, published in articles, shared at conferences and also shared with all participants and the college. None of your information will be able to be identified. I will use pseudonyms at the beginning of each interview record and in your stories described in my report and the publications. Also, your interview transcripts and audiotapes as well as any document/ note/ record/ form emerging from the conducting of this project will be kept in a safe locked place and disposed of three years after the study is completed.

Participant's Rights

You are under no obligation to accept this invitation and your participation is confidential. If you decide to participate, you have the right to:

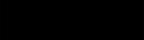
- provide your information based on your opinions; there are no right or wrong answers and your responses will have no influence on any of your academic subject scores;
- decline to answer any particular question;
- ask for the recorder to be turned off at any time during the interview;
- withdraw from the study up until the data collection is completed if you want, without effect on your studies;

- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- listen to, or change your previous information record during the data collection process;
- view and approve the use of any photo taking during your practical studies;
- be given access to a summary of the project findings in the process of validating the preliminary findings and when it is concluded.

Project Contacts

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 10/63. If you have any concerns about the conduct of this research, please contact Professor Julie Boddy, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 2541, e-mail: humanethicsoutha@massey.ac.nz (mailto: humanethicsoutha@massey.ac.nz). Alternatively, you could contact me or the research supervisors at the addresses:

The researcher: Miss Chittinan Pongsuwan

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Email: bquantar@hotmail.com

กระบวนการพัฒนาทักษะการพยาบาลสู่ความเป็นวิชาชีพของนักศึกษา

หลักสูตรพยาบาลศาสตรบัณฑิต

รายละเอียดข้อมูลโครงการวิจัย

ข้อมูลผู้วิจัย

ดิฉัน นางสาวจิตตินันท์ พงสุวรรณ อาจารย์ประจำวิทยาลัยพยาบาลบรมราชชนนี [REDACTED] ปัจจุบันกำลังศึกษาปริญญาเอกสาขาการพยาบาล ณ มหาวิทยาลัยแมสซัซเซตส์ ประเทศนิวซีแลนด์ มีความประสงค์ที่จะศึกษาวิจัย เรื่อง “กระบวนการพัฒนาทักษะการพยาบาลสู่ความเป็นวิชาชีพของนักศึกษาหลักสูตรพยาบาลศาสตรบัณฑิต” ณ วิทยาลัยพยาบาลบรมราชชนนี [REDACTED] เพื่อนำไปสู่การสร้างทฤษฎี “การพัฒนาทักษะการพยาบาล ของนักศึกษาที่เรียนในระบบวิทยาลัยพยาบาลสังกัดสถาบันการศึกษาของกระทรวงสาธารณสุข” โครงการวิจัยนี้อยู่ภายใต้การควบคุมดูแลของอาจารย์ผู้รับผิดชอบหลักสูตร 3 ท่าน ในจำนวนนี้ 2 ท่านอยู่ในประเทศนิวซีแลนด์ คือ ศาสตราจารย์ (Professor) Julie Boddy และรองศาสตราจารย์ (Associate Professor) Annette Huntington และอีก 1 ท่าน เป็นอาจารย์ที่รับผิดชอบดูแลในช่วงของการเก็บรวบรวมข้อมูลในประเทศไทย คือ ผศ. ดร. ขวัญตา บาลทิพย์

ความเป็นมาและวิธีการวิจัย

ผลการศึกษาที่ผ่านมา พบว่า นักศึกษาที่เรียนในระบบวิทยาลัยพยาบาลสังกัดสถาบันการศึกษาของกระทรวงสาธารณสุข ต้องเผชิญกับปัญหาการเรียน และนักศึกษาส่วนใหญ่รับรู้ว่าการจะสอบขึ้นทะเบียนเป็นพยาบาลวิชาชีพให้ผ่านในรอบแรกเป็นเรื่องที่ทำได้ยาก ในขณะที่ปัจจุบันยังไม่มีการศึกษาวิจัยด้านการเรียนการสอนพยาบาลเกี่ยวกับวิธีการเรียนรู้ เพื่อพัฒนาทักษะการพยาบาลตามมุมมองของนักศึกษาโดยตรง โครงการศึกษาวิจัยนี้ ต้องการทำความเข้าใจเกี่ยวกับกระบวนการเรียนรู้ เพื่อพัฒนาทักษะการพยาบาลสู่ความเป็นวิชาชีพ ของนักศึกษาหลักสูตรพยาบาลศาสตรบัณฑิต โดยเก็บข้อมูลด้วยวิธีการสัมภาษณ์พร้อมบันทึกเทป การสังเกตกิจกรรมการพยาบาลและการมีปฏิสัมพันธ์กับผู้ที่เกี่ยวข้องขณะฝึกปฏิบัติงาน ตลอดจนจดบันทึกข้อมูลบางส่วนจากการสังเกตและจากเอกสารการเรียนรู้ที่เกี่ยวข้องของผู้ให้ข้อมูล ผลการวิจัยครั้งนี้ จะเป็นแนวทางในการพัฒนาระบบการจัดการเรียนการสอนพยาบาลของวิทยาลัยพยาบาลสังกัดสถาบันการศึกษาของกระทรวงสาธารณสุข

ดิฉันมีความยินดีที่จะขอเชิญท่านเข้าร่วมงานวิจัยนี้ในฐานะผู้ให้ข้อมูล หากท่านมีความประสงค์จะเข้าร่วมโครงการ ท่านสามารถแจ้งความประสงค์ได้ที่ผู้วิจัยโดยตรงหรืออาจารย์ประจำชั้นของท่าน จากนั้นผู้วิจัยจะไปพบท่านพร้อมอธิบายข้อมูลเกี่ยวกับโครงการวิจัยนี้อีกครั้งก่อนขอให้ท่านเซ็นใบยินยอมการเข้าร่วมโครงการวิจัย

ผู้เข้าร่วมโครงการวิจัย

โครงการวิจัยนี้ต้องการเก็บข้อมูลในนักศึกษาของวิทยาลัยพยาบาลแห่งนี้ จำนวน 30-35 คน โดยเป็นผู้ที่ 1) มีอายุตั้งแต่ 20 ปีขึ้นไป 2) มีประสบการณ์ในการฝึกภาคปฏิบัติการพยาบาล และ 3) สมัครใจเข้าร่วมโครงการ ในระยะแรก of โครงการ ผู้วิจัยประสงค์จะขอสัมภาษณ์นักศึกษาที่มีคุณสมบัติดังกล่าว จำนวน 10 คน โดยขออาสาสมัครนักศึกษาชั้นปีที่ 4 และ 3 จำนวนชั้นปีละ 5 คน หลังจากเก็บข้อมูลในนักศึกษากลุ่มดังกล่าวเสร็จแล้ว ในระยะที่สองของโครงการ เป็นการค้นหาข้อมูลเพื่ออธิบายสมมติฐานที่เกิดขึ้นจากการเก็บข้อมูลในระยะแรก ผู้วิจัยใคร่ขอสัมภาษณ์ผู้ให้ข้อมูลเพิ่มอีก จำนวน 20-25 คน โดยเป็นผู้ที่มีคุณสมบัติข้างต้นและสามารถให้ข้อมูลที่ผู้วิจัยต้องการอธิบายได้ ซึ่งการคัดเลือกผู้ให้ข้อมูลในระยะนี้ ผู้วิจัยอาจจะสอบถามจากผู้ที่เคยให้สัมภาษณ์หรืออาจารย์ประจำชั้นของท่าน

ขั้นตอนการเก็บข้อมูล

1. ณ ที่ประชุมประจำวันของนักศึกษาพยาบาลวันนี้ ผู้วิจัยสรุปรายละเอียดข้อมูลของโครงการ การพิทักษ์สิทธิ์ผู้ให้ข้อมูล และระยะเวลาเข้าร่วมโครงการของผู้ให้ข้อมูล แก่ผู้ที่สามารถเป็นกลุ่มตัวอย่างได้ พร้อมทั้งแจกเอกสารรายละเอียดข้อมูลโครงการวิจัยแก่ทุกท่าน
2. ท่านผู้สนใจศึกษาเอกสารรายละเอียดข้อมูลโครงการวิจัยเพิ่มเติม หากท่านมีคำถามหรือข้อสงสัยเกี่ยวกับโครงการ ท่านสามารถสอบถามข้อมูลได้จากผู้วิจัย

หมายเหตุ ท่านไม่จำเป็นต้องตอบรับคำเชิญ แต่ท่านมีสิทธิ์ตัดสินใจในการเข้าร่วมโครงการนี้หรือไม่ด้วยตัวท่านเอง

3. เมื่อท่านตัดสินใจสมัครเข้าร่วมโครงการ ผู้วิจัยจะขอให้ท่านเซ็นใบยินยอมการเข้าร่วมโครงการวิจัย
4. ผู้วิจัยจะเริ่มเก็บข้อมูล โดยให้ผู้ให้ข้อมูลนัดหมาย วัน เวลา และสถานที่ ของแต่ละครั้งในการสัมภาษณ์ และการสังเกตกิจกรรมในขณะที่ฝึกปฏิบัติงานได้ตามความสะดวกของผู้ให้ข้อมูล โดยผู้วิจัยจะขอสัมภาษณ์ผู้ให้ข้อมูลแต่ละรายประมาณ 2-3 ครั้ง ขึ้นอยู่กับความอึดตัวของข้อมูล

5. ในการสัมภาษณ์ผู้วิจัยจะขอให้ผู้ให้ข้อมูลอธิบาย: 1) ลักษณะการฝึกปฏิบัติงานของท่านเป็นอย่างไร
- 2) ในขณะที่ฝึกปฏิบัติงาน ท่านเรียนรู้และจัดการกับปัญหาผู้ป่วยที่ได้รับมอบหมายอย่างไร
6. ระหว่างการสัมภาษณ์ ผู้วิจัยจะขออนุญาตบันทึกเทปการสนทนา และอาจจะขอฉบับที่ข้อมูลบางอย่างที่ได้จากการสังเกต
7. ผู้วิจัยขอสังเกตกิจกรรมการพยาบาลและการมีปฏิสัมพันธ์กับผู้ที่เกี่ยวข้องของผู้ให้ข้อมูล ขณะฝึกปฏิบัติงานประมาณ 1-2 ครั้ง และอาจจะขอบันทึกภาพกิจกรรมและการมีปฏิสัมพันธ์ที่ผู้วิจัยเห็นว่าสำคัญและควรนำเสนอเผยแพร่ร่วมด้วย
8. หากท่านสะดวก ผู้วิจัยอาจจะขออ่านเอกสารที่เกี่ยวข้องกับการเรียนรู้เพื่อพัฒนาทักษะทางการพยาบาลของผู้ให้ข้อมูลที่ได้รับการประเมินแล้วร่วมด้วย เช่น แผนการพยาบาล กรณีศึกษาผู้ป่วย เฉพาะราย โครงการพัฒนาชุมชนด้านสุขภาพ
9. ระยะเวลาการเก็บข้อมูลของโครงการ จะเริ่มในเดือนตุลาคม 2553 และคาดว่าจะสิ้นสุดในเดือนพฤษภาคม 2554
10. ก่อนสิ้นสุดการวิจัย ผู้วิจัยใคร่ขอความร่วมมือผู้ให้ข้อมูล เข้าร่วมตรวจสอบและยืนยันความถูกต้องของผลการวิจัยเบื้องต้น ในเดือนกุมภาพันธ์ 2555

การเข้าร่วมหรือไม่เข้าร่วมโครงการวิจัยนี้ จะไม่มีผลใดๆ ต่อการเรียนหรือคะแนนในรายวิชาต่างๆของท่าน

การจัดการข้อมูลและการเก็บรักษาข้อมูล

บทสัมภาษณ์ของผู้ให้ข้อมูลจะถูกถอดเทปเป็นข้อความเชิงบรรยาย ผู้วิจัยจะให้ผู้ให้ข้อมูลตรวจสอบและยืนยันความถูกต้องของข้อมูลในครั้งถัดไปของการสัมภาษณ์ จากนั้นผู้วิจัยจะเป็นผู้วิเคราะห์ข้อมูลที่ได้ทั้งหมด และส่งผลการวิจัยเบื้องต้นให้ผู้ให้ข้อมูลร่วมตรวจสอบความถูกต้องก่อนนำมาเขียนเป็นวิทยานิพนธ์ ตีพิมพ์ในวารสาร และนำเสนอในที่ประชุมวิชาการที่เกี่ยวข้อง ตลอดจนที่ประชุมของวิทยาลัยแหล่งข้อมูล พร้อมทั้งส่งผลการวิจัยที่ได้ให้ผู้ให้ข้อมูลและวิทยาลัยแหล่งข้อมูลร่วมด้วย ผู้วิจัยจะใช้นามสมมติทั้งในการเขียนวิทยานิพนธ์และรายงานรูปแบบต่างๆ ซึ่งข้อมูลส่วนตัวของผู้ให้ข้อมูลจะไม่ถูกนำเสนอ เทปบันทึกการสัมภาษณ์ บันทึกการสัมภาษณ์ และเอกสารต่างๆที่กล่าวถึงข้อมูลส่วนตัวของผู้ให้ข้อมูลที่เกิดขึ้นจากโครงการวิจัยนี้ จะถูกเก็บรักษาไว้ในที่ปลอดภัย และจะถูกทำลายภายใน 3 ปีหลังจากการวิจัยเสร็จสมบูรณ์

สิทธิของผู้ให้ข้อมูล

ท่านไม่ได้ผูกมัดตัวเองที่จะต้องตอบรับคำเชิญ และการเข้าร่วมวิจัยของท่านเป็นความลับ แต่หากท่านตัดสินใจเข้าร่วมโครงการวิจัยนี้ ท่านจะมีสิทธิ์ ดังนี้

- ให้ข้อมูลตามความคิดเห็นของท่าน ซึ่งไม่มีคำตอบที่ถูกหรือผิด และไม่มีผลต่อคะแนนในรายวิชาใดๆ
- ปฏิเสธที่จะตอบคำถามบางคำถามที่ท่านไม่สะดวกที่จะให้ข้อมูล
- ขอให้ผู้วิจัยปิดอุปกรณ์บันทึกเสียงในขณะที่สัมภาษณ์ได้ในช่วงที่ท่านไม่ต้องการให้บันทึก
- ถอนตัวออกจากโครงการวิจัยได้ตลอดเวลา หากท่านต้องการ โดยไม่มีผลใดๆต่อการเรียนของท่าน
- ถามคำถามเกี่ยวกับโครงการวิจัยได้ตลอดเวลาที่ท่านเข้าร่วมโครงการ
- ให้ข้อมูลโดยมั่นใจได้ว่าข้อมูลส่วนตัวของท่านจะไม่ถูกเปิดเผย ยกเว้นท่านอนุญาตให้ผู้วิจัยเปิดเผยได้
- ขอฟังและเปลี่ยนแปลงบทสัมภาษณ์ของท่านได้ตลอดระยะเวลาการเก็บข้อมูลของโครงการ
- ขอดูและแสดงความเห็นในการเผยแพร่ภาพกิจกรรมและการมีปฏิสัมพันธ์ของผู้ให้ข้อมูลขณะฝึกปฏิบัติงาน
- ร่วมตรวจสอบและยืนยันความถูกต้องของผลการวิจัยเบื้องต้น และเมื่อโครงการวิจัยเสร็จสมบูรณ์ท่านจะได้รับผลการวิจัยฉบับตีพิมพ์เผยแพร่ร่วมด้วย

โครงการวิจัยนี้ผ่านความเห็นชอบของคณะกรรมการจริยธรรมการวิจัยที่เกี่ยวข้องกับมนุษย์ มหาวิทยาลัยแมสซีย์ เลขที่ 10/63 หากท่านมีข้อสงสัยใดๆ เกี่ยวกับกระบวนการวิจัย ท่านสามารถสอบถามข้อมูลได้จากประธานคณะกรรมการ ศาสตราจารย์ (Professor) Julie Boddy โทรศัพท์ 06 350 5799 x 2541 e-mail: humanethicsoutha@massey.ac.nz (mailto: humanethicsoutha@massey.ac.nz) หรือท่านสามารถติดต่อผู้วิจัยได้โดยตรง หรือที่ปรึกษาโครงการได้ตามที่อยู่ข้างล่างนี้

ท่านสามารถติดต่อผู้วิจัยได้ที่

ในประเทศไทย :

วิทยาลัยพยาบาลบรมราชชนนี

โทรศัพท์:

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ที่ปรึกษาโครงการและที่อยู่สำหรับติดต่อ

ในประเทศนิวซีแลนด์:

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***The Learning Processes of Undergraduate Nursing Students in
Developing Nursing Skills to Become Professional Nurses***

PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I agree/do not agree to allow the researcher to observe and sometimes take image recordings of parts of my nursing care activities and social interactions with other persons during my practical studies, with the verbal permission of those persons

I agree/do not agree to allow the researcher to read my assessed learning documents such as nursing care plans, case studies, and community health projects.

I agree/do not agree to participate in the process of validating the preliminary findings of the study

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: **Date:**

Full Name
(printed)

กระบวนการพัฒนาทักษะการพยาบาลสู่ความเป็นวิชาชีพของนักศึกษา
หลักสูตรพยาบาลศาสตรบัณฑิต

ใบยินยอมการเข้าร่วมโครงการวิจัย

ข้าพเจ้าได้อ่านและได้รับการอธิบายเกี่ยวกับรายละเอียดของการศึกษาวิจัยนี้
ผู้วิจัยได้ตอบคำถามของข้าพเจ้าเกี่ยวกับการศึกษาวิจัยนี้อย่างเป็นที่พอใจ และข้าพเจ้ารับทราบว่า
ข้าพเจ้าสามารถถามคำถามอื่นๆเกี่ยวกับการวิจัยนี้ได้ตลอดเวลา

ข้าพเจ้า ยินยอม / ไม่ยินยอม ให้บันทึกเทปการสัมภาษณ์

ข้าพเจ้า ยินยอม / ไม่ยินยอม ให้ผู้วิจัยสังเกตและบันทึกภาพกิจกรรมการพยาบาลของข้าพเจ้า ตลอดจน
การมีปฏิสัมพันธ์ของข้าพเจ้ากับบุคคลที่ข้าพเจ้าต้องเกี่ยวข้องขณะฝึกปฏิบัติงาน โดยบุคคลเหล่านั้น
ได้อนุญาตผู้วิจัยด้วยวาจาแล้ว

ข้าพเจ้า ยินยอม / ไม่ยินยอม ให้ผู้วิจัยศึกษาเอกสารเกี่ยวกับการเรียนรู้และพัฒนาทักษะการพยาบาล
ของข้าพเจ้าที่ได้รับการประเมินจากผู้นิเทศแล้ว เช่น แผนการพยาบาล กรณีศึกษาผู้ป่วยเฉพาะราย
โครงการพัฒนาชุมชนด้านสุขภาพ

ข้าพเจ้า ยินยอม / ไม่ยินยอม ที่จะเข้าร่วมตรวจสอบและยืนยันความถูกต้องของข้อมูลที่ได้จากการวิจัย
ข้าพเจ้ายินยอมเข้าร่วมโครงการวิจัยนี้ภายใต้เงื่อนไขที่ระบุในรายละเอียดข้อมูลโครงการวิจัย

ลายเซ็น..... วันที่.....

ชื่อ-สกุล (ตัวบรรจง).....

*The Learning Processes of Undergraduate Nursing Students in
Developing Nursing Skills to Become Professional Nurses*

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: **Date:**

**Full Name
(printed)**

กระบวนการพัฒนาทักษะการพยาบาลสู่ความเป็นวิชาชีพของนักศึกษา
หลักสูตรพยาบาลศาสตรบัณฑิต

คำยินยอมให้เผยแพร่สำเนาเทพ

ข้าพเจ้ายืนยันว่าข้าพเจ้ามีสิทธิ์ที่จะอ่านและแก้ไขสำเนาเทพจากการสัมภาษณ์ที่ข้าพเจ้าเข้าร่วม
โครงการวิจัยนี้

ข้าพเจ้ายินดีที่จะให้นำสำเนาเทพที่ผ่านการแก้ไขแล้ว ไปใช้ในรายงานการวิจัยและตีพิมพ์เผยแพร่
ผลการวิจัยนี้

ลายเซ็น..... วันที่.....

ชื่อ-สกุล (ตัวบรรจง).....