

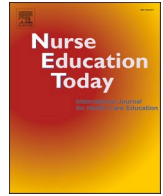
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Title	Factors which influence the effectiveness of clinical supervision for student nurses in Sri Lanka: A qualitative research study
Type	Article
URL	https://clock.uclan.ac.uk/id/eprint/41826/
DOI	https://doi.org/10.1016/j.nedt.2022.105387
Date	2022
Citation	Hill, Elaine Alais susannna and Abhayasinghe, Kalpani (2022) Factors which influence the effectiveness of clinical supervision for student nurses in Sri Lanka: A qualitative research study. Nurse Education Today. p. 105387. ISSN 02606917
Creators	Hill, Elaine Alais susannna and Abhayasinghe, Kalpani

It is advisable to refer to the publisher's version if you intend to cite from the work.
<https://doi.org/10.1016/j.nedt.2022.105387>

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Factors which influence the effectiveness of clinical supervision for student nurses in Sri Lanka: A qualitative research study

Elaine Hill ^{a,*}, Kalpani Abhayasinghe ^b

^a School of Sport and Health Sciences, University of Central Lancashire, Preston PR1 2HE, UK

^b Department of Nursing and Midwifery, General Sir John Kotelawala Defence University, Ratmalana, Sri Lanka

ARTICLE INFO

Keywords:

Clinical supervision
Clinical competence
Sri Lanka
Students, nursing
Hospitals, teaching
Developing countries
Health education

ABSTRACT

Background: Clinical placements are an essential part of student nurse education, but their effectiveness is influenced by the type and availability of supervision and existing resources. In Sri Lanka, the specific socio-political context in which nursing, and nurse education, operate may also be important.

Objectives: To examine the impact of socio-political factors on Sri Lankan nurses' supervisory practices and student nurses' experiences of clinical supervision.

Design: Qualitative descriptive.

Settings: Four teaching hospitals and four educational establishments in Colombo district, Sri Lanka.

Participants: 217 student nurses in years 2–4 of their programmes. 205 qualified nurses (clinical and academic) with a minimum of two years' supervisory experience.

Methods: Written responses to three open questions, followed by reflexive thematic analysis with inductive, semantic coding.

Results: Two themes were identified: 1. Personal and professional development 2. Tensions and conflicts. Sociocultural norms and governance structures, which limited nurses' professional recognition and self-determination, negatively affected clinical supervision.

Conclusions: The sociocultural changes necessary to raise the professional status of Sri Lankan nurses will take time to occur. Approval of a mentorship education programme for supervisors, recognition of their role and greater support for students are important first steps in this process.

1. Introduction

Clinical placements are integral to nurse education, enabling learners to become safe and competent practitioners, with the support of qualified staff (Perry et al., 2018; Donough and Van der Heever, 2018; Tuomikoski et al., 2020). In common with many low and middle-income countries (LMICs), the ability of Sri Lankan nurses to supervise students effectively is limited by time and physical resources (Silva et al., 2017), resulting in a high student:supervisor ratio, group supervision and task-focussed delivery (De Silva and Rolls, 2010; Jayasekera and Amarasekara, 2015). Clinical supervision in Sri Lanka focusses on skills assessment and adherence to protocols and procedures, rather than holistic care. In addition, continuing professional development (CPD) programmes for nurses are rare (Jayasekera and Amarasekara, 2015) so supervisors are generally unprepared for their role. Students report high levels of stress, anxiety and depression on clinical placements

(Rathnayake and Ekanayaka, 2016; Silva et al., 2017), primarily due to lack of guidance and support (Ilankoon and Warnakulasooriya, 2014).

2. Background

The political and social context in which Sri Lankan nurses work limits their professional power and self-determination, though the potential impact of this on clinical supervision has not been explored. They are employed either clinically or in education. Academic nurses are the responsibility of the Ministry of Higher Education whilst clinical nurses are answerable to the Ministry of Health (Aluwihare-Samaranayake et al., 2017). Though both are registered practitioners, and both teach, assess and supervise students in clinical settings, academic nurses are not permitted to work clinically as they are not employed by the Ministry of Health. Furthermore, nurses who graduate with a Diploma from Ministry of Health training institutions are allocated positions country-

* Corresponding author.

E-mail addresses: eashill@uclan.ac.uk (E. Hill), mpkw.abhayasinghe@kdu.ac.lk (K. Abhayasinghe).

<https://doi.org/10.1016/j.nedt.2022.105387>

Received 9 July 2021; Received in revised form 5 April 2022; Accepted 25 April 2022

Available online 29 April 2022

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wide in government hospitals, with little influence over their speciality or location (Aluwihare-Samaranayake et al., 2017; Ministry of Health and World Health Organisation (WHO), 2018).

Nurses' power and voices have also been muted by the dominance of medicine (De Silva and Rolls, 2010; Hewa, 2014; Aluwihare-Samaranayake et al., 2017). Until 2014 nurses were registered under the Medical Ordinance Act (Ministry of Justice Sri Lanka (MoJ), 1988) and placed on a dedicated section of the medical register, limiting their professional recognition. Although registration by the Sri Lanka Nurses' Council is now operational this is taking time to have an impact and it too was initially physician-led (Aluwihare-Samaranayake et al., 2017). In addition, nurses are under-represented in senior healthcare management positions. Further information on clinical and academic nursing roles in Sri Lanka is provided in Table 1.

This study sought to answer two questions: 1. What are Sri Lankan nurses' and nursing students' experiences of clinical supervision? 2. How does the professional status and power of nurses influence these experiences?

3. Study

3.1. Design

We used a qualitative descriptive design to represent the experiences and perceptions of participants as accurately and unbiasedly as possible (Braun and Clarke, 2006).

3.2. Ethical considerations

Ethical approval was obtained from General Sir John Kotelawala Defence University (KDU), Sri Lanka (RP/2018/07) and the University of Central Lancashire, UK (STEMH 902). Participants were recruited from nurses or students at participating institutions. Taking part was voluntary and all participants received a participant information leaflet and gave written consent. Data were stored anonymously, with each participant identified only by a code. One author taught at the same university as some of the students but was not involved in the data collection. The other author had no relationship with any of the participants.

3.3. Setting

Four teaching hospitals and four educational establishments in Colombo district, Sri Lanka.

3.4. Participants

205 qualified nurses (193 clinical, 12 academic) and 217 student nurses participated. To be included, qualified nurses required a minimum of two years' experience as clinical supervisors and could be

working at any grade in either clinical or academic roles. Student nurses needed to be in years 2–4 of BSc or Diploma programmes. Participants were a self-selecting sample from all relevant staff and students who were approached at participating institutions.

3.5. Recruitment

Research assistants recruited participants by directly approaching eligible nurses and students. They visited both the participating hospitals and educational establishments to inform staff about the study and spoke to relevant students at the start of lectures. Participant information leaflets, consent forms and the written study questions were provided to those who were interested.

3.6. Data collection and management

Data was collected from March to June 2019. Participants completed written consent forms and three open, written questions (Table 2), which were available in Sinhalese, Tamil and English. They also provided basic, demographic data. Completed documents were returned to secure collecting boxes, which were later retrieved by the research assistants. Participants had one week to answer the questions. This approach was used both because it is culturally acceptable and because many people lack email addresses or internet connections. The choice of written questions to gather the qualitative data was a pragmatic, cultural adaptation. Qualitative research is currently uncommon in Sri Lanka and written, open questions resemble established quantitative questionnaires.

The research assistants transcribed the responses into an electronic format and translated them into English where necessary. They were fluent in English as it is the language used within higher education teaching and research. Transcriptions and translations were also checked by another member of the team. The research assistants were trained for their role by a member of the research team.

3.7. Data analysis

Reflexive thematic analysis with inductive, semantic coding was used to interpret the data. In accordance with accepted practices for this approach, one researcher (EH) analysed and coded the data whilst the second (KA) reviewed (Braun and Clarke, 2013; Elo et al., 2014). We adhered to the six phases of reflexive thematic analysis outlined by Braun and Clarke (2006). Both authors discussed and reflected on the analysis at each stage and reached consensus. The initial thematic map and agreed themes are provided in Figs. 1 and 2 respectively.

We employed Lincoln and Guba's (1985) criterion for trustworthiness to limit threats to validity, reliability and objectivity. Credibility was met by piloting the questionnaires before the study, long immersion in the data by both authors, and discussion between them to reach consensus regarding codes and distinct, agreed themes. Transferability was assured through the large sample size, reaching saturation in the data when new topics stopped being identified and thick description of context. Dependability was ensured by transparent description of each stage of the research process and finally confirmability was assured by providing rationale for the theoretical, methodological and analytical approaches used, reflection and discussion between authors and use of the COREQ tool (Tong et al., 2007) and Braun and Clarke's (2006) checklist to enable comprehensive reporting.

Table 2

Research questions.

1. What do you think are the main benefits of supervision in clinical practice (for the supervisor and the student)?
2. What do you feel are the principal limitations of clinical supervision?
3. What do you consider to be the greatest challenges of clinical supervision (for the supervisor and the student)?

Table 1

Clinical and academic nursing roles in Sri Lanka.

Clinical nurses	
Nursing Officer	The initial grade for qualified nurses. They deliver the majority of patient care.
Sister/Master	Ward managers
Special Grade Nursing Officers	Manage the Nursing Officers and ward managers and have overall responsibility for clinical areas.
Academic nurses	
Academic	Teach theory and practice in universities and teach/assess clinical skills in practice
Tutor	Teach theory and practice in government nurse training schools and teach/assess clinical skills in practice

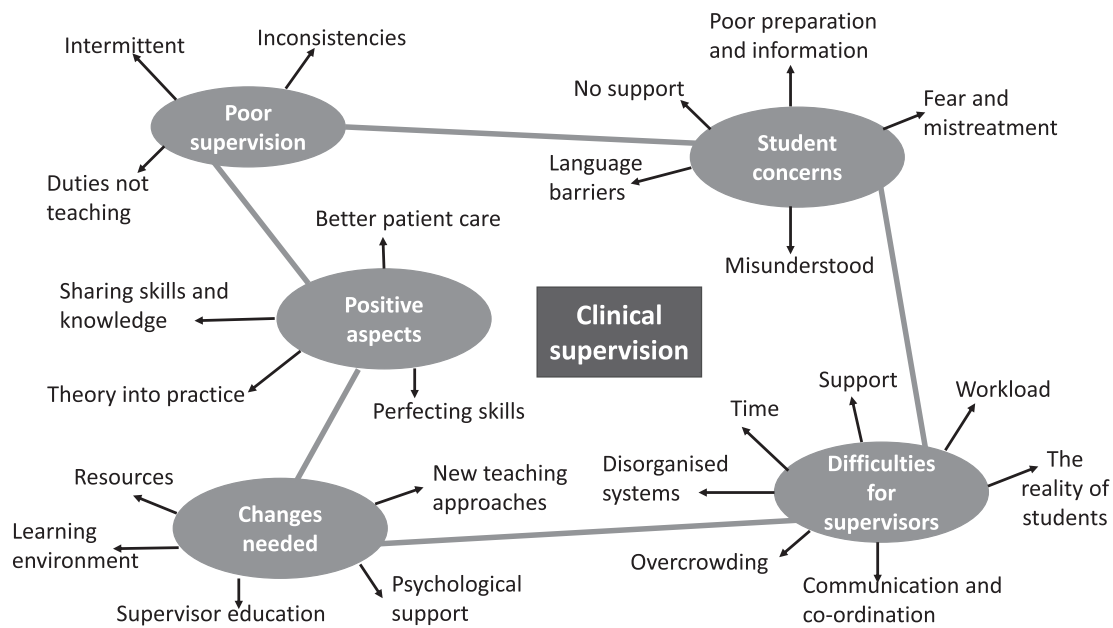


Fig. 1. Initial thematic map.

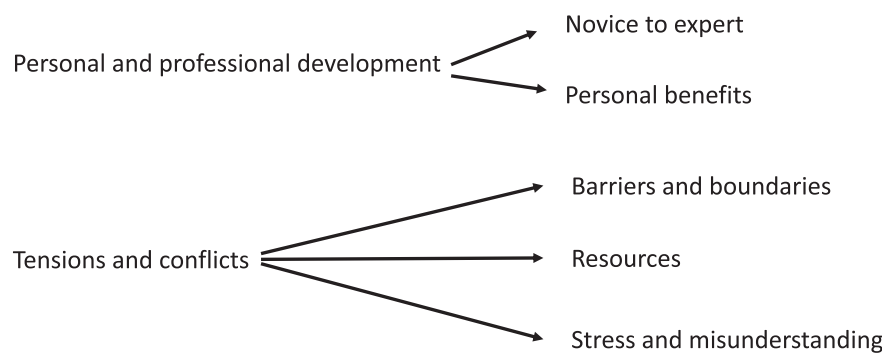


Fig. 2. Themes and subthemes.

In addition, both authors used reflective field notes and discussion to examine their respective conceptual lenses, explicit and implicit assumptions, preconceptions and values, and their impact on research decisions at all stages of the study (Nowell et al., 2017) as we were aware that these could potentially influence data interpretation. The field notes were taken from the initial planning stages of the study until the drafting of the paper. One author was a middle-aged, white British woman and the other a younger, Sinhalese, Sri Lankan woman who had had collaborated previously on the design and implementation of a health-care education programme in Sri Lanka and had spent time in both cultures.

4. Findings

Summary demographic data are shown in Table 3. The reflexive thematic analysis identified two themes and 5 subthemes.

4.1. Personal and professional development

i. Novice to expert.

Both qualified nurses and students highlighted the benefits of effective clinical supervision for developing competent and confident practitioners. Students tended to focus on perfecting clinical skills and following correct procedures, which was often linked to passing their

practical assessments. One student explained:

‘Supervision is to train students to follow clinical procedures in the correct way. It increases confidence to perform the duty once qualified.’ [Student 21].

By contrast, qualified nurses acknowledged clinical skills in context as one part of a wider range of professional competencies required for delivering safe and effective patient care. In addition to teaching and assessing skills, supervisors enabled students to see the ‘bigger picture’ by using clarification, discussion, and role-modelling to help them apply theory to practice, develop confidence and learn the skills of self-assessment and reflection required of professional nurses. One Ward Manager explained that effective supervision enabled students to:

‘Identify their weaknesses and strengths and improve overall quality of care.’ (Ward Manager 2).

Students commented that good supervisors aided their transition from novice to qualified nurse and supervisors expressed pride at seeing this happen.

ii. Personal benefits

Many nurses regarded clinical supervision as an opportunity for professional development. Clinical nurses described gaining leadership and inter-personal skills, updating their own knowledge and improving

Table 3
Demographic data.

Qualified nurses (n = 205)		
Gender	Female	95%
	Male	5%
Highest level of educational qualification	Diploma	59%
	Bachelor's degree	24.5%
	Post-basic diploma	10%
	Master's degree	4%
	MPhil/PhD	2.5%
Speciality		
Clinical (94.1%)	Special grade nursing officer	7.8%
	Sister/master	17.1%
	Nursing officer	75.1%
Education (5.9%)	Academic	83.3%
	Tutor	16.7%
Modal time as a supervisor	Clinical nurses	5 years
	Academic nurses	2 years
Modal weekly supervision hours	Clinical and academic nurses	3 h
Student nurses (n = 217)		
Gender	Female	86.2%
	Male	13.8%
Study programme	Diploma in nursing	23%
	Bachelor's degree	77%
Year of study	Second	37%
	Third	35%
	Fourth	28%
Clinical supervision received	Group	77.4%
	Individual	19.8%

their teaching and support skills to better supervise students. Academic nurses used supervision both to 'keep in touch' with clinical practice and to forge closer working relationships with their clinical colleagues. They benefitted personally from updating their clinical knowledge and their students also gained as academics amended their teaching to meet the students' needs on placement, as one academic explained:

'[I] understand how effective the class-based teaching/ learning process is when put into practice and make necessary modifications where required' (Academic 7).

Overall, undertaking supervision increased nurses' engagement and satisfaction with their work, leaving one tutor feeling:

'I was motivated to go with the students and do some bedside teaching.' (Tutor 2).

4.2. Tensions and conflicts

i. Barriers and boundaries

Nurses and students highlighted several barriers to effective supervision and student learning.

They reported that lack of co-ordination and communication between academic and clinical institutions sometimes resulted in disorganised, or poorly structured, education programmes. Students commented that they had insufficient information to prepare them for clinical placements and that ward nurses were often unprepared for their arrival as they were unsure when placements would commence. One student explained:

'[We] have to face lots of difficulties due to not giving proper information and guidance before starting clinical placements.' (Student 38).

In addition, students' placement documentation was frequently unavailable or provided insufficient guidance for clinical supervisors regarding what needed to be taught or assessed. Some clinical nurses were also concerned that competency schedules were inappropriate or limited in scope and that discrepancies existed between the procedures taught in academic environments and ward practices. One Special Grade Nursing Officer explained:

'[There is a] significant difference between nursing principles taught at the [INSTITUTE NAME] and what is being practiced' (Special Grade Nursing Officer 4).

Consequently, clinical nurses corrected students' practices as they differed to the approaches used on the wards. This affected the students' confidence and confused and frustrated them as they believed they had been taught correctly, whilst the ward staff were using outdated approaches. A specific frustration for academic nurses arose from the requirement to demonstrate and supervise clinical skills on wards when the regulations did not permit them to work clinically. As one academic explained:

'As academics [we are] not allowed to carry out procedures; instead [we] need to provide them under the guidance of a practice nurse.' (Academic 1).

Within the clinical environment supervision was negatively affected by intra-professional tensions between different grades of clinical nurses. Some Ward Managers felt unsupported by their junior staff, whilst the latter explained they had little control and influence over the situation as they lacked both individual power and support from colleagues and administrators. One Nursing Officer explained:

'My in-charge does not like when I spend more time with students. I love teaching them, but I have no opportunity' (Nursing Officer 10).

Inter-professional conflicts between nurses and medical consultants also arose and were witnessed by students. One source of tension was described by a Ward Manager as:

'Objections of few consultants for nurse training' (Ward Manager 6).

This could result in students being unable to undertake their placements if consultants objected to their presence in the clinical area.

One Ward Manager clearly articulated the importance of recognising that nurses, and nurse education, are essential and that supervision cannot be undertaken effectively if this is not acknowledged. Her frustrations were apparent as she explained:

'[We need] the support of all other HCPs [health-care professionals], including doctors, for nurse supervision' (Ward Manager 5).

An occasional difficulty was student:nurse miscommunication due to linguistic differences. Sri Lanka has three official languages – Sinhalese, Tamil and English – and the latter is commonly used in educational settings. Some students commented that their supervisors were unable to speak or understand good English, which inhibited effective supervision and clinical learning if it was the only language the student and supervisor had in common. However, nurses suggested the most likely explanation was supervisors lacking confidence, and therefore being reluctant to speak English, not lack of ability.

Both nurses and students proposed greater collaboration between academic and clinical institutions, and across professional boundaries, to improve the planning, co-ordination and quality of clinical placements. This included allowing academic nurses to maintain their clinical skills through working in practice and interprofessional education (IPE) for students through participation in consultants' ward rounds and case discussions.

ii. Resources

Lack of resources impacted negatively on clinical supervision.

Clinical nurses had limited time for supervision due to over-crowded wards, staff shortages and high clinical and administrative workloads, as one Nursing Officer explained:

'We have very less [little] time and opportunities for in-service programmes with this workload. We are understaffed in most shifts and have no time to teach them really.' (Nursing Officer 9).

This curtailed their ability to form supportive relationships with students and could result in students feeling that they were used as nursing assistants and anxious as they were not practicing the tasks they would be assessed on. As well as being difficult to manage, large numbers of students on the ward could also be detrimental to patients' privacy and dignity. As several were competing for the same clinical learning opportunities, they were often present around a patient's bed as a large group. One tutor explained it could be challenging:

'Preserving patients' rights during clinical training' (Tutor 3).

Lack of space for confidential discussions often resulted in feedback to students being given in front of patients. This could both limit what the supervisor felt able to say and result in students feeling uncomfortable or distrusted by patients if feedback was not entirely positive. One student expressed their concerns thus:

'Blaming in front of patients causes lack of patients' trust in us.' (Student 23).

Scarcity of physical resources sometimes created poor educational environments as procedures had to be adapted to fit those available, which affected students in two ways. Firstly, they struggled to perform what they had been taught without the expected equipment and secondly, they were confused by nurses using a variety of approaches as they wanted the security of a definitive set of steps. One student observed:

'To expect the ideal procedure steps during practical exams at the ward setting is not practical.' (Student 22).

Whilst both nurses and students found the situation difficult and stressful, students also appreciated that the nurses were doing their best in difficult circumstances.

Limited resources also contributed to a lack of training and preparation for supervisors and the requirement to prioritise clinical duties affected the time available for the role. Consequently, some supervisors had insufficient experience or skills to provide appropriate support. In addition, the absence of a dedicated, named supervisor prevented continuity of supervision and the need to undertake supervision in groups negated the provision of individually tailored support. As one student explained:

'There's no systematic appointment of supervisors. Staff members are not specifically assigned to supervise students, so no-one is taking responsibility.' (Student 22).

iii. Stress and misunderstanding

Both supervisors and students were adversely affected by the same underlying issues.

Clinical nurses were stressed by working conditions and their negative impact on student support. As time for supervision was short, they could become frustrated when students struggled, sometimes accusing them of lacking the necessary commitment, motivation or mental stability. One Nursing Officer described the problem as:

'[Students'] failure to obtain maximum use of clinical training due to wrong attitudes.' (Nursing Officer 40).

Several students described supervisors blaming or bullying them for not understanding or performing as expected, with negative consequences for their mental health, resilience, engagement with supervision and their ability to think critically and creatively. One student summed

up their experience as:

'Most of the time supervision is not humanitarian [it] gives much psychological distress' (Student 26).

Students reported that academic nurses failed to fully appreciate their circumstances, which further intensified their distress and feelings of powerlessness.

Both students and supervisors suggested that improved supervision could mitigate some of the problems. They highlighted the need to develop recognised supervisor education and specific selection criteria to ensure that appropriate candidates were chosen. They also proposed that supervision should focus on their psychological needs and professional development, alongside the correct performance of skills. They emphasised the importance of ongoing one-to-one supervision, tailored to student needs and underpinned by a trusting student:supervisor relationship to aid learning and development. As one student explained:

'[We] need to improve mutual understanding and friendliness/close relationship between mentor and student.' (Student 22).

5. Discussion

The benefits for students and nurses from effective clinical supervision found in the study are consistent with previous research (Ryland et al., 2017; Donough and Van der Heever, 2018; Ekstedt et al., 2019). The use of the supervisory role as a form of CPD by nurses was unique and may have arisen from nurses using lateral thinking, and making best use of the opportunities provided, as the availability of CPD programmes is limited.

Several factors limited the provision and effectiveness of clinical supervision; these were driven by either governance structures in which the nurses worked, or sociocultural factors.

Clinical nurses struggled to supervise students as they were required to prioritise clinical duties due to overcrowded wards and understaffing; undervaluing nurse education may also have contributed. Nurses were unable to address the issues as they lacked the necessary authority, and they clearly felt frustrated and unheard. These findings are consistent with research highlighting Sri Lankan nurses' lack of voice, influence and professional self-determination arising from medical dominance and consequent under-representation in leadership and senior management positions (Aluwihare-Samaranayake et al., 2017; De Silva and Rolls (2010).

Nurses' lack of professional power, combined with the location of academic and clinical staff under separate ministries, may have contributed to poor communication and co-ordination between institutions over clinical placements and the resulting lack of preparedness by both supervisors and students. In addition, lack of timely, appropriate assessment documentation resulted in disagreements and misunderstandings between clinical and academic nurses over what needed to be assessed and what constituted correct performance. Both academic and clinical nurses believed they were right, and students became trapped in the resulting disputes, with negative consequences for their confidence and satisfaction with placements (Jayasekera and Amarasekera, 2015; Rathnayake and Ekanayaka, 2016; Silva et al., 2017) and clinical supervision. Academic nurses' frustrations are understandable. They have access to current guidelines but are not permitted to demonstrate procedures, whilst the clinical nurses - who must demonstrate for them - are generally limited to learning by observing senior colleagues (De Silva and Rolls, 2010), which is known to promote outdated practices (Kamphinda and Chilemba, 2019; Ekstedt et al., 2019; Khan et al., 2020). Effective communication between academic and clinical institutions and staff is essential to ensure appropriate content and delivery of educational programmes (Pramila-Savukosi et al., 2019; Foolchand and Maritz, 2020), including clinical supervision and assessment. Such problems are usually addressed through academic/clinical course management teams, who oversee programmes,

but although these have been proposed in Sri Lanka (Silva et al., 2017) they have yet to be implemented.

The stress experienced by staff and students in relation to practice is consistent with previous research findings in Sri Lanka (De Silva and Rolls, 2010; Jayasekera and Amarasekara, 2015; Rathnayake and Ekanayaka, 2016; Silva et al., 2017). Good supervisor:student relationships are key to supporting learners (D'Souza et al., 2015; Pramila-Savukosi et al., 2019) but these often failed to develop due to lack of supervisors' time or individual support. It seems that supervisors sometimes vented their frustrations on struggling students to restore some sense of control when their ability to manage their stress was exceeded; a recognised problem in nursing (Dong and Temple, 2011; Gillespie et al., 2017). Consequently, students felt unsupported by supervisors and unhappy on placement. Nurses were also concerned by the impact of group supervision and overcrowded wards on patients. Nurses are accountable for their practice and ensuring patients' dignity and safety are fundamental to codes of nursing practice and ethics (Nursing and Midwifery Council (NMC), 2018). Failing to meet ethical standards is morally distressing and increases the risk of staff burnout (Bradshaw, 2019; Bagnasco et al., 2020).

Both nurses and students highlighted the need for changes to current supervisory practices. They proposed appropriate selection and recognised training for supervisors, alongside dedicated supervision time, student-focussed approaches, IPE and a broader emphasis on education and professional development to replace the narrow focus on skills.

6. Limitations

The research is limited by using written questions to gather data as these are likely to have resulted in less detailed responses than interviews or focus groups. As data was collected in work and study locations, concerns about anonymity may have influenced participants' responses. Finally, translating data into English for analysis may have subtly changed its meaning and the cultural perspectives of the authors may have influenced their interpretation of the data.

7. Conclusions

Sri Lankan nurses' abilities to effectively supervise students may be influenced by governance structures and lack of professional self-determination and power, which can leave them without the necessary time, resources, and preparation for the role. Both nurses and students find the situation stressful. Raising the profile and status of Sri Lankan nurses will take time and input from many different sources.

As a result of this study, a mentorship education programme for qualified nurses supervising students was developed to meet these requirements and approved by the Sri Lankan Ministry of Health in November 2019. This represents a small, but significant, change which acknowledges the importance of nurses and nurse education. This will hopefully pave the way for increased professional recognition and development opportunities for nurses in the future.

CRedit authorship contribution statement

Elaine Hill: conceptualisation, methodology, formal analysis, data curation, writing – original draft, writing – review and editing, supervision, project administration, funding acquisition.

Kalpani Abhayasinghe: conceptualisation, methodology, formal analysis, writing – original draft, writing – review and editing.

Declaration of competing interest

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

Acknowledgements

The authors wish to thank Dr. Thamasi Makuloluwa, Nirosha Edirisinghe and research assistants Krishani Jayasinghe, Chavika Samarasinghe and K.D.M. Nadeeshani for gathering and preparing the data and the Institute for Research and Development in Health and Social Care (IRD), Sri Lanka, for their support.

This work was supported by the Lancashire Research Institute for Global Health and Wellbeing (LIFE) and the Higher Education Innovation Fund via the University of Central Lancashire, UK. The funders were not involved in the collection, analysis or interpretation of data, writing the paper or the decision to submit the work for publication.

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