The lived experiences of student nurses in clinical placement.

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Jean Astley-Cooper

SUMMARY

Nurse education over the last 30 years has undergone radical change which has transformed the nature, design and content of pre-registration nurse education. In Britain there is little known about the total impact of practice placement on learning and development of nurses' identity from the students' perspective. How nursing practice is understood and interpreted influences students practice experience, in addition to how they learn and construct their identity as registered professionals.

This research study explores student nurses' experiences of clinical placement whilst undertaking a pre-registration adult branch nursing course. A qualitative hermeneutical phenomenological approach was used and after ethical approval was received the experiences of 9 student nurses were collected using unstructured, individual interviews which were transcribed and analysed.

The key findings showed that clinical placement experience fell into three main categories: successful, unsuccessful and failing communities of practice. Mentors influenced the experience students had in practice in these three categories. In successful placements, students practiced alongside registered nurses with opportunities to observe these nurses at work. In unsuccessful practice communities, students described impressions of not belonging, loneliness and confusion, and compartmentalised their experience into the work and learning which affected their over-all learning experience. Failing communities of practice exposed and subjected the students to unprofessional values and behaviours from registered nurses, which if adopted and applied, impacted detrimentally on the care that patients received.

As the experience of clinical placement influences how students are socialised into the practice of nursing, how they learn and construct their identities as registered nurses, solutions designed to strengthen the clinical placement component of nurse education have been suggested in the following areas: belonging and modelling, placement quality and organisation, curriculum development, and mentor preparation and updating.

DECLARATIONS AND STATEMENTS

The lived experiences of student nurses in clinical placement.

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed..... Date...17th March 2012

(Candidate)

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s).

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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Chapter one

Setting the scene

1.0 Introduction

This study focuses on the lived experiences of student nurses undertaking pre-registration adult nursing courses in relation to their clinical placement component. It is set within a Faculty of Health and Life Sciences which is contracted to deliver and run pre-registration nurse education courses. The faculty in question is part of a large university in England. This chapter explores:

- My interest in the topic
- The research question that this study intends to cover
- Placement component of nurse education
- Background and context of the study

1.1 My interest in the topic

I first became interested in the topic when I was employed as a principal lecturer in the department of nursing within a university. As well as fulfilling the role of principal lecturer my key role was as Placement Development Manager where I was responsible for negotiating and securing quality placements for pre and post registration nursing and midwifery provision, as well as the overall organisation of placement management. My interest was conceived when I noticed that I used to have requests from pre-registration student nurses undertaking an adult nursing course to change their clinical placement. There were a variety of reasons why students wanted to change, but this particular day the student told me that she did not want to be placed in that particular area as she would have to do the "vile work" of nursing. I began to notice that this was not the only request I was getting. A small number of students were also making similar requests for a change of placement citing the same reason. This made

me very curious as to what this work entailed, so after engaging the students in conversation I discovered they were referring to participating in meeting the patients' physical care needs, such as washing, dressing, mobilising and nutrition. I was curious as well as being unsettled, as this challenged my view of the nature of nursing as I had never conceptualised basic nursing care as vile work.

Professional governance advocates individualised holistic nursing which I ascribe to. The essence of nursing for me was caring for patients in a variety of circumstances which included helping them to meet their individual basic needs. Caring is at the heart of my understanding of nursing. Asrif (2009) describes caring as involving compassion and thoughtfulness, consideration and mindfulness and vigilance and safe keeping which I relate to. Although on first hearing these requests I thought the students were uncaring, this didn't satisfy my desire to further understand the background behind these requests and why students had this idea about nursing. I believed that by exploring this phenomenon it would provide me with a deeper understanding which would help to inform my work, as I placed students into placements every day and could also provide a greater insight into the clinical component of pre-registration nurse education.

1.2 Placement component of nurse education

Exposing students to the practice of nursing by allocating them to clinical placement has been enshrined within nurse education since the time of Florence Nightingale (Rafferty 1996) and its place within nurse education has rarely been challenged (Nolan &Chung 1999). It is assumed that students require placement exposure in order to learn the practice of nursing and consequently clinical placement is part of the preparation to become a registered nurse. The clinical learning component consists mainly of two categories of experience, providing the student with extensive and varied learning opportunities.

These include:

- Simulated practice
- Practical experience in real life work placements

(Andrews et al 2005, Brodie et al 2004, Freshwater & Stickley 2004, Ip & Chan 2005, Mallick & Aylott 2005, Mannix et al 2006, NMC 2004, 2006).

This study will only consider practical experience in real life work placements, which I have referred to as clinical placement.

The clinical nursing placement experience for students is influenced by how nursing practice is understood and interpreted. This will influence what and how students are taught and what they learn. Nursing practice can be interpreted as skills acquisition, meaning the development of psychomotor skills (Macleod Clark, Maben & Jones 1997) or clinical skill development involving the development of clinical "knowhow" which is espoused by Benner (1984).This is further discussed in chapter two section 2.2. The nature of the placement experience is currently set by the Nursing and Midwifery Council (NMC), the professional body of nursing, and is laid out within their standards for pre-registration nurse education (NMC 2004, 2010). Under the current standards, students are allocated to a variety of clinical placements for a total currently of 2,300 hours which is structured as part of the pre-registration nursing course.

1.3 The research question

The aim of this study has been to explore through the lens of the student the phenomenon of clinical placement in relation to learning and the construction of their identity as a nurse, to discover the common patterns that arise to enable a greater understanding of this experience. A working hypothesis was that a greater insight and understanding of the nature of the student experience of clinical placement would firstly help to inform my practice as Placement Development Manager and secondly to enlighten pre-registration nurse education. Viewing the phenomenon from a different perspective could provide

greater insight which may challenge current thinking of nurse educators including my own, which could influence educational practice including curriculum development. A research question and objectives have provided a framework for the enquiry and given direction for the literature review and informed the methodology. The question is:

"To examine how the lived experience of clinical placement impacts the learning and identity of student nurses"

My objectives for the study were:

- To examine the lived experiences of student nurses in clinical placement at a university in England.
- To review the literature in relation to clinical learning, socialisation and identity
- To explore the relationship between learning and identity
- To examine how the theories of learning interpret learning and identity
- To analyse the findings from the study.
- To inform my practice as Placement Development Manager
- To examine the implications of the findings for nurse education
- To generate new knowledge

Since the research question was to examine student nurses' direct experiences of clinical placement in order to gain insight and understanding, a method which supported this exploration was needed. Direct experience relates to our relationships with people and objects and the thoughts, emotions and memories it generates (van Manen 2003). Hermeneutic Heideggerian phenomenology was chosen because it allows for the investigation and analysis of experience, and Heidegger's use of phenomenology avoids the fragmentation of the person from their context of everyday living. Heidegger believed that knowing and understanding the world from the Cartesian custom of the division between the mind and the body resulting in "subjects knowing objects" (Magee 1987 page 255) provided unacceptable descriptions of our relationship to things (Magee

1987). This study therefore adopted a Qualitative Heideggerian Hermeneutic Approach.

1.4 Background and context of the study

Pre-registration nurse education, by its very nature, spans both the world of education and health care delivery, with the students being socialised into the culture of each. In Britain it has always been a balancing act between health service needs, available financial resources and the educational vision of the day (Hart 2004). Traditionally the nature, structure and organisation of nurse education has been shaped mainly by two powerful forces; education and healthcare, whose influence ultimately decide its shape and development but within which are a number of secondary forces at play both within nursing (internal), outside of nursing (external) and locally (at point of delivery) which also affect it. These forces not only influence the blueprint containing the direction and general outline of pre-registration nurse education but also the day to day delivery, affecting the experiences of the students. Nursing placements are the zone where these two forces meet. It is during clinical placement where pre-registration nursing students will have to manage and cope with both the cultures of education and health care. It is assumed that the more congruence between these worlds, the less likely that the students will experience conflict, whilst the more the differences become apparent the potential for issues increases. The mix of these forces will affect the student experience in clinical placement.

1.4.1 The nature of education

Nurse education will be influenced by the understanding and interpretation of education within society. Such insights will help to contextualise nurse education. The nature of education is not clear cut and can often give rise to conflicts and confusion. These conflicts reflect the balancing act between meeting the needs of society and the freedom of the individual (Borrelli 2004). The needs of society are immersed in what is best for the society whilst the

freedom of the individual emphasises autonomy and self emancipation and reflects the utopian nature of education (Borrelli 2004). As educational theory usually reflects aspects of both this often leads to tensions and paradoxes which Borelli (2004) has identified as:

- Releasing the individual from the view of empirical reality whilst realising it is this which produces the person
- Preparing individuals in autonomy and self determination so that they can recognise and resist the determining influences of society.
- Freeing individuals from the regulated freedom held by society

Borrelli's (2004) key paradoxes identify the conflicting nature of education, which on the one hand is about socialising the individual into society, but on the other to make the individual aware of what is happening by exposing the "conditions and determinants of such socialisation" (page 445). This means that education often takes up a stance against itself by reflecting on its commitment to specific positions which can challenge the view of empirical reality (Borelli 2004). Such conflicts are translated into the traditions of teaching and learning. Hinchcliffe (2001) describes two types of teaching and learning that reflect the elements described by Borelli above. Instrumental learning, with its measurable specific objectives, develops the well formed person to meet political, social and economic ends which reflects political power and the economy and places learning at the service of government. Student centred learning which engages in a form of enquiry that is essentially open and underpinned by the values of creativity, freedom and critique and which focuses essentially on the needs and development of the individual. Although the latter approach to education is less constrained than its counterpart it still must provide certain skills and knowledge.

1.4.2 Nurse education and policy

The conflicting nature of education is reflected in nurses education which in Britain has always been an attempt at congruence between health service

needs, available financial resources and the educational vision of the day, which has usually emphasised the needs of society (Hart 2004). However, the balance did shift towards individual freedom with the introduction of the Project 2000 reforms which was driven by the ideological vision for a practice-led profession. Project 2000 was embedded in the principles of autonomy and accountability and reflective practice which formed the foundation for this new vision (Kitson 2001). The profession was driving and shaping nursing and these reforms, which were accepted and implemented by the conservative government of the day, contained a new educational strategy for preparing registered nurses.

It has been assumed in the past that nursing is a unitary profession with values and beliefs which are recognized and shared by its members. However at the time of these reforms White (1988) argued that nursing was a plural society with three distinguishable groups which include: the managers who control many staff for the benefit of the service; the generalists who carry out the job; and the specialists with a specialist knowledge base who support a professional basis for nursing. Such diversity within the profession makes the implementation of the vision more difficult and complex. For these reforms in nurse education to be successful, they had to be accepted and enacted by the profession of nursing which is dependent on how its members interpret and act on it. If it is not accepted, then it is not enacted, thus impeding the change as the vision becomes unfulfilled and meaningless (Evans 2008).

These reforms were not well received by all nurses (Bradshaw 1998, Kitson 2001) nor did they take account of the social and political situation within which nursing was located (Dunne 2007). The Project 2000 reforms were at odds with the government of the day, whose values reflected fundamentalism, economic individualism and moral authoritarianism compared to the values of new democracy reflected within nursing's Project 2000 reforms (Kitson 2001). These government values were translated into the health care policy framework of the time which did not support this vision for nursing and nurses did not have the power to enact the changes necessary to bring this vision to full fruition. The

Griffiths reforms of the National Health Service (NHS) of 1983 led to the removal of nurses from key positions within the health service, thus removing their opportunity to influence the position of nursing within the external world of the NHS (DHSS 1983). It has been argued that it was this invisibility of nursing that enabled these reforms to slip through the conservative government of the time as they did not appreciate that they had endorsed reforms at odds with their own set of values (Kitson 2001). Reforms that are at odds with the ideological position of the government in power are in danger of being misunderstood and sabotaged (Kitson 2001). This was demonstrated with the implementation of project 2000.

Project 2000, the educational strategy for pre-registration nurse education was implemented as part of these reforms over a period of approximately 10 years, beginning in the late 80s but it was highly criticised for not preparing students for their role in the workplace as evidenced by the evaluations (Carlisle et al, 1999, Lucker et al 1997). This left nursing in a weakened and vulnerable position. Towards the end of the lifespan of Project 2000 there was a change of government to Labour with their underpinning values and beliefs of social democracy which was in line with the values of nursing. Though there appeared to be congruence, this Government used the evidence from the evaluations to bring about change to pre-registration nurse education and was successful in wrestling control of pre-registration nurse education back from nurses and placing it firmly within the National Health Service who now had the power, through the Department of Health, to shape and direct this provision. This was reflected within government policies (DH 1999c) and demonstrated the returning emphasis to nurse education meeting the needs of society controlled by the Government in power. This led to the influence of nursing to shape its own future ebbing away as control for pre-registration nurse education returned to the National Health Service who would have the power to decide nursing's future. Further details of these reforms will be discussed under the current strategy of nurse education in section 1.4.6.

1.4.3 Professionalising nursing

Project 2000 was a professionalising strategy for the purpose of promoting the recognition of nursing as a profession by improving the status, power and authority for nursing (White 1988). A profession is defined as an occupation practice or vocation requiring mastery of a complex set of knowledge and skills through formal education and practical experience which is governed by a professional body (Cruess et al 2004). This is enacted through professionalism. However, this concept lacks clarity (Evans 2008) and has changed with the times. Troman (1996) believes professionalism to be a socially constructed, contextually variable and contested concept defined by management and expressed in its expectation of workers and the stipulation of tasks they will perform. In the past, Hoyle (1975) defined professionalism as those strategies employed by its members to obtain status, salary and conditions. Such a definition implied that the profession was under the control of professionals who had the power to decide their remit and responsibilities. More recent definitions have recognised the external political influence on professions. Hoyle (2001) now sees professionalism in relation to the quality of professional practice which is influenced by external forces outside the profession.

1.4.4 Changing nature of professions and professionalism

The most significant change to the nature of professionalism over the last 30 years has been in relation to control. Professionalism incorporates the content of the work carried out by a profession, and as such, includes the roles and responsibilities, the key functions and remits, the requisite skills and knowledge and the nature of work related tasks. In the past professions have been very much in charge of deciding these for themselves, whereas in the last thirty years or so professions have been subject to increasing control from outside, particularly from the government (Evans 2008). This has resulted in a power shift away from professions which has led to changes in the nature of professions and professional practice, culminating in a blurring of boundaries between professions. Blurring of professional boundaries in relation to health

care has led to changes in functions, roles and work tasks being undertaken by the professions. An example is the changing nature of nursing to incorporate functions and work tasks previously undertaken by the medical profession such as nurse prescribing (DH 1991, NHS Management Executive 1991). To incorporate these, nurses have devolved some of their functions and tasks to support workers. Changes to the nature of a profession and its practice will impinge on the education and professional development required by that profession.

Professionalism includes two elements: professional culture, which is the behaviour and attitudes of the members of that profession; as well as the functional relating to the key functions, remit and nature of the work tasks involved (Evans 2008). A key element within professionalism appears to be a commonality amongst the members (Evans 2008). Day (1999) describes this as "a consensus of norms" (page 13) including being and behaving as a professional within personal organisational and broader political conditions. This implies a collective notion shared by many (i.e. the members). Any attempt to impose professionalism on a profession must take into account the influence and nature of its professional culture if success is to be achieved, as changes requires its members to be accepting and adopting of these (Evans 2008). If this is not the case then the changes to professionalism envisaged, whether externally or internally initiated, will not be enacted by its members and therefore will fail.

1.4.5 The profession of nursing

I have suggested that it was thought that nursing in the past had been viewed as a unitary profession with a shared consensus of norms. However this idea was challenged in the late 80s when White (1988) proposed that nursing was a plural society made up of three distinguishable groups, the managers, the generalists (the workers) and the specialists, each with their own value system. Although this research is now over 20 years old, there is some evidence that this may still be the case in nursing. Kitson (2001) highlights differences within

the profession between those who cling to the traditional values reflecting the religious and military origins of nursing and the deep gendered stereotypes and those who aspire to new nursing based on the principles of social democracy. Such differences will influence how the members of the nursing profession accept and adopt changes. This will impact on the practice of nursing.

1.4.6 "Making a Difference" – the current pre-registration nurse education strategy

Current pre-registration nurse education has been shaped from key government and nursing policies, including "Making a Difference" (DH 1999c) and "Fitness to practice (UKCC 1999). The policies of the Government and the professional body of nursing (DH 1999, UKCC 1999) guiding nurse education in the 21st century formed part of a wider policy framework of globalization, innovation and the adoption of market principles in education and healthcare which have all influenced how pre-registration nurse education has been ultimately shaped and delivered. The policies shaping and directing nurse education reflected the discontent, particularly among the NHS management (Carlisle et al 1999, Lucker et al 1997), who felt that pre-registration nurse education did not prepare nurses at the point of registration to undertake the work because of a skills deficit and a theory practice gap.

It is not surprising that the driving force for the educational strategy for pre-registration nurse education sets out to resolve and rectify the discontent felt from Project 2000.The focus of the vision was therefore to ensure that students at the point of registration should be fit for purpose and practice. This is demonstrated by the government's vision:

> "Nurses at the point of registration who are "fit for purpose", with excellent skills and the knowledge and ability to provide best care possible in the modern National Health Service" (DH 1999c page 23).

Alongside the Department of Health demands for nurses to be fit for purpose, nursing's professional body demands that the student at the point of registration

has to be fit for practice. Again, there was no clear picture as to what fitness for practice was, although there were a number of recommendations made as to how it could be achieved (UKCC 1999). It is unclear whether fitness to practice and fitness for purpose concur, as both statements lack clarity leading to possible confusion and conflict.

1.4.7 Ideology of health care policy

The current pre-registration nurse education strategy was introduced at the time when the labour government was modernising the health service, and together these would impact on the nursing profession. The health care policy underpinning the current health education strategy was part of the new democratising vision for the United Kingdom, which was built around the key principles of social justice; equity and individual freedom; protection of vulnerable individuals; freedom as autonomy; no rights without responsibility; no authority without democracy; diversity and philosophic conservatism (Kitson 2001). These principles are reflected in a number of health care policy documents (DH 1997, DH 1999a, DH 1999b). This modernisation was not confined to health care but reflective of general change within society. The Government introduced a new delivery system in an attempt to produce the infrastructure necessary to bring about the new vision (Kitson 2001) which affected all levels in society. In health care this involved radical change, including innovation and new ways of working.

1.4.8 Health care policy and nursing

According to Davies (1995) the ideologies of nursing and new democracy complimented each other, and as such, nursing was thought to be better placed than other health care professionals to cope with the modernisation agenda (Kitson 2001). However, to be successful would require nursing to address a number of complex issues inherent within the social democratising principles, including equity between the sexes, mutual respect, autonomy, decision making through communication and freedom from violence and would require its

practitioners to adopt a new professional nature of nursing and changes to the relationship with medicine, patients and clients (Kitson 2001). However there was much support from nursing and other health care professions particularly medicine to maintain the traditional roles (Bradshaw 1998b).This had been fuelled by the criticisms of nursing within the media (NMC 2005) and the perceived failure of Project 2000. This left the nursing profession weakened, vulnerable and in turmoil. The blame for the problems within nursing was being laid at the door of nurse education, which influenced the educational reforms and their implementation (Kitson 2001). It is therefore not surprising that the Labour government did not trust nurse education to deliver its reforms.

1.4.9 Implementation

The Government's educational reform "Making a difference" (DH 1999) implied by its prescriptive nature that nursing education was not capable of understanding the necessary changes, and thus required these changes to be imposed. The Government imposed a framework of national competencies to be achieved through pre-registration nurse education. This raised the question of how competence should be assessed what should be assessed and who should make the assessment. The challenge for the nursing profession was to deliver a scheme that would meet the government's requirements as well as delivering the best for patients and clients and the profession of nursing (Kitson 2001). This was complicated by nursing not having a clear vision of itself, whilst those outside the profession had the power to decide. The traditionalists wanted the competencies to reflect a behavioural model of nursing whereas the professionals wanted a framework that enabled nurses to become safe accountable autonomous responsible and reflective practitioners (Kitson 2001). However the decisions regarding the competencies would be influenced by external forces such as the Department of Health and service organisations.

The outcome according to Taylor et al (2010) was a competency framework where the emphasis for assessment was on psychomotor competence and care delivery /management capabilities with less focus on critical thinking, problem

solving and decision making skills. Such an emphasis was not a surprise as previous nurse educational reforms such as Project 2000 were criticised for not developing the students' practical nursing knowledge and skills. Instead, it was thought to be too theoretical, especially at the start of the pre-registration nurse education programmes (Carlisle et al 1999). Thus, these intellectual skills, thought necessary for nursing and recognised by the Department of Health as being required by nurses (DH 1999c), were not translated through the nursing practice competency agenda which adopted a behavioural approach to skill development. This gave rise to a paradox as nurse education moved into higher education where such intellectual skills are thought to be fostered. This has limited the impact of the educational reforms in nursing on delivering the modernisation agenda envisaged by the government (Taylor et al 2010).

This was further impeded by the Government's stance on the development of new knowledge. The Government at this time favoured a positivist approach to this (Rolfe 2002) which can be seen in their actions through the setting up of The National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (DH 1997) and in the approach taken in relation to the assessment of research by UK universities. This was narrow and reductionist and favoured technical rationality at the expense of other epistemological positions. According to Antobus (1997), the implication of such an approach has the potential to lead to human beings being seen as a fragmentation of parts and systems at the expense of understanding human actions and concerns. This can have a dehumanising effect (Antrobus 1997). It also conflicts with holistic individualised patient care advocated by the Department of Health and the UKCC (DH 1999c, UKCC 1999).

The knowledge base underpinning a profession will shape and influence the education and the professional practice (Eraut 1999, Standish 2007). Nursing underpinned by a knowledge base developed using only a rational scientific view of understanding human beings constrains and limits nursing knowledge. This approach favours technical competence (Standish 2007) over holistic

individual nursing care (Kenny 2004). Much of the new knowledge that could develop nursing, including pain control, adequate nutrition, hydration and comfort measures require the use of a variety of epistemological approaches but these are seen as being of less importance (Kitson 2001). Such developments however would help to enhance the evidence base for nursing, and thus inform the delivery of nursing care.

1.4.10 Working in partnership

This educational vision for nursing reflected within " Making a Difference "was to be achieved by focusing attention on three key areas for development which included skill development, integration of theory and practice and teacher support for students in placement. Pre-registration nurse education was to remain within higher education institutes, reflecting an international norm (Watson 2006) and one which the government saw as being positive (DH 1999c).This approach was reliant on partnership working between the key stakeholders of education and healthcare. Success or failure rested on the quality of the partnership working. The key stakeholders in practice had a responsibility to articulate how nurses should be prepared for their future role in the health service, whilst educational institutes had the responsibility to translate this into programs that would deliver these outputs. From experience, stakeholders in practice find this difficult to articulate. This is partly due to the continuing changing nature of the roles and responsibilities of nurses in response to the transformation of health care services (Spilsbury & Meyer 2001). Read et al (1999) identified over 3,000 roles for registered nurses illustrating that the role of the registered nurse is not uniform or static.

Both organisations; healthcare and education, involved in pre-registration nurse education were being driven and shaped by the ideology of the market and market principles within a culture of accountability, transparency and standardisation (Drummond 2007). According to Readings (1996), the characteristic of a higher education institute based on such an ideology is efficiency and effectiveness and changes the nature of education and

knowledge to that of a commodity (Grace 1989). Education born out of such a set of beliefs embraces technical rationality, and attempts to apply the same control and standardisation to human practices as it does to objects (Dunne 2007). Health care organisations also embraced efficiency and effectiveness (Mannion et al 2005) to achieve their health care outcomes. However both had their own sets of values and priorities. This led to the potential for underlying tensions which could spill over. Such tensions would be more likely to be felt by the students during their placement experience as these were the settings where the students were exposed to the two differing forces of healthcare and education each with their own sets of values and behaviours.

1.4.11 Evaluation of "Making a Difference" - the current pre-registration nurse education strategy

Although stakeholders thought that the changes to pre-registration nurse education introduced at the beginning of the new millennium brought a number of improvements, the evaluation by Scholes et al (2004) uncovered a number of issues that were still problematic. These included:

- Skill development
- Assessment of practice
- Teaching support in placement
- Integration of theory and practice

Skill development

The evaluation of the previous reforms highlighted that nurses were deficient in practical skills at the point of registration (Lucker et al 1997). This news gathered momentum through the attention given by the media (NMC 2005), even though these deficits were short lived and that newly registered nurses caught up within a few months of being in the job. As a result employers and government, alerted to this issue, became dissatisfied and wanted newly registered nurses to be "fit for purpose" by ensuring that these new registrants had the skills to provide best care (Lucker et al 1997). Although the focus for

pre-registration education was on skill development which was competency based, reflecting the government's vision of public sector productivity and skilling up the workforce, there was discrepancy over the choice of skills. Stakeholders in practice wanted students at the point of registration to meet the demands of practice and "*hit the ground running*" (Carlisle et al 1999 page 1262, NMC 2005 page 82). However the changing complex nature of health care, requiring adjustments to the registered nurses' roles, responsibilities and work (DH 1997), made this difficult to translate, resulting in NHS organisations asking for different skills and competencies which did not demonstrate uniformity or consistency (Scholes et al 2004). Thus there was no clear understanding of the meaning of 'Fitness for Purpose' and this could vary from region to region. O'Connor et al (2001) also identified that senior nurses tended to have lower expectations of competency than the actual level of competency demonstrated by new registrants.

Assessment of practice

Even though there were a number of limitations and criticisms about a competency based approach to education, including its bureaucratic, reductionist and restrictive nature (Girot 1993, Le Var 1996), the UKCC followed the government's lead and adopted this approach for pre-registration nurse education (UKCC 1999). In reality, this approach proved difficult to translate into practice, with confusion around the definition and meaning of competence making it difficult to apply (Bradshaw 2000, Watson et al 2002a, and Watson et al 2002b). This lack of clarity was reflected in the assessment tools used to measure clinical competence as the majority of these were locally constructed without being tested for reliability and validity, and were difficult to understand and apply in practice (Norman et al 2002). This raises the question as to whether the standard of competence envisaged in the new registrants has been achieved.

Teaching support in placement

Schön (1991) believed that for students to learn a professional practice they needed professional practitioners who could cue them into seeing the practice situation and help them to experiment safely, requiring the student and the professional practitioner to be involved in the same practice situation. This does not appear to be always possible in nursing due to the organisation of the work.

Scholes et al (2004) found students and registered nurses within the clinical placement were involved in differing aspects of the placement work. She found that the students were involved in basic nursing whilst registered nurses were involved in organisation and management (Scholes et al 2004). This made it more difficult for the registered nurses, the professional practitioners, to cue students into the practice situation. Scholes et al (2004), however, also found that mentors had deficits in their knowledge base and did not ask students probing questions which could also be a contributing factor as to why registered nurses did not always cue students into the practice situations they encountered. They found that students were not cued in by their mentors into learning opportunities that presented whilst they were undertaking basic nursing care, in particular the opportunity to learn higher order skills (Scholes et al 2004), which Carr (2008) believed registered nurses performed as part of their advanced technical and managerial functions. Thus, if students are not cued into these higher order skills by registered nurses it is probable that students do not recognise them.

For this to occur, it would require professional practitioners, who have such skills to demonstrate these whilst working alongside the student. In this way students could learn the skills. However evidence shows that this does not always happen. This could be due to a number of factors such as the organisation of the work in placement preventing students and registered nurses working together and/or a competency based model if focussed on the concrete, specific and measurable aspects of nursing as this is thought by Chapman (1999) to hinder the development of higher order skills.

Scholes et al (2004) discovered that both registered nurses and students saw joining of higher order skill learning with fundamental skill development as unrealistic. Students were also having difficulty in seeing the relevance of being trained in basic care (fundamental nursing skills) when registered nurses were expected to do organization and management (Scholes et al 2004). Aspects of nursing work not normally delivered by registered nurses can be given little value by the student or can be omitted from their conceptualisation of the nature of nursing, and therefore their inclusion in the curriculum can be difficult for the student to comprehend. According to Carr (2008), the modern nurse spends her time undertaking advanced technical skills or managerial functions (Carr 2008) in response to the changing complex nature of health care, requiring amendments to their roles, responsibilities and work (Spilsbury & Meyer 2001). If students are to be prepared to be fit for purpose then students have to be prepared to undertake these roles, responsibilities and functions. This is difficult to translate into practice due to the diverse nature of the registered nurses' role.

During the introduction of the current pre-registration nurse education strategy, at the beginning of the new millennium, the NHS was experiencing the worst shortage of registered nurses in twenty five years (Mitchell 2003, Scott 2003). This reduced the numbers of registered nurses and mentors available to support the student's learning in clinical placement. This was further impeded as the commissions for pre-registration nurse education increased in response to the crisis (DH 1999c) adding further burdens to, the registered nurses particularly the mentors who have responsibility for student learning in placement. Although the government did identify the need to support students and mentors in clinical placement which led to a new breed of teachers, such as practice educators (DH 1999c) the numbers employed in this role tended to be small.

Integration of theory and practice

It had been thought that integration of knowledge, attitudes and skills could be realised through the structure, planning and organization of the curriculum, which assumed that students in practice could recognise situations and apply

appropriate theory to practice, but Scholes et al (2004) found this not always to be the case. She found that students often needed help to integrate theory to practice during clinical placement, but such help was not always forthcoming, a finding which highlighted an issue with how this was to be achieved (Scholes 2004). It was also proving difficult for the planners of pre-registration nurse education to achieve structuring which would reflect integration as the rise in the student numbers due to the increased commissions (RCN 2003) made it difficult to logically sequence theory and practice due to the increased numbers requiring clinical placement.

1.4.12 Standards of proficiency for pre-registration nursing education

The main function of the Nursing and Midwifery Council is to protect the health and well-being of the public using or needing the services of registered nurses. It does this by setting the standards of education, training and conduct and monitoring these to ensure they are applied. In relation to education, this is done through course approvals and ongoing quality monitoring. In 2004, the NMC updated the standards for pre-registration nursing education, reflecting what it considered necessary for safe and effective practice (NMC 2004). The Standards of proficiency for pre-registration nursing education (NMC 2004) were in place during the majority of the life of this study. The pre-registration nursing course (adult branch) undertaken by the participants in this study was developed and quality monitored using these standards. In 2010 the NMC published new standards for pre-registration nursing education. These are discussed below and will be reviewed to see whether they address the findings from this study. References to standards for pre-registration nurse education (NMC 2004, 2010) are cited as appropriate throughout the thesis.

1.4.13 The future: Nursing as a graduate profession

At the beginning of the new millennium the UKCC was superseded by the NMC as a result of a governmental review. The Nursing and Midwifery Council, the professional body for nursing in the United Kingdom, has introduced a

significant change to the criteria for registration, and potential registrants will in future have to have a degree in order to register as a nurse. Although this change has already been achieved in other parts of the United Kingdom, this is a new development in England, and all pre-registration nursing courses will be at degree level by 2013. This move is in keeping with other health care professional courses such as medicine, physiotherapy and occupational therapy, all of which only offer courses at degree level or above.

The Standards for pre-registration nurse education have changed to reflect this shift (NMC 2010). The emphasis now reflects the key elements of communication, professionalism, decision making and professional judgement and leadership and management (NMC 2010), which indicates a higher level of functioning than is currently expected of diploma students in England. This suggests that registered nurses in the future will be required to demonstrate higher order skills on completion of their pre-registration nursing course. This change also corresponds to changes within the health care workforce, and a new role of Assistant Practitioner is being developed and introduced to the work place (DH 2002). This role has been developed to assist health care professionals and preparation for the role is mainly through work- based learning with some theoretical input. It is envisaged that Assistant Practitioners for nursing will be involved in direct nursing care as well as some selective technical skills,and these developments have the potential to impact on the role of the registered nurse which will in turn have an impact on the preparation of student nurses.

1.5 Thesis layout

This thesis consists of nine chapters. Chapter one has set the scene of the study; chapter two discusses and critiques the literature pertinent to the subject including the purpose of placement within pre-registration nurse education and some of the contemporaneous issues that impact on student learning and their effects. Chapter three concentrates on the methodology and study design and outlines the way in which the researcher undertook the study. Chapters' four to

eight cover in detail the findings from the data collected, whilst chapter nine synthesises the findings for a deeper understanding of the whole. Finally, Chapter 10 discusses how the study impacts on nursing practice.

1.6 Summary

The aim of this chapter has been to set the scene for the study and to introduce how this topic came to be of personal interest to me. It outlines the research question to be examined and the method used to investigate the topic. It also begins to contextualise the study as well as introducing some of the issues associated with clinical placement. Clinical placement is a complex phenomenon which is influenced and shaped by multiple and varied factors which will be explored in the next chapter through an examination of the literature.

Chapter two

The literature review

2.0 Introduction

Clinical placement has always been seen as a significant and important component of the preparation of registered nurses, not only within Britain but around the world (Rafferty 1996, Briggs 1972, Baillie 1993, Dunn and Handsford 1997, May and Veitch 1998, Walker 2005, Mallick & Aylott 2005, Levett- Jones and Lathlean 2008, DH 1999, UKCC 1986,1999 NMC 2004, 2006, 2010). Its position in the preparation of nurses has never been challenged in the literature. It is assumed that students require placement exposure in order to learn the practice of nursing. The clinical learning component consists mainly of two categories of experience in providing the student with extensive and various learning opportunities. These include:

- Simulated practice
- Practical experience in real life work placements

(Mannix et al 2006, NMC 2004,2006, Ip & Chan 2005, Brodie et al 2004, Andrew et al 2005, Freshwater & Stickley 2004, Mallick & Aylott 2005).

This study will only consider practical experience in real life work placements, which will be referred to as clinical placements. The intention of this chapter is to examine and review the literature in relation to the nature, purpose of clinical learning in nursing and the factors which impact upon the students learning in clinical placement.

2.1 The literature review

The literature review sets out to identify the key elements associated with learning in clinical placement and how these impact on the students' learning and their construction of identity. It has been developed in stages and it was like peeling an onion as soon as one layer was removed another revealed itself. I

found it difficult to know where to start but decided to begin by looking at the purpose of clinical education. As well as being able to identify the key elements in relation to purpose it also helped to direct my next stage which were factors that promote learning in clinical placement. After reviewing and analysing this literature I was able to discover the main aspects which are discussed later in the chapter. These stages were carried out prior to collecting the data from this study and provided a foundation to undertake the next phase of the study.

The final two parts of the literature review, the factors hindering learning and the impact on learning have been undertaken as the study progressed. In order to further understand the issues and complexities being raised on the effects on learning, it was necessary to expand the search into the complimentary fields of psychology and biology. The key themes from this literature are introduced in this chapter and are picked up again in the findings chapter where they are developed to help with interpreting and understanding the data.

The literature review has been an ongoing process in this study and has provided a broad overview of learning in clinical placement and includes the purpose of clinical education, the factors that promote learning, the factors that hinder learning and the effects of these on learning. As it has progressed and developed it became more apparent that the key elements of clinical education needed to be viewed together in order to have a holistic understanding. Each stage will now be addressed under the following sections.

2.2 The purpose of clinical education

The aim of professional education according to Wong et al (1995) is to prepare professionals who can apply theoretical knowledge to the real world of practice. This real world where nurses practice their craft is constantly undergoing change leading to continually evolving roles within the practice of nursing (Ousey & Johnson 2007). If nurse education is to fulfil the aim as presented by Wong et al (1995) it has to respond to these changes and prepare students with the education to practice. From the review and analysis of the literature the key

functions which emerged as to the purpose of clinical education in the preparation of registered nurses were:

- Developing skills
- Integrating theory with practice
- Being socialised into the profession of nursing

Each of these will be evaluated as to their purpose within nurse education and the specific implications these have on the practitioner in their role as a nurse.

2.2.1 Skill development

The nature and content of skill acquisition for pre-registration nurse education is not made clear within the literature. Nolan (1998) believes that skill development should provide nursing with the necessary abilities needed in order to facilitate student nurses' passage into the workplace as a registered nurse. However, this does not help with identifying the nature of clinical skill acquisition or with identifying the skill set for registered nurses, as the role of the registered nurse is not uniform or static. Read et al (1999) identified over 3,000 roles for registered nurses. Some of the named skills found in the literature included an assortment of, for example, psychomotor skills such as those required for recording clinical observation, cognitive skills such as problem solving, decision making, clinical judgement and applied social skills (Nolan 1998, Evans 2006, Edmond 2001, Dunn et al 2000, Rance & Grealish 2007). Although the literature identifies and discusses a number of skills under various headings it is less clear as to the meaning or content of the term *skill* or the definition of skill acquisition.

The kind of knowledge that the profession embodies (Dunne 2007), including the conceptualisation of its professional practice, will influence how skills acquisition is understood and interpreted. This will influence how clinical placement learning is developed, implemented and experienced.

Up to the start of the 80s skill development in nursing was clearly defined and prescribed. The General Nursing Council produced nursing syllabuses which contained the specific skills which had to be assessed and measured to the standard they laid down before any nursing student could be awarded registration (Bradshaw & Merriman 2008). The identification of practical skills has in the past been linked to a "trade" not a criterion for professional status (Eraut 1999). Such an approach to developing competence in nursing focussed on training rather than education and was underpinned by behaviourism; a common tradition used post war. This approach relies on the detailed specifications of competent behaviour which tend to concentrate on the technical processes of skill development to the detriment of the social and political aspects leading to the criticism of it being too restrictive and narrow (Eraut 1999). The approach developed influences the design of the teaching and instruction.

The apprenticeship model was used to prepare nurses in the skills they required. According to Eraut (1999) the adoption of such an approach provides control over the qualifications and tightly links training to the specifications of need (Eraut 1999). However in a variety of occupations the nature of professional work changes rapidly in response to technological advances as well as the social and institutional change reflected in the constant redefining of public sector workers roles. It is therefore not surprising that by the late 60s and 70s there was a recognition that such a system was not providing nurses with the skills they required to do the job as they were not keeping pace with the medical and technical developments happening within health care at the time (Briggs 1972).There was also a recognition by Briggs (1972) that such a system of training impacted on the recruitment and retention as it failed to attract and retain nurses.

In the 80s nursing underwent a major ideological shift in the preparation of registered nurses from training to education. This new shift signalled a change in direction from the clear definitions and prescriptions of the past towards a

more collegiate, self reliant, flexible and self directed approach (Bradshaw & Merriman 2008). The new United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) wanted to provide students with opportunity which would lead them to be responsible for their own professional development including acquiring the necessary competencies (Bradshaw 2000). This approach was designed to produce a new breed of nurse "the knowledgeable doer" which Bradshaw & Merriman (2008) describe as a nurse who is confident, politically, socially and economically aware and can network. The standards and competencies to this new approach were not clearly defined, guidelines were vague allowing interpretation. Prescriptive regulations were few and these did not include detailed measures for the assessment of competence either in theory or practice. Such an approach to education emphasised individual development rather than meeting the needs of society. It was hoped that such a system would develop individuals in autonomy and self determination which was part of the vision at that time for nursing (Kitson 2001).

This move required changes to the designs for teaching and learning. There was a perception that more time was allocated to theory than practice. This lower proportion of practice is not uncommon in high level occupations and is designed to accommodate a large knowledge base all of which cannot be assessed in practice (Eraut 1999). Student centred learning with its emphasis on the needs and development of the students was introduced. Teaching and learning needed to reflect a form of enquiry that was open and underpinned by the values of creativity, freedom and critique. A teaching strategy which was introduced to help students learn from their practical experience was reflective practice.

Although there are numerous theories of reflective practice an influential approach to reflective practice at the time was developed by Donald Schön (1991) and became popular in nursing. Taylor and White (2000) believe that the popularity of Schön's reflective practice lies in the emphasis of this theory to the minutiae of day to day practice rather than the application of technical

knowledge. It is this focus on day to day practice that seems to resonate with professionals and give credence to the problems caused by differences between how we think professionals perform in the work setting and the reality.

This approach by Schön (1991) to reflective practice is based on the theories of action in practice developed from the earlier work by Argysis & Schön (1974) and uses the notion of framing. Schön (1991) believed that the nature of the day to day work of professionals required them to conceptualize, frame and re-frame problems as well as find solutions to deal with ill-defined situations which occur regularly in the work setting. This involved professionals drawing on their own practical experience in an intuitive manner whilst reflecting at the same time on what they were doing, which Schön called reflection-in-action (Schön 1991). As well as this, professionals can also be involved in reflection-on-action, which is to reflect on action after it has occurred (Schön 1991).

Framing and re-framing is a key element in the theory of reflective practice by Schön (1991). Kinsella (2006) believes that Schön has also drawn from the work of Goodman who has described in detail the processes involved in the acts of naming and framing, which are composition and decomposition, weighting, ordering, deletion and supplementation and deprivation. However as Schön did not make explicit this link one can't be sure that Goodman's processes of naming and framing is what he was meaning in relation to reflective practice. It is the way that such a challenge is framed and re-framed which is important as it affects what can be seen and eventually what action can be taken. Schön (1991) believed that it was important for the performer to be able to develop a range of ways of seeing. Hence framing and re-framing of challenges was the key to its successful application.

This experience of practice situations allows the practitioner to respond to the current event and modify and adapt the established practice to the individual practice situation to produce familiar outcomes. This implies a decision making process for the practitioner as opposed to the more passive role of applying standardised practice to all recipients. Thus for students to learn the knowledge

of a professional practice requires them to be exposed to practice situations under the support of experienced practitioners. Effective reflective practice according to Cranton (1996) can help to uncover and make available the professional knowledge base helping to link theory and practice. However the success as to whether this is achieved rests with how the theory is understood and applied by its practitioners. It is dependent on the ability of the professional practitioners to be able to deconstruct and reconstruct their practice for the benefit of the students. Without such support students may make erroneous suppositions based on their own personal reflections.

It has been suggested that the reflective approach applied to nursing is not being used as envisaged as it is being used to confirm competence rather than reflection for facilitation (Phillips et al 2002) and is mostly at a superficial level (Field 2004). According to Swanwick (2005) reflective practice where the individual mind frames, reframes or constructs the problems of practice does not adequately explain what happens in relation to apprentice style professional education. Swanwick (2005) argues that it is important in these circumstances to consider how the individual is shaped and developed through forms of participation within a society and how such participation impacts and transforms social practice itself.

The major criticism to this educational reform was that the health care policy and therefore the needs of society were not being met by such an approach. There is a recognition that a skilled and knowledgeable workforce is required to deliver government policy on health care and that this requires the education and training to be cognisant of these policies and future policy changes and directions in order to produce practitioners who are appropriately educated (Storey 1998). However this was not happening in nursing. Nurse education according to Bradshaw & Merriman (2008) was in a mess with a growing gulf between theory and practice. The lack of definition of competence gave rise to problems within nursing which was reflected in the evaluations at the time (Macleod Clark et al 1997, Lucker et al 1997). This lead to the government of

the day who was aware of these concerns instigating a review of nursing's professional body (Bradshaw & Merriman 2008) leading to the demise of the UKCC and the birth of the Nursing and Midwifery Council (NMC). A new era in nurse education began.

The next era in skill development for nurses was based on a competency based education approach which was attractive as it had the potential to clearly outline the competencies required to register as a nurse (Kenny 2004). This development re-introduced prescription and behaviourism back into nurse education. The teaching strategies changed to accommodate this including the teaching of skills and simulation of practice in newly established clinical skills laboratories within higher education institutes to rectify the faults of clinical competence. This approach appeared to mirror the approach adopted by the General Nursing Council previously discussed. The difference according to Bradshaw & Merriman (2008) was that the skills were not clearly defined and the standards for assessment not clearly laid out as it was in the approach prior to the 80s. Functional analysis is a method employed to develop occupational standards which are statements of competence for performance and include the range of work related activities, including the underpinning skills, knowledge and understanding needed in employment. Such an approach applied to nursing could have helped to identify more clearly the knowledge skills and understanding required however this was resisted by nursing (Storey 1998).

There are numerous definitions about the nature of knowledge (Eraut 1999). A criticism of occupational standards related to their interpretation of knowledge and understanding as it tended to favour propositional knowledge at the detriment of other forms (Eraut 1999). Propositional knowledge includes discipline theories and concepts based on a coherent systematic knowledge base, general principles relating to the professional practice and specific propositions about special cases, decisions and actions (Eraut 1999). It does not include the know-how knowledge required to perform these activities (Eraut 1999). According to Clark (1993) the development of occupational standards

had the potential to undermine professionals by reducing their qualifications to a series of technical skills.

Competency based approaches to education have been criticised for their reductionist and restrictive nature (Kenny 2004, Le Var 1996) however this depends on how competence is understood and applied. According to Kitson (2001) the challenge for nursing was to develop a coherent strategy which met the government's agenda for health care as well as incorporating the best for the patient.

The competencies were shaped by the powerful forces including the state, the economy and employers resulting in an educational strategy that favoured technical rationality and focused on technical competence at the expense of holism (Kenny 2004). A techno rational approach to skills acquisition in nursing is underpinned by the belief that action is preceded by thought (Standish 2007). It is underpinned by a propositional knowledge base which is the one most favoured by professions (Eraut 1999). Propositional knowledge emphasises objectivity and detachment, favouring the third person perspective which yields generalised findings using clearly formulated publically agreed procedures (Eraut 1999). Using this as a basis, the knowledge of a professional practice can generate general procedures, rules and formulae which can then be applied as prescribed in practice to solve the problems which arise to produce the particular outcomes envisaged (Dunne, 2007). This is achieved by attempting to predict, organise and regulate human action and interaction (Standish 2007). Standish (2007) calls this technising a practice.

Inherent within a techno rational approach to professional practice is the assumption that practitioners can use these procedures, rules and formulae in the straightforward way envisaged and that the problems can be solved through their application (Dunne 2007).This would imply that individual practice situations have no specific significance that has not already been reflected within the knowledge, and therefore would not require to be reviewed for their uniqueness and new insights, thus ignoring the human context of the individual

situation (Dunne 2007). This in turn makes possible a system where control, efficiency and accountability are possible through the standardisation of practice as the methodology and implementation employed can be monitored systematically and unambiguously (Standish 2007). It would thus appear that this approach is minimally dependent on the discretion and judgement of the individual professionals, providing a more practitioner proof mode of practice which is thought to be safer, as the risk from individual practitioners is thought to be reduced (Dunne 2007).

This approach to professional practice is thought to constrict and narrow the practice (Dunne 2007). "A practice", according to MacIntyre (1985), is a coherent complex set of activities consisting of technical competence and virtues that have evolved over time and are shared and practiced by its practitioners. A practice requires both technical competence and virtues: one without the other is not a practice. In order to become a practitioner, one has to learn both, since one without the other is insufficient. It is the combination of both which gives "a practice" its unique form (MacIntyre 1985). The current educational strategy according to Kenny (2004) emphasises technical competency which can have the effect of changing the nature of the practice (Standish 2007). The experience students have during their preparation to become a nurse will shape their understanding of nursing and their identity as a nurse. Thus the more students are being exposed to the changes envisaged by Kenny (2004) the more this impact will be demonstrated in the nature and practice of nursing. Such an approach, which reduces and fragments, can make it difficult for learners to see the interconnectedness of the practice situations they encounter.

Other approaches to skill development have been identified in the literature which has moved away from the assumption that learning is solely an individual process. A growing body of educationalists now espouse that learning also involves acculturation into the social processes and is based on the assumption that the mind would not exist without culture (Bruner 1996). Social

constructivism, which forms the basis of these approaches, postulates that knowledge, is located within cultures and that social meanings are shaped through communication with others (Rogoff 1990). It is the stories we tell and the conversations we have about them that lead to the construction of our world view (Swanwick 2005).

Lave (1996) states that learning is the life project of individuals and develops from the participation in social situated activities within communities of practice. Such a view places social contexts at the centre of the learning experience and that activity and experience take central importance in learning. This enables the novice not only to learn the discourse but also the behaviours of the members of the social group. Thus, the novices learn how to talk the talk and walk the walk by adopting the symbolic representations and the professional behaviours of the social group. It is this which defines how a profession thinks feels and acts (Swanwick 2005). Opportunities to participate in the professional group also help to develop professional identity (Swanwick 2005). Such an approach is not only dependent on knowledge from formal sources but also on social interaction from knowledgeable members of the social grouping.

An educational strategy underpinned by the understanding of learning in this way would require nursing to rethink the development of skills and would require redesigning pre-registration nurse education to accommodate it. This will not be developed further at this time as the skill development within nursing did not reflect this as a key approach to skill development in pre-registration nurse education.

2.2.2 Socialisation

Socialisation is the process by which individuals obtain the values, attitudes, morals, knowledge and skills of the adopted group (Price 2009). This is a complex process in nursing and it is unclear from the literature when the process begins and ends.

The literature suggests that student nurses enter nursing with some identified construction or mental image of an ideal nurse (Price 2009, Spouse 2000) usually focused around the notions of caring, nurturing and compassion (Price 2009). Calderhead (1991) suggests that it is these mental images which cue students to pay attention to particular aspects of their programme as well as providing a framework on which to organise their practice. These images, however, according to Kosslyn (1981) do not remain static but develop incrementally over periods of time and can be reshaped and modified according to perceptions of experience. Images appear to be developed from various sources, including past experiences as well as the media. These include experiences such as previous health roles or direct interaction with nurses and it is these rather than the media which are thought to give a more realistic and deeper level of understanding of the demands of the nursing profession (Andersson 1993, Gregg & Magilvy 2001). During the socialisation process, nursing students are required to translate what they have learned in a classroom into patient care while learning how to work within a health care setting (Oermann & Garvin 2002) with their organisational and bureaucratic work structures (Maben et al 2006, Hamilton 2005).

Professional socialisation has been defined as:

> "a complex interactive process by which the content of the professional role is learned and the values, attitudes and goals integral to the profession and sense of occupational identity which are characteristic of a member of that profession are internalized" (Goldenberg & Iwaisw 1993 Page 4)

This definition illustrates a combination of two strands that of learning the content of the role (the work) as well as the professional culture that makes the practices unique to that profession. The process for nursing involves not only learning the content of role but performing it in a way that reflects the values, attitudes and expected behaviours of the nursing profession. This can give rise to problems if there is incongruence between these two elements.

Since Florence Nightingale, the profession of nursing has been seen as the art of caring, however in recent times, rather than building the profession around caring, nurses have aligned their practice to technology and science (Stevens & Crouch1995). This can have the effect of devaluing work associated with caring and areas of work where caring activities predominate. Drombeck (2003) found that the notions of caring associated with the ideal images of the nurse proved to be a source of discontent and that nurses did not only want to be associated with caring. Stevens & Crouch (1995), in a small longitudinal study employing a survey method carried out in Australia, found a negative perception to work in aged care where caring activities predominated. However, care must be taken when applying this to Britain as the education and health care systems are different to Australia. According to Macintosh (2000) it is as if students are socialised not to care, either due to the constraints imposed by the conditions of their work which mitigate against care, or as a result of the personal and emotional damage constant involvement with caring can inflict.

Role identity and professional identification has been linked to others perceptions and expectations of the role (Drombeck 2003). These perceptions and expectations will affect the socialisation process as according to Hinds & Harley (2001), nurses often internalise the values, beliefs and behaviours of the nursing culture to seek acceptance from others. However these values and beliefs in nursing are not uniform, which can give rise to cognitive dissonance. Price (2009) undertook a Meta study of early socialisation and career choice in nursing and found that nurses experienced dissonance between assumed ideals and the shocking reality of the work (Price 2009) and that over time this led to the reconstruction of their notions of nursing practice in order to cope. However, this finding cannot be generalised as it was based on 10 qualitative studies where the sample sizes were small and the participants were normally drawn from one setting. This cognitive dissonance experienced by nurses during the socialisation process appears to stem from the paradoxical position of caring in nursing (Price 2009, MacIntosh 2000), leading to the incongruence between the expectations of role of the nurse and the profession of nursing

(Mackintosh 2006) and the lack of a set of unified values, beliefs and behaviours (White 1988, Gott 1984).

There appear to be considerable differences between what nurses do as part of the work in clinical setting and the ethical, moral and altruistic principles of care presented by numerous nursing theorists for example Leninger (1988) and Watson (1989). Studies by Bullough et al (1991) and Kiger (1993) found that students sublimated their personal beliefs in order to survive and that this often meant fitting into the normative practices of their colleagues. Mooney (2007) undertook a small qualitative study recruiting 12 newly qualified registered nurses employed within Ireland. She found that all the participants eventually conceded that they had conformed to ward rules and routines as they were keen to fit in to the ward routines and not cause trouble for themselves (Mooney 2007).

A number of North American studies (Kramer 1974, Davis 1975, Day et al 1995) found that the students were influenced by their clinical colleagues' value systems which were different from their teachers. Melia (1987) also found this to be the case in Britain. However, approximately 10 years later students were being influenced by the values and beliefs of their teachers. Kelly (1996) found in her qualitative study undertaken in Britain that the participants demonstrated a loyalty to the educational institution which required them to work hard at convincing the hospital staff that their education did not impede them from being a good practical nurse. However, this put a great deal of pressure on the students and they felt under pressure from the staff to conform to the ward routines which led them to experience stress due to role anxiety.

In nursing there seems to be disparity between the value set as espoused by those in the educational establishments and those in the clinical areas which has led newly registered nurses to experience dissonance. Gott (1984) proposed that there was conflict between teachers' professional model of nursing practice and the bureaucratic model held by the practitioners. Philpin (1999), in her qualitative study exploring the impact of project 2000 reforms on

the occupational socialisation of nurses, found that these participants experienced dissonance between the ideology of the educational institution and that of the clinical area, leading to difficulties for the students in delivering the nursing care they had been taught and in their relationships with the clinical staff. The examples cited related to not being able to deliver individualised holistic patient care due to the work being broken down into specific tasks and performed by a number of different nurses and support workers.

The nurse education policy contains the values, beliefs and behaviours of the nursing profession which will influence the professional model of nursing held by the teachers which can impact on the students' perceptions of nursing. Macleod Clark et al (1997) undertook a large scale two centre study examining the impact of project 2000 educational reforms on the perceptions of the philosophy of the practice of nursing. The study found that students' perception of nursing changed over the duration of the pre-registration nurse education course from an ill-health medical model to a health focus which included holism and health promotion. The influence of educational policy on nursing students' perceptions of nursing practice has also been found in other countries. Manninen (1998), in a large scale longitudinal study undertaken across 26 institutions in Finland, also found that student nurses perceptions of nursing changed to reflect the change in nurse education policy from the biomedical approach towards a human scientific model.

2.2.3 Integration of theory with practice

Where the purpose of clinical learning is discussed in the literature, the detail as to what the integration of theory to practice actually means or entails is not generally developed or discussed. However, there is an underlying assumption that pre-registration nursing preparation needs to have both a theoretical and practical element and that these need to be used together in order for nurses to practice. Edmond (2001) describes how the assimilation and application of propositional knowledge and the repeated exposure to practice situations allows the student to learn the "when and how" of nursing practice.

Theory and practice as applied to learning in nursing suggest that there are different elements to the learning process. Theory has been defined as the knowledge and principles needed to understand the "why of nursing" (Corlett 2000 page 501). Application of theory to practice assumes that the theory taught can be applied within the practice situations encountered. Corlett (2000) found that students encountered differences between the theory taught in the classroom and the practice they experienced in the clinical setting making it difficult for them to apply this to practice being experienced (Corlett 2000, Landers 2000, Spouse 2001, Burns & Poster 2008, Evans 2009, Moss et al 2010). Where students were taught the theory of individualised patient care but exposed to task allocation as the approach to care during their exposure to clinical practice (Corlett 2000) is an example of the theory practice dichotomy.

In a number of countries including Britain, the theoretical and practical components of pre-registration nurse education is split between an educational provider who normally has the responsibility for the total course and delivers the theory, and a placement provider the practice.

A common thread which runs through the clinical education component is the need for educational establishments to work with health care institutions in order to provide students in pre-registration nurse education with clinical experience where they have opportunity to experience real live practice and integrate theory and practice (Elliot 2002).The nature of this relationship varies across the globe. In some countries universities are required to pay for placement experience, whereas in Britain the National Health Service (NHS) is expected to provide this experience free of charge as a moral obligation. The quality of the student experience in practice is partly dependent on the relationship between the educational provider and the service provider.

2.3 Choices and decisions

The nature of nurse education will be shaped and influenced by the choices and decisions that are made in relation to the key areas identified above, including

the dominant knowledge type reflecting underlying beliefs and values, the conceptualisation of practice or clinical skills and the resultant approach to skill development, the relationship between theory and practice and the quality of the clinical learning experiences which will shape the students' professional socialisation. Together these impact on student learning.

2.4 Factors impacting on learning in clinical placement

The goal of pre-registration nurse education is to ensure that the student has enough theoretical and practical clinical experiences, usually in complex health care settings, to enable the student to develop the knowledge and skills they need to put together and manage the work of the practice setting (Budgen & Gamroth 2008, Edmond 2001). Students spend varying amounts of time during their preparation to become a registered nurse in clinical placements. The Nursing and Midwifery Council (NMC) sets down the regulations and standards as guidance to be followed when planning the practice component of pre-registration nursing education (NMC, 2004, 2010). This is then interpreted into pre-registration nurse education curricula which have to be approved by the NMC. In Britain, the length of clinical placement experience has been determined currently as 2,300 hours (NMC, 2004, 2010), whereas in Australia it ranges from as little as 520 to 2000 hours (Nolan 1998).

Clinical placements in nursing have often been perceived as physical experiences which have been traditionally thought of as single geographical placements such as wards, clinics or health centres (Donnelly 2003). The majority of the clinical experience for pre-registration nursing, particularly adult branch, has been traditionally assigned to the acute setting, especially hospital wards. However, this is beginning to change to reflect the transition to a primary care focused NHS (DH 2008 a & b, DH 2007a & b). It is also changing in the light of increasing pressure on placement capacity due to an increase in the number of pre-registration nursing commissions in recent years (RCN 2003), which has led to the development of new and innovative learning experiences

(Anderson 2009), an example is the learning pathway which focuses on the patient journey (Whitehead & Bailey 2006).

The popular notion which exists in nursing is that length of exposure in clinical placement is directly related to clinical performance, although Battersby & Hemmings (1991) found no such correlation. Hale (2003) states that there is no evidence available which identifies the clinical hours required for a student nurse to become competent in clinical practice. More hours does not necessarily equate to better clinical performance. However the labour government of the late 90s associated the skill deficit in newly registered nurses identified within the evaluations of project 2000 to be due to the reduction in practice hours within project 2000 curricula, signalling the need to increase this component (DH 1999) which had to be undertaken in clinical placements. Though a small proportion of these hours can now be met through simulated practice within for example clinical skills laboratories (NMC 2007a).

The most influential factor according to Chung-Heung & French (1997) in relation to clinical placement was not in relation to hours spent in clinical placement time but was the setting where the student experienced their practice, in particular the learning climate within the clinical environment. This view is supported by Nolan (1998), who stated that clinical performance was more related to the quality of the clinical learning environment, specifically the support of the registered nurses rather than the length of time the student was allocated to a placement. Students can be exposed to the allotted hours through skills labs sessions and other modes of clinical practice but this does not mean that the students' learning experience is effective. Research has also revealed that students can work alone for approximately 60% of their time on clinical placement and be left for up to 75% participating in patient care without direct supervision from registered nurses. (Polifroni et al1995).

The quality of clinical education has always been an issue for nursing globally (Rance & Gearlish 2007, Nolan 1998, Polifroni et al 1995, Andrews et al 2006, Edwards et al 2004, Mannix et al 2006, Mallick & Aylott 2004) and this is no

different in twenty-first century Britain, even after educational reforms and the move of nurse education into the higher education sector. The issue of clinical education continues to challenge both academics and practitioners (Edmond 2001). Concerns are consistently being raised regarding the nature and quality of this clinical placement education component among the key stakeholders particularly in relation to producing nurses that are fit for purpose (Mallik & Aylott 2005). Components linked to the successful transition from student to registered nurse, are a positive clinical learning environment (Nash et al 2009) the need to belong, feel accepted and for the student to be valued and recognized for their nursing contribution (Hart & Rotem 1994, Levett-Jones & Lathlean 2008b).

2.4.1 The clinical learning environment

The clinical learning environment has been described by Papp et al (2003) as one that encompasses all that surrounds the student nurse, including the clinical setting, the staff, the patient, the nurse mentor and the nurse educator. Papp et al (2003) identified that an important factor in creating a positive learning environment was linked to the attitude and behaviour of the registered nurses towards the students or newly qualified registered nurses. This involved an endorsement of students as colleagues, a good working atmosphere, democratic work allocation and cooperation between work colleagues whilst supporting, respecting and valuing their contribution (Chan 2001). Such an experience where the environment is stimulating and supportive has a positive effect on the clinical placement experience which will have a positive impact on the learning experience (Dunn & Hansford 1997).

Supportive clinical placements were found to provide valuable learning opportunities for students in relation to skills, knowledge, practice reflection and cultural socialisation (Meyer et al 2007, Lee & French 1997, Thorel–Ekstrand & Bjorvell 1995). Although a positive clinical environment has been identified in relation to the transition of neophytes into the profession, it would also appear to be an important aspect during all student nurses' exposure to practice as it is mainly during these experiences that they learn their practice and are socialised

into the profession of nursing. Although students recognise the importance of the placement experience to their learning of skills and knowledge, many felt threatened by the prospect (Cambell et al 1994, Chan 2001) and found it difficult separating their student role from that of worker (Melia 1987, Nolan 1998). According to Nolan (1998) this required students to make adjustments from an environment that promotes thinking to one which promotes doing. The belief that practice requires the integration of both thinking and doing as well as feeling is advocated (Edmond 2001).

2.4.2 Sense of belonging

An emergent theme from the literature is the need for nursing students and newly registered nurses to feel that they fit in or feel a sense of belonging to the placements they have been assigned to (Gok & Watt 2003, Gray & Smith 1999, Hart & Rotem 1994, Levett-Jones & Lathlean 2008b, 2009a, Levett-Jones et al 2007, Levett-Jones et al 2008a, McKenna & Newton 2008, Nolan 1998, Robinson et al 2008, Turner et al 2006, Walker et al 2005). The studies in nursing on this subject are predominantly qualitative in nature, which is not surprising given the nature of the phenomenon under review. The exception is the research of Levett-Jones & Lathlean (2008b) who employed a mixed methodology. They used the belongingness scale to quantify students' perceptions of belonging and semi structured interviews to qualify their perceptions and experiences of this phenomenon. The sense of belonging is not unique to pre-registration nursing students but is also a recurrent theme in studies involving post registered nurses. Two studies have been undertaken to examine the transition phase of graduates at various times during and after completion of the graduate program of clinical experience (Gok & Watt 2003, McKenna & Newton 2008). Gok & Watt (2003) used a qualitative grounded theory approach to examine the perceptions of the transition experience of 5 new nurse graduates in Australia. It revealed that the students had an overwhelming need to fit into the ward team; fitting in was associated with learning the ward routines and developing professional working relationships, all

of which took time. By fitting in, the students could then replicate the behaviours that were socially acceptable to the placement. Fitting in and belonging was not made easy as graduates normally rotated around different placements during this period. Apart from revealing that a sense of not belonging was an issue and highlighting the need for clinical practice experience to satisfy new graduates and the health care organisation, this finding was not explored further.

McKenna & Newton (2008) explored how new graduates develop their knowledge and skill over the first 18 months following graduation as well as factors promoting or inhibiting their development. This qualitative study used focus groups which were undertaken at 6 monthly intervals for 18 months to identify how students developed their knowledge and were socialised. The finding of the last focus group with a total of 9 graduate nurses revealed that a sense of belonging only became achievable after completing the graduate program and that the development of a sense of belonging was associated by these nurses with contentment at being able to settle and belong to one ward. It was only during this time that the graduates began to feel accepted and be treated as equal by their colleagues. McKenna & Newton's (2008) results identified that the regular changing of placements, which involved the process of socialisation within each new area may increase student stress. Both studies give a deeper insight and understanding of the phenomenon of belongingness and the effect it has on student learning, and the need for further investigation in the British clinical placement setting.

Levett-Jones & Lathlean (2008b) undertook a mixed method investigation of student nurses' experiences of belongingness and the influence of the length of clinical placement on belongingness. This study surveyed 362 third year undergraduate students from 2 Australian universities and one university in Britain using the belongingness scale followed by semi structured interviews from 18 of the participants. The tool used was modified from an existing tool and had a Cronbach alpha score of 0.92. Cronbach alpha measures reliability and such a score would indicate this however it depends what was being compared

and measured and that is not clear. This was a self reporting tool and the participants remained anonymous, which would help to reduce the problem of participants giving answers that they think may be more acceptable. The findings showed that the duration of placement was a significant influence on the students' experience of belonging and that those students who had placements of a longer duration had higher belongingness scores. The results from the British university, where the placements range in length from 4-12 weeks, had higher belongingness scores. Although there appears to be a link between the two variables, this needs to be explored further before cause and effect can be established. Other studies Nolan (1998), Hart & Rotem (1994) however, support this connection.

Nolan (1998) undertook a qualitative interpretive study to understand the clinical learning experiences of under graduate nursing students. The participants included six second year nursing students. From her findings, where students identified that they felt they did not feel they belonged to the clinical placement, she concluded that placements should be longer in duration to maximize learning time. Hart & Rotem (1994) also found that students identified that the length of time they spent on placements influenced their sense of belonging. However these studies did not indicate the time periods involved in relation to placement length. In Australia where this study was conducted, the placement length can be as short as a few days which differs from Britain where policy reports have supported the move to longer placements (DH 1999, UKCC 1999). This usually means that the placement length within pre-registration nursing courses is normally not less than four weeks and usually up to 12 weeks. Again, these studies surmise the influence of the link between length of placement and belongingness rather than an established link through research findings. In comparison however, other research suggests that the quality of the support and guidance given to the students during the placement has more influence on the students' experience of belongingness (Battersby & Hemmings 1991, Edmond 2001). Many of the studies which uncovered a sense of belonging as part of their findings did not explore this concept in depth. However, this is not

the case with the study undertaken by Levett-Jones & Lathlean (2008b). From their work they have developed a definition of belongingness as:

> " A deeply personal and contextually mediated experience that evolves in response to the degree to which the individual feels (a) secure, accepted, included , valued and respected by a defined group, (b) connected with or integral to the group and (c) that their professional and /or personal values are in harmony with those of the group. The experience of belongingness may evolve passively in response to the actions of the group to which one aspires to belong and / or actively through the actions initiated by the individual". (Levett Jones et al 2008a page 9)

Such a definition assumes that you want the students to adopt the professional and personal values of the group however this becomes problematic where the personal and professional values of the nurses working in the clinical area are personally and/or professionally unsound. In these circumstances you would not want the students to be in harmony with the groups' values. It is a difficult balance between belonging and institutionalism.

The definition reveals the social relations involved in belonging, whether you experience a sense of belonging will be dependent upon how the group behaves towards you and how you behave towards the group. A sense of belongingness in student nurses related to the receptiveness of the nursing staff on the placement, particularly in relation to four key areas which included:

- The welcome which impacted on whether the students felt included as part of the team or excluded.
- Legitimisation of the student role which influenced whether the student felt valued or just a nuisance.
- Recognition and appreciation which affected whether the student felt trusted and valued or just in the way
- Challenge and support which had an effect on whether the student felt they were being pushed to develop or overwhelmed by expectation.

(Levett-Jones et al 2009a, Papp et al 2003, Spouse 2001). This study provided a deeper understanding to the concept.

2.4.3 Feeling valued and accepted

Feeling valued and accepted as a student on practice placement has been identified as contributing to the students feeling of belongingness (Levett-Jones et al 2009a) and as being important in contributing to quality of clinical learning (Chan 2001, Levett-Jones et al 2009a). The achievement of such a feeling whilst on placement is influenced by the attitudes and behaviour of the staff in the placement, particularly the registered nurses (Levett-Jones et al 2009a, Papp et al 2003) whose behaviour towards the students will ultimately affect the quality of the students' clinical learning experiences.

The planning and organisation of the clinical education component within pre-registration nurse education varies from country to country and in the United States from state to state. Furthermore, the models used to support the students on placement vary (Budgen & Gamroth 2008). In Britain students are supported by mentors, who are registered nurses working in the placement setting who have been prepared for the role of facilitating and assessing student learning in placement (Andrews & Wallis 1999). However, these practitioners are not given any additional time or remuneration to undertake the mentoring role. They are expected to undertake the support of the student during their normal work duties. This means that the quality of the support is dependent on the individual skills and / or theoretical knowledge of the mentor, the daily context of care and the goodwill of the mentor to give personal, quality time to their individual students and their learning needs (Jackson & Mannix 2000, Jones et al 2001).

In the early introductory years of the mentoring role into pre-registration nursing, confusion existed as to its nature and the role itself, which is reflected within the literature (Armitage & Burnard 1991, Donovan 1990, Cahill 1996, Neary et al 1994). Following this, the emphasis in the literature was given to the students' perceptions of the role of mentor (Gray & Smith 2000, Neary 2000, Watson

1999). Since then, a definition of a mentor, criteria and standards for mentoring have been developed by the professional body for nursing and midwifery (NMC 2006, 2008). Registered nurses who want to become a mentor now have to go through a formal preparation for the role which normally involves a formal course of study, which has not always been identified as effective (Neary et al 1994, Wilson Barnett 1995). Many mentors after preparation felt ill-prepared for their role and lacked self-belief that they could support the students (Andrews & Chiltren 2000, Neary 2000). Andrews and Willis (1999) believe that mentors learn the role by doing it.

The key aspects of the role of mentoring in the literature reviewed involve supporting the student in placement, facilitation of the student's learning experience, teaching and assessing as well as acting as a role model (Jones et al 2001, Spouse 1996, Spouse 1998, Wilson Barnett et al 1995). One of the most recent studies reviewing mentoring has been undertaken by Myall et al (2008).

Myall et al (2008) undertook an exploratory study into the role of the mentor in contemporary nursing practice in the United Kingdom. As part of the second phase of the study, pre-registration nursing students were surveyed from one higher educational institute within the U.K. using a questionnaire containing both open and closed questions. A significant finding was the amount of time that mentors spent with the student on clinical placement (Myall et al 2008) which impacted on the students experience of mentoring. The students felt that mentoring only worked if they were in regular contact with their mentor (Cahill 1996). Contact time in the study by Myall et al (2008) was described as being able to work with the mentor during the first week in a new placement, being able to spend three or more shifts working with them in addition to other protected time. This is more than the standard set by the NMC, which is currently 40% of the placement time working with the mentor (NMC 2004, NMC 2010). The amount of time a mentor has to spend with a student has been shown to be influenced by a number of organisational and contextual issues

including workload (Mitchell 2003), staff shortages (Edmond 2001), and staff student ratio in the clinical placement (Hutchings et al 2005). Even though mentors experienced constraints around increased workloads and lack of time to carry out this role, Myall et al (2008), found evidence of commitment to providing students with quality mentoring and many of the students in the study reported having productive and positive experiences with an allocated mentor with whom they worked regularly, and who had provided opportunities to discuss their learning outcomes (Myall et al 2008). However, these results have to be viewed with caution as the student and mentor return rate to the survey was only 10% and 25% respectively.

Other findings from this study revealed that the students saw their mentor as a source of support, as being important in helping them to connect to the placement by being welcoming, being valued as a team member, being treated as a valid and legitimate learner and providing the key in creating opportunities for learning (Myall et al 2008). Again, these results need to be treated with caution due to the low response rate (10%). It is also unclear as to the reliability and validity of the data collection tool, which is not discussed and which was developed for the purpose of the study.

A number of the elements identified by the students are similar to previous findings except that the students have emphasised the nature of the interpersonal relationship. This seems to be a vital component in relation to the quality of the students' learning experience in clinical placement which the mentor is responsible for. This relates to the qualities of the mentor which have been identified as good communication skills, knowledge, professional attributes as well as being motivated to teach and support the students (Davies et al 1994). A longitudinal qualitative study undertaken by Gray & Smith (2000) presented data in which the pre-registration nursing students described a similar set of mentor qualities but also revealed that a good mentor was enthusiastic, friendly, approachable, patient, understanding and with a good sense of humour. Poor mentoring, which all but one student had experienced,

described these mentors as breaking promises, lacking knowledge and expertise, having poor teaching skills which was disjointed and lacked structure (Gray & Smith 2000). These mentors were either over protective and prevented students from developing or threw them in at the deep end (Gray & Smith 2000). These findings cannot be generalized but provide more insight into mentoring and mentors.

The nature and quality of the mentor relationship is a fundamental part of the mentoring process and a key component in ensuring a quality learning experience for the student. Part of this revolves around the qualities of the mentors, including the personal characteristics and interpersonal skills (Andrews & Wallis 1999). Another significant factor is the relationship itself. Spouse (1996) found when the mentor relationship was based on partnership and mutual respect, the clinical learning experience was more effective. Levett-Jones et al (2006) found that students who identified supportive relationships with mentors felt more connected within the clinical area, had an improved sense of belonging and felt more valued and accepted within the team. In particular, orientation and induction as well as being made to feel welcome were singled out by the students as being important (Myall et al 2008).

Students who did not experience the sense of connectedness and belonging often felt they were on the periphery of the nursing team (Levett-Jones et al 2006). Supernumerary status awarded to students in the British university within this study had the potential to contribute to the detachment that the students felt. Supernumerary status meant that students were no longer employees of a healthcare organisation. According to Edwards (2007), this led to students being seen as "outsiders" where previously they had been on the inside by virtue of their employee status. This impacted on how students were viewed, as the students no longer had allegiance to their place of work as they were no longer employees; their base during their pre-registration nursing course was the educational institute. This raises the question of the effect that such a move has had on students' socialisation into the practice of nursing. Students have to

cope and manage with the potential for differing value systems between the educational institute and the healthcare organisation, each with their own priorities: the former valuing the teaching and learning whereas the latter valuing the work (Price 2009). It will depend how well these are assimilated within the placement as to how easily the pre-registration nursing students fit in and what difficulties, if any, they experience.

Jones et al (2001) discovered that mentors could be the key for students to access the cultural knowledge and practices of the team, particularly if the mentor was a respected member of the nursing team. This helped students to develop their identity within the nursing team and where this was missing students had difficulty as their access to the cultural knowledge and practices was inhibited, making learning in these situations more difficult for the student (Spouse 1998).

2.5 Factors that hinder learning in clinical placement

Nursing students in Britain spend 50% of their time in practice placements during their pre-registration nursing course. The quality of the program hinges significantly on the effectiveness of the student clinical experience (Pearcey & Elliot 2004) as the practice setting is the most influential in the development of nursing skills and knowledge and professional socialisation (Chun-Heung & French 2004).

The literature identifies a number of issues in relation to the quality of clinical education which have an impact on the student and their learning. Fortunately, not all studies found this. The students in the qualitative study by Kinsella (1999) found the clinical placement encounter was relevant and useful and deemed to be a popular and influential aspect of their learning. Having a positive experience in clinical placement is important as there is evidence that indicates that a negative placement experience can have lasting effects on the student which can colour their perceptions about nursing as well as the health care organisation involved (Andrews et al 2005). A number of factors have been

highlighted in the literature as impacting negatively on the students learning experience, these include:

- Not belonging or fitting in
- Work Abuse
- Stress and Anxiety
- Poor mentoring and support
- Theory practice gap

Each issue will be examined and discussed in more depth in the following sections to illustrate how they hinder students learning.

2.5.1 Not belonging or fitting in

There is evidence from the literature suggesting that nursing students on clinical placement can have problems fitting in and belonging which impedes their learning (Kiger 1992, Levett-Jones & Lathlean 2009a, Mooney 2007, Philpin 1999),. According to DeWall et al (2008) individuals have a basic need to be accepted, which Baumeister & Leary (1995) consider being one of the most powerful and important human drives. The psycho social wellbeing of individuals is dependent on being able to have positive and lasting relationships with other human beings, and when this is achieved the outcomes for individuals are positive (DeWall et al 2008). Psychologists have studied belongingness, particularly in relation to the effects of being or feeling excluded from social groups. Social exclusion can occur from different social situations including for example, alienation – the feeling of being different (Schabracq & Cooper 2003); ostracism – being excluded and ignored (Williams 2001); and marginalization – living between two cultures or two levels within a hierarchy (Boychuk Duchscher & Cowin 2004).

Social exclusion, whatever the cause, leads to negative outcomes which impact on the behaviour, emotion and cognition of the individuals who experience it (Baumeister & Leary 1995, Baumeister et al 2007, DeWall et al 2008,Twenge et al 2001, Zadro 2006).

Behavioural effects

The desire to belong, or not to be socially excluded from a group is thought to be an innate desire which is linked to human survival and happiness (DeWall et al 2009). The research into the human drive to belong has shown that it is complex and it is unclear from the research whether belonging fits into the standard motivational pattern. Baumeister & Leary's (1995) and Baumeister et al's (2005) findings were inconclusive on this aspect. DeWall et al (2008) carried out seven experiments in total using undergraduate students as participants to measure the effects of social acceptance and social exclusion on self regulatory performance. Their findings showed that under certain conditions i.e. when circumstances are directly relevant to satisfying the desire, the need to belong fits standard motivational patterns in that impeding the need to belong intensifies it whereas satisfying the need results in a temporary fall in the drive.

These pieces of research examined the self regulation mechanism which Baumeister et al (2005) proposed was a key adaptation that made the complex forms of social and cultural life in humans possible. Self regulation requires effort on the part of the individuals as they are required to sacrifice their wants in order to conform to the rules, standards and demands of the social group in order to receive the immense benefits of belonging to the group. Baumeister et al (2005) called this the implicit bargain which can be broken by either party. The individual can break the rules and be rejected or the social grouping can exclude the individual which can leave the person feeling that it is no longer worth making the effort and sacrifices needed for self regulation (Baumeister et al 2005, Twenge et al 2007), except when the rejected person feels that social acceptance is still possible with more effort on their part.

Emotional effects

The emotional effects that not belonging not fitting in and rejection have on the individual include a variety of symptoms such as stress, anxiety, depression and diminished self esteem (Baumeister & Tice 1990, Hagerty &

Williams 1990). Baumeister et al (2007) proposed that, comparable to rejected animals, social exclusion in humans causes an immediate lack of emotion leading to numbness, which results in a loss of physical and emotional sensitivity. This is supported by Twenge et al 2007 who also found a reduction in empathy, which has implications as humans use their emotional systems to interpret the behaviour of others (Baumeister et al 2007). Empathy is dependent on the individual's ability to imagine what another person is experiencing and being able to generate appropriate emotional responses. However, this ability is affected by emotional numbness experienced by rejection resulting in an inability to judge the seriousness of other people's problems. Without this, the individual has no compulsion to help the other person.

Social exclusion has often been linked to aggressive behaviour in those individuals who have suffered social rejection (Baumeister et al 2005, DeWall et al 2009, Twenge et al 2007), but the reason for this aggression is poorly defined and rationalised in these studies, and therefore difficult to understand. DeWall et al (2009) found from their experiments that socially excluded individuals are more primed to see violence and aggression in others in neutral acts and respond accordingly, which may help to explain the aggressiveness described but not necessarily why this should be the case.

Cognitive effects

Baumeister et al (2002) found that social exclusion led to a drop in intelligent thought which mainly impaired logical reasoning, extrapolation and other mental operations involving moving from one set of information to a different conclusion. It has been proposed that such thinking is associated with the mechanism of self control which is affected by social exclusion (Baumeister et al 2005). Individuals who have been socially rejected are not willing to self regulate and it has been surmised that they are not willing to expend the time, energy and resources on intellectual tasks to which they can see no immediate benefit to themselves. This would suggest that this is more a motivational

problem rather than social exclusion damaging the individuals' intellectual mechanism.

2.5.2 Work abuse

The literature shows that work abuse in nursing is not only a problem in Britain but a global problem within the Western World for example Europe, USA, Australia, New Zealand and Canada (Hinchberger 2009, Kelly & Ahern 2008, McKenna et al 2003, Randle 2003, Stevenson et al 2006, Thomas & Burk 2009) and the victims include students as well as registered nurses. Work abuse is difficult to name and identify but attempts have been made to define it. An example of a definition of work place abuse is:

> "Incidents where staff are abused, threatened or assaulted in circumstances related to their work , including commuting to and from work, involving an explicit or implicit challenge to their safety, well being or health"(International Labour Office 2002 page 3).

The nursing literature distinguishes two types of work abuse; horizontal and vertical violence. Horizontal violence is where the violence is perpetrated between nurses at the same level in the hierarchical system and vertical violence describes abusive behaviours from a co-worker in a superior position towards a subordinate. The study of work abuse includes examples of both qualitative and quantitative research from around the world. Qualitative findings cannot be generalized but do give more insight into the phenomenon of work abuse. The majority of the quantitative research cited has involved surveys and the samples have tended to be small and specific, relating to a particular group or place. The prevalence of work place abuse in some countries has been estimated as high as 65% to 75% and 65-82% in some institutions (Rippon 2000, Rowe & Sherlock 2005, Stanley & Martin 2007, Whitehorn & Nowland 1997) and health care workers are 16 times more likely than other workers to experience work place abuse (Kingma 2001), with nurses in the highest risk

group (Kingma 2001). These figures have to be viewed with caution as they reflect individual institutions within Canada and the USA not Britain.

Workplace abuse is difficult to define, adding to the problem of its identification (St Pierre & Holmes 2008), which could mean that the prevalence is higher than that reported. Farrell (1997) believes that fear of retaliation causes nurses to refrain from reporting such incidents. Although definitions of work abuse vary within the literature there are some common threads running through them. These include the notion that it is an act that can be verbal or physical against another individual who as a result experiences unpleasant feelings. Work abuse also includes the literature on bullying which is a type of work abuse.

The literature in relation to student nurses experiences of work abuse will be examined in more depth in keeping with the focus of the study. There are four studies using different methodologies from Britain and the USA that researched work abuse in nursing students (Hinchberger 2009, Randle 2003, Stevenson et al 2006, Thomas & Burk 2009). The research of Randle (2003) and Stevenson et al (2006) were undertaken in Britain and both revealed evidence of bullying of nursing students during their clinical placement experience. Randle's (2003) three year longitudinal study on 39 student nurses in Britain was not focused on work abuse but on self esteem and how experiences within pre-registration nursing affected its development. The findings from the qualitative data identified that bullying was a common theme that emerged from the students' narratives. All students described situations where nurses used their positions of power to ridicule, humiliate or belittle them or isolate patients, and identified a bullying attitude within the nursing staff. The research also revealed that students began to adopt such attitudes and behaviours into their nursing practice (Randle 2003) a discovery which has also been supported by other literature (Gray & Smith 2000)

Socialisation, sense of belonging and work abuse are all complex concepts that can at times be interconnected. The socialisation of nursing involves being acculturated into the values, norms and expectations of the profession

(Mackintosh 2006), which assumes that there is a value set to share, that it is known and shared by its members and that it is something worthy and positive to pass on to aspiring novice practitioners. The process of socialisation for student nurses normally happens in the practice setting during the students' placement experience (Chun- Heung & French 1997) and often involves the student having to comply and conform in order to fit in and be accepted (Day et al 1995, Manninen 1998, Melia 1987) which allows the student to feel some sense of belonging. One of the most important factors in the student's socialisation process is the behaviour and attitudes of the registered nurses the students encountered during their experiences on clinical placement (Papp et al 2003). It is through their interactions with this group that students will learn the value set of nursing.

Baumeister & Tice (1990) found that individuals, in order to avoid exclusion, would be willing to conform, obey, comply, work hard and change in an attempt to be accepted and belong. This can lead to the unquestioning acceptance and adoption of negative behaviours endorsed by the group members (Baumeister & Leary I995, Clark 1992). Student nurses have described how they were prepared to conform to the rules, standards of work practices and ethics of the placement in order to be accepted and fit in regardless of whether these were considered best practice (Levett-Jones & Lathlean 2009a, Nolan 1998). This contravenes what is expected of student nurses on placement as they are expected to abide by the professional code of conduct for nursing and speak out against any poor practice. However students can be severely sanctioned for doing so (McDonald & Ahern 2000). Levett-Jones & Lathlean (2009a) deduce that exposure to such experiences influence and impact on the future behaviour of nursing students which can lead to the adoption of poor practices in nursing. Thus students were being socialised to see these as the value set for the profession of nursing. Although these findings cannot be generalised, it does give more insight and understanding as to the experience of clinical placement to the learning and socialisation of nursing students and to raise questions as to

previously held assumptions of the unquestionable value of clinical placement in the preparation of student nurses.

Stevenson et al (2006) study surveyed 400 nursing students from a different institution from where the researchers were based, using an established work place bullying tool which was slightly modified for use with students. The return rate was high 78.3%. Of those that responded, 53% had experienced one or more forms of work abuse as described in the survey. The perpetrators of the bullying were often reported to be doctors or health care assistants. Although the response rate was high and the tool was an established one, caution needs to be exerted with regard to generalising these findings as, the survey is still targeted to one institution and is small in number.

Hinchberger (2009) undertook a survey in the USA on "violence against student nurses in the workplace". It is not made clear where the survey was conducted, but as the survey was posted online for the students, this suggests that it was undertaken at the same educational establishment as the researcher. The sample size was 173 with a response rate of 73.9%. Of the students who responded to the questionnaire (100%), all had either observed or witnessed violence in their clinical placements. 50% of the perpetrators of these episodes were staff members, with patients and visitors making up the remaining 50%. The commonest form of abuse was verbal with 69% followed by bullying at 21%. The weakness of the study is in relation to the tool used. There is no discussion as to the validity or reliability of the tool being used to collect the data in fact the tool was originally designed as a sample incident reporting form. This weakens the findings.

Thomas & Burke (2009) undertook a qualitative study into the vertical violence occurring between students and registered nurses and student nurses. They collected and analysed 221 narratives on anger that had been experienced in connection with nursing classes or clinical placement experience from junior students at one university in the USA. The findings showed incidents of anger occurred more frequently in clinical placement and one of the most common

causes was the unfair treatment of students themselves. Although the incidents described by the students involved a variety of health care personnel in general the most common perpetrators were hospital staff nurses. The study highlighted a range of abusive behaviours including being patronised, rudeness, condescension, sarcasm, disrespect and degradation. As there was a power imbalance between the registered nurses and the students in the study they could not see how they could confront the perpetrators themselves in these instances. Students described how they felt cheated out of their learning experience. The effects of vertical violence on academic achievement , learning outcomes and the construction of identity requires further research as the research in this area is sparse (Thomas & Burke 2009). Students also described how they found it difficult to let go of the anger they felt in these circumstances which according to Thomas (2004) will be suppressed and linger if there is no opportunity to engage in dialogue or problem solve with the provocateur. The effects of these abusive behaviours can have detrimental consequences for the individual's health and wellbeing (Thomas 2004) as well as on the profession itself as it can impact negatively on retention (McKenna et al 2003). As the students were not cued directly into the authors' interest on abusive behaviours and the data were anonymised, this adds credibility to the study.

2.5.3 Stress and anxiety

Practice placement experience has been shown to cause stress and anxiety for pre-registration nursing students (Brodie et al 2005, Kleehammer et al 1990, Lindop 1999, Lo 2002, Meisenhelder 1987, Timmins & Kaliszer 2002). Kleehammer et al (1990) found that the factors that caused the highest levels of anxiety in American nursing students included the initial clinical experience and fear of making mistakes, clinical procedures, hospital equipment, talking to doctors and being late. A number of predominantly British studies have identified anxiety amongst students at the start of clinical placement (Brodie et al 2005, Elcock et al 2007, Levett-Jones & Lathlean 2008b). For many this anxiety was related to fear of the unknown (Levett-Jones & Lathlean 2008b).

Unless this fear and anxiety within the students was addressed through planned orientation to the placement, the students' need for psychological safety and security was not addressed (Levett-Jones-Lathlean 2008b). Planned orientation indicated to students that the staff were receptive and ready for them, which helped the students to feel more comfortable (Levett-Jones & Lathlean 2008b). This helped students to begin the process of settling in and become accepted. This however, did not always happen. Lathlean & Myall (2006) found that more than 50% of the students they surveyed did not have an orientation to each new clinical placement area. This impacted on their sense of belonging.

Baumeister & Tice (1990) found a major cause of anxiety to be exclusion from social groups. Anxiety can be confined to the event itself or to associated stimuli that anticipate the feared event, as it is believed that the individual learns the association of anxiety to these through conditioning. It has been hypothesised that anxiety developed as a mechanism designed to safeguard membership of the social group (Baumeister & Tice 1990). It is thought to work by interrupting behavioural sequence to enable the individual to re-evaluate their actions for any threats or dangers to their membership and to initiate reassessment of ongoing courses of action. This is thus a powerful way of getting people to stop doing things that may jeopardise their inclusion in the group. Anxiety as a motivational aid to self regulation would make it possible for some individuals to use it positively as a means of motivating themselves to succeed (Baumeister & Tice 1990)

Anxiety and stress as a result of work abuse can also be physically and psychologically damaging and distressing to individuals' health (Broome 2008, Mattiesen & Einarson 2004, Randle 2003, RCN 2002, Thomas & Burk 2009). Stress related problems, including raised blood pressure, depression, anxiety cause avoidance of professional relationships and lowered work performance (Robertson 2004). Mattiesen & Einarsen (2004) showed that individuals who were exposed to persistent and recurrent bullying demonstrated symptoms of post traumatic stress disorder. It has also been seen to reduce self esteem,

which impacts on the development of one's social identity (Farrell 2001). It can lead to aggressive behaviour due to being exposed and acculturated into this way of behaving (Farrell 2001). These effects can all impact on the quality of nursing care delivered and that the patient receives.

2.5.4 Poor mentoring and support

Poor mentoring had been experienced by all but one student in a study conducted by Gray & Smith (2000). The students described these mentors as lacking knowledge and expertise, having poor teaching skills which was disjointed, unstructured, and as promise breakers. These mentors were either over protective and prevented students from developing or threw them in at the deep end (Gray & Smith 2000). These findings cannot be generalised but provide insight into the meaning of poor mentorship for student nurses.

The time mentors had available to support students on placement was also a key issue in relation to the quality of mentorship. Jones et al (2001) found that the amount of time mentors had to fulfil the role remained constant regardless of the number of students that they had to mentor. The time available had to be divided up amongst the students and other clinical duties, leading to less individual attention. This impacted on the quality of mentorship which was further adversely affected when staffing levels were low as it reduced the opportunity for supervision (Jones et al 2001). Gray & Smith (1999) found that those students who work unsupervised were likely to be allocated to tasks similar to those appropriate to nursing auxiliaries rather than qualified nurses, or else they were left to their own devices. Therefore, the amount of time that students spent with their mentor was seen as influencing the quality of their placement experience. (Myall et al 2008).

2.5.5 Theory practice gap

The literature describes a gap between the theory and practice of nurse education as a division between the components of nursing practice and education, and the cohesiveness which should exist between the two

components is fragmented (Ashworth & Morrison 1989, Burns &Poster 2008, Evans 2009, Gallagher 2004,Haigh 2008, Landers 2000). This is demonstrated by the changes to nurse education which resulted in nurse education being relocated within higher education institutes, resulting in the learning of the theory and practice of nursing taking place in separate institutions (Hewison & Wildeman 1996), where in the past they have been delivered in one institution and seen as a potential whole. There is an assumption that this gap should be narrowed or closed so that nurse education can be whole again, which would require a close working relationship between the parties involved .However, according to Andrews & Reece (1996) this is not happening which has had very little impact on closing the gap. However in 1996 when this research was undertaken, partnership working was relatively new and still developing.

The student is at the centre of the theory practice gap (Landers 2000). The students have to establish a balance between the theoretical and practical components if they want to successfully complete their nursing course (Ashworth & Morrison 1989). This can give rise to ambiguities for the student, particularly in relation to the role of the student in the placement as learner or worker (Ashworth & Morrison 1989). This ambiguity was made more acute when students were awarded supernumerary status, where the purpose of clinical placement was on learning rather than on service need (Ferguson & Jinks 1994) and students were no longer employees of the health care organisations. This led to confusion as to how the students were conceived and subsequently treated. In some placements they were still seen as workers who were there to ensure the efficient and smooth running of the ward, and in others they were seen as learners who were supernumerary which excluded them from many activities (Ashworth & Morrison 1989). There were multiple variations between these two extremes. This dichotomy left students at odd with their status within clinical placement, the health care organisation and lack of clarity as to where they fitted into the nursing hierarchy.

2.6 The effects on learning

The factors that hinder learning normally impact negatively on the students learning experience in various ways, which will be discussed in the following section.

2.6.1 Not belonging and learning

Motivation is one of the most important factors for learning. It has been defined as a force which steers individuals to attempt to achieve some objective in order to meet a need or expectation (Mullins 1996). Maslow's theory of motivation identified a hierarchy of needs which included the differing levels of physiological need (food, warmth), safety (physical and psychological), belongingness, love and self esteem and self actualisation (Maslow 1897). Each level in the hierarchy needs to be satisfied before the individual can progress to the next level (Maslow 1987). Learning can be limited if the first three levels in the hierarchy are not met, as the individual will spend their time in meeting these before they can progress. This is thought to be one of the main reasons why students' motivation and learning is adversely affected by the absence of a feeling of belonging during exposure to clinical placement (Levett-Jones & Lathlean 2008b, Nolan 1998).

In Levett-Jones & Lathlean's (2008b) study, students were still being exposed to placements where the absence of the sense of belonging was a notable problem, which adversely impacted on their learning experience. A sense of belonging may be made more difficult due to the transient nature of student placement (Ashworth & Morrison 1989, Greeno et al 1999), as each placement experience only lasts a specified period of time: anything from a few days to a number of weeks. Melia (1987) called this just passing through and found that learning could not begin until fitting in takes place, as the students' time and energy is taken up with this. This finding is also supported by Nolan (1998).

2.6.2 Conforming

Conforming means to accept and adopt the behaviour and practices of the social group without question. Baumeister & Tice (1990) found that individuals, in order to avoid social exclusion, would be willing to conform, obey comply, work hard and change in an attempt to be accepted and belong. This can lead to the unquestioning acceptance and adoption of negative behaviours endorsed by the group members rather than the adoption of a questioning approach (Baumeister & Leary 1995, Baumeister and Tice 1990,Bradby 1990, Clark 1992, Kelly 1998, Tradewell 1996). These findings have been found in nursing where student nurses have described how they were prepared to conform to the rules, standards and work practices of the placement in order to be accepted and fit in, regardless of whether these were considered best practice (Levett-Jones & Lathlean 2009a, Nolan 1998). This would not be a problem if students' experience during their exposure to practice demonstrated quality nursing but this is not always the case. The key negative consequences of conformity on professional development have been identified as a lack of critical awareness of professional practice; the continuation of ritualistic practices and traditional views; the significance of a set of taken for granted nursing characteristics and the loss of idealism and work abuse (Andersson 1993, Ashworth & Morrison 1989, Day et al 1995, Gray & Smith 2000, Goldenberg & Iwasiw 1993, Stevens & Crouch 1995, Wilson & Startup 1991). This would expose students to inappropriate learning experiences and have a detrimental effect on their professional development. Students can learn to adopt negative behaviour and poor nursing practices unquestioningly, which will lead to poor quality of patient care.

2.6.3 Cognitive impairment and learning

Cognition is a complex concept that incorporates a number of differing cognitive and meta-cognitive processes, including attention, information processing, memory, reasoning, problem solving and social cognition. Cognition is

associated with critical thinking, which utilises reason and self discipline and has been defined as:

> "Purposeful self regulatory judgement that results in interpretation, analysis, evaluation, and inference as well as the explanation of evidential, conceptual, methodological, criteriological or contextual considerations upon which the judgement is based"
>
> (Facione 1990 page 2).

Meta-cognition has been linked to reflective thinking, which has been defined as the:

> "Examination of issues of concern related to an experience"
>
> (Kuiper & Pesut, 2004, page 384).

Nursing practice is dependent on nurses being able to make clinical decisions, which involves the ability to critically think and reflect (Kuiper 2005, Kuiper & Pesut 2004). The inclusion of these skills are part of the pre-registration nursing courses in Britain therefore requires nurses to learn and develop these skills in order to become a registered nurse (NMC 2004, 2010). The practice placement is where students will learn clinical reasoning skills, thus the quality of these experiences will either enhance or impair their development

In placements where the staff were unreceptive and did not facilitate the students' learning, a long term negative effect on the student's confidence and ability to become actively involved in experiential learning opportunities has been identified (Lofmak & Wikbald 2001). The emphasis for the student in these situations was on pleasing the teacher, which acted as a barrier to students being able to possibly synthesise knowledge from their clinical nursing practice (Gillespie 2002). These findings are supported by the work of Baumeister et al (2002), who found that social exclusion led to a drop in intelligent thought which mainly impaired logical reasoning, extrapolation and other mental operations involving moving from one set of information to a

different conclusion. These problems are associated with the higher order domain of executive function. Executive function includes a number of interrelated processes involving understanding concepts, planning, abstract reasoning and problem solving (Jaeger et al 2003). This will impact on the student's ability to problem solve, make decisions and formulate professional judgements. It has been proposed that such thinking is associated with the mechanism of self control, which is affected by social exclusion (Baumeister et al 2005).

Individuals who have been socially rejected are not willing to self regulate and it has been surmised that they are not willing to expend the time and energy and resources on intellectual tasks to which they can see no immediate benefit to themselves. This would suggest that this is more a motivational problem rather than social exclusion damaging the individuals intellectual mechanism. In placements where there was a problem with connectedness the students still describe learning but the scope and depth were affected. In these circumstances students' learning was limited to skills, technical aspects of nursing and rote learning (Gillespie 2002).

2.6.4 Emotional impairment and learning

According to Groccia (1992) motivation is what drives students to obtain, convert and use knowledge. The processes involved are both instinctive and rational (Cole 1993). It is "the engine that powers and directs behaviour". Pintrich (1991) identified three key determinants of motivation:

- Perceived value of the task which relates to the importance that the individual places on the task. The value of the task is higher in students who can give meaning to, especially in relation to their experiences and objects and goals (Pelaccia 2009)
- Perception of self efficacy, which is the individual's beliefs about their abilities to perform the task. This is a major component of motivation.

Students are more likely to engage in tasks where they feel competent and avoid those where they feel they are not (Pelaccia 2009)

- Beliefs about control relating to the individual's level of autonomy and control while carrying out the task which is the individual's beliefs that their effort to learn will result in a positive outcome. Deci &Ryan (1985) believe that it is this which is the most relevant in explaining the choices made. If students believe that the outcome of their learning rests with themselves, they are more likely to engage in the learning activities

These three things are shaped and influenced by the person's personal history and past experiences. Therefore past experiences in clinical placement will help to shape these, impacting on the student's motivation in future placements.

Emotional states have an impact on these determinants of motivation and thus can have a positive or negative effect on learning. Bloom (1971) hypothesised that an individual's personal feelings about learning tasks will not only affect their desire for further learning, but also the value they place on such learning. Morrison et al (2004) found that negative emotions and attitudes towards the learning situation significantly reduced learning and retention. One such emotional state relates to high levels of anxiety, which has been shown to decrease learning (Eysenck 1970, Hannel & Lippett 1985, Hunsley 1985 and Yates). Chronic stress leading to anxiety has been shown to effect the learning and memory in mice (Huang et al 2009). The mice in this study were exposed to electric shocks, causing chronic stress confirmed by raised plasma corticosterone levels in the blood. In the experiments that followed, the mice demonstrated impairment to spatial learning and memory but no such effect on motor activity. This is consistent with other studies in the same field (Koba et al 2001, Li et al 2006). If chronic stress and anxiety had the same effect on humans as for mice, then this would also have a detrimental effect on learning for students suffering chronic stress. Problems with working memory are associated with reduced learning capacity which impacts negatively on the

acquisition of work skills (Liberman et al 2004, Sergi et al 2005). Stress and anxiety has also been found to reduce a person's beliefs about their abilities to perform the requisite activities (Pelaccia 2009) and thus impact on their motivation to learn, which in turn will negatively affect their ability to learn. This may explain why, in a study by Stephenson et al (2006), the students who were anxious about a course demonstrated avoidance behaviours and low achievement which had an adverse effect on the achievement of the learning outcomes. High levels of stress and anxiety have been associated with clinical placement (Brodie et al 2005, Kleehammer et al 1990,Lindop 1999, Lo 2002, Meisenhelder 1987, Timms & Kaliszer 2002).

Emotional state of the individual is adversely affected by being excluded from social groups. The effect of exclusion leaves the emotional system numb (Twenge et al 2007). A functioning emotional system helps the individual to interpret the behaviour of others, particularly to recognise distress states in others. An emotional system which has been numbed by social exclusion reduces the individual's empathic abilities. This means that the affected individual does not recognise distress in others and does not respond to them. Students who feel they do not belong in practice placement can feel rejected from this social group, which can lead to emotional numbness and reduced empathic abilities. Empathy has always been considered as a critical element within nursing, particularly in relation to the formulation of the nurse-patient relationships which normally provide a source of comfort to the patient (Morse et al 1992). Empathic insight enables the person to instantaneously recognise the plight of another who is in distress, giving rise to reflexive feelings of helping that produce appropriate behavioural responses (Morse et al 1992). It is crucial that students develop empathic insight to enable them to respond and react appropriately to their patients. If social exclusion has dampered the emotional system of the student nurse, reducing their empathic ability, the student will be unable to recognise distress in their patients. This will impact on their ability to identify distressed states and learn appropriate reactions for responding thus reducing their opportunity to learn.

Aggressiveness is another behaviour pattern in those individuals who are socially excluded. Therefore it is assumed that student nurses who feel socially excluded from the placement may well exhibit similar patterns of behaviour. This would mean that they are more likely to be more aggressive and interpret the neutral actions of their mentor and nursing staff in an aggressive way and respond accordingly. This has the potential to adversely affect the interpersonal relationships with these individuals. As the mentor is key to helping students access learning opportunities, this can have a detrimental effect on the student's learning experience.

2.6.5 Inadequate mentoring and support on learning

Lloyd-Jones et al (2001) stressed how insufficient time with the mentor or having no identified mentor whilst in clinical placement (Jones et al 2001) can have an adverse impact for the student in achieving their identified learning outcomes.

The mentoring role can have an impact on the mentors themselves. Mentors who were unhappy or felt over burdened often saw students as another added pressure, leading to less support for the students compared to staff that were keen and able to support the students (Levett-Jones & Lathlean 2009a). This had an impact on the quality of the clinical learning experience. Students whose named mentors were absent spent significantly less time working with other registered nurses to deliver patient care (Jones et al 2001). In the mentor's absence, students were often reduced to "hanging about" or "tagging on" (Phillips et al 1996). Spouse (1996) also found that where there is lack of partnership working in the mentor relationship, it can also have an adverse effect on the student's learning. Students can be left to trail around looking for chance learning opportunities even when their mentor is present (Spouse 1996).

2.6.6 Work abuse and learning

Students who suffer the effects of work abuse which is also termed horizontal violence or who encounter an antagonistic atmosphere whilst on clinical

placement are often disempowered and find it difficult to challenge the antagonism of violence they suffered which resulted in them suffering from reduced confidence and lowered self esteem (Magnusson and Admundson 2003, McKenna et al 2003, Pearson 1998). An individual will process information in keeping with their view of self. Individuals who have a healthy self esteem will feel good about themselves and as they become more positive about themselves they become more positive towards others (Andersson 1993). Nurses who display a healthy self esteem are said to display the characteristics of authentic self, empathy, the delivery of holistic individualised patient care and continuing in the face of adversity (Randle 2003). Positive self esteem helps in the development of good interpersonal relationships with colleagues and patients. An individual who has a lowered self esteem will tend to overemphasise their weaknesses and deficits whilst underestimating their strengths and assets (Wheelen et al 2007). Lowered self esteem has been linked to deprivation of belongingness (Maslow 1987). Lowered self esteem will also have a detrimental impact on the establishment of effective interpersonal relationships between colleagues and patients. This can affect the student mentor relationship, thus impacting on the student's learning experience. When disempowerment is experienced, it often reduces the students' motivation to learn. It can also lead to despondency and a desire to leave the programme (Bradbury-Jones, Sambrook & Irvine 2007). Lack of understanding, encouragement and responsibility whilst learning in clinical placement were seen as factors contributing to the disempowerment of students, whilst the organisational factors of effective mentorship, continuity of placement, and time were seen to be important for students to feel empowered whilst on placement (Mckenna et al 2003).

2.6.7 Theory practice gap on learning

Nursing education is developed on the assumption that the student will integrate knowledge from both the academic and clinical settings (NMC 2004). This is required for understanding and solving patients' problems (Rauk 2003).

Knowledge integration is the creation of new knowledge through the making of connections within and between new information and prior knowledge (Rauk 2003). Hayes-Roth & Thorndyke (1979) define integration as:

> "the process of putting separately acquired facts together to form new ideas" (page 91).

This integration is thought to occur during the cognitive processing phase between working memory and during the transition between working memory and long term memory (Rauk 2003). According to Rauk (2003) the processes involved are encoding, elaboration, retrieval, reconstruction and the preparation of long-term memory storage. The learner is required to actively search for prior knowledge in their long term memory and transfer this to working memory. The learner is then required to construct new knowledge by making connections between the incoming information and prior knowledge (Weinstein & Meyer 1986).

Pre-registration nursing courses are now modular, where knowledge has been fragmented into units of learning. Their construction has been designed to attempt to facilitate the content, moving from the simple and concrete material to more abstract material in a logical order. However, with such a structure it can be difficult for the students to make the connections between what is often seen as discrete pieces of knowledge (Rauk 2003), and how this knowledge is applied in practice. This can disadvantage students when they are expected to learn new material which requires them to have mastered and use prior information, giving rise to problems of integration (Rauk 2003). Students may have difficulty in drawing on previous knowledge such as anatomy and physiology to understand disordered physiology. This may be even more difficult when applying knowledge to resolve patients' physiological problems. The issue which is raised is whether these problems are as a result of difficulties with integration (putting it all together).

Working and long-term memory and higher executive cognitive functioning are of key importance to knowledge integration. Many of the factors previously discussed that hinder learning, such as stress and anxiety, work abuse and social exclusion affect memory and cognitive functioning, particularly higher executive functioning, which are the key working parts required for an individual to make connections and construct new knowledge. It is therefore assumed that this must impact detrimentally on the students' abilities to integrate knowledge and therefore to successfully connect the pieces and pull it all together in order to solve patients' problems using their previous knowledge from their theory and practice.

2.7 Summary

I began this journey with a question to answer which was to examine why basic nursing care was perceived as being vile work by some student nurses. I began my search with reviewing the literature into clinical education component for pre-registration nursing. I felt that I needed to examine what it is and the factors that influence it in order to begin to have a better understanding of the nature of clinical education. This has meant that I have reviewed a broad range of literature relating to the purpose of clinical education and the factors that influence it and their impact on student learning. As each element is normally treated as a separate entity which contributes to clinical education there is a dearth of literature which tries to make sense of how all these elements impact on each other. I felt that there was a gap in the literature relating to the bringing together of these strands in order to have a better understanding as to how they interconnected from the students' perspective for the purpose of having a greater insight into the phenomenon. This is important as clinical placement is where students will develop their nursing skills, be socialised into the profession and have opportunity to integrate theory with practice. Thus this experience will greatly contribute to the students' meanings and understandings of the concept of nursing and will help to shape and construct their identity as a registered nurse which will ultimately impact on the profession of nursing.

The future of the profession of nursing rests with ensuring that this experience reflects what is required to become a registered nurse. This assumes that this is known, which is not necessarily the case for nursing, as was discussed in chapter one between the struggle for fitness to practice and fitness for purpose. It is also important that the quality of clinical education is at an acceptable standard and that this is known and can be measured. The literature has given insight into the many issues and concerns relating to clinical education which I have compiled under key areas. In order to examine how these different factors interconnect it is necessary to examine the students' experience of clinical placement. The research methodology and method was chosen to enable this to happen and is discussed in detail in the following chapter.

Chapter three

Research design

3.0 Introduction

My study sought to examine the lived experiences of student nurses in clinical placement in order to understand more fully how this contributes to their learning and understanding of nursing and their construction of identity. Although the literature has given insight into the many issues and concerns relating to the clinical education component within nurse education this has not normally focused on the students' perspective or how these factors interconnect. The purpose of my study is to begin to fill this gap. This chapter discusses the research methodology, design and methods chosen to achieve this.

3.1 The purpose of the study

In order to begin my research I identified the research question and objectives to direct the focus of the study. These are as follows:

"To examine how the lived experience of clinical placement impacts the learning and identity of student nurses".

My objectives for the study were:

- To examine the lived experiences of student nurses in clinical placement at a university in England
- To review the literature in relation to clinical learning, socialisation and identity
- To explore the relationship between learning and identity
- To examine how the theories of learning interpret learning and identity
- To analyse the findings from the study
- To inform my practice as placement development manager
- To examine the implications of the findings for nurse education

- To generate new knowledge

In order to answer this question and to meet the objectives a qualitative hermeneutical phenomenological approach has been chosen.

3.2 Rationale for choosing a qualitative hermeneutical phenomenological approach

Student nurses are situated within the everyday world of nursing and as such rely on their understandings of the shared meanings and common practices of nursing to enable them to function as a nurse (Benner et al, 1996). All students, however, come to nursing with their own understanding of the world which they have acquired by being socialised through their previous encounters of everyday living. This is their starting point from which to interpret the world of nursing. Although they will come into nursing with their own understanding of the world built from their personal and cultural history, these apprentices have to learn to function and cope as a nurse. It is assumed that apprentices of nursing, through their experience of the practice of nursing, will be exposed to the shared meanings and common practices which will enable them to acquire these background understandings they will need to function in their chosen profession. The lived experiences of student nurses learning in placement are the most obvious place to begin the search to understand this experience. When we understand the situation of other people we are able to imagine their lifeworld (Fjelland & Gjengedal 1994). Although lifeworlds are private to the individual, they have a great deal in common. By exposing these common patterns within the texts of student nurses we can begin to understand the everydayness of learning the practice of nursing. Such understanding can uncover possibilities that could enrich not only the lives of the student but patients as well. This approach enables me to do this.

Heidegger believes that understanding the person within the context of their everyday living provides enriched descriptions of the world, particularly their relations to things (Magee1987). He believed that human beings lived in a world

with shared meanings and practices developed from culture, discourse and history which they began to learn early in life through the process of socialisation (Heidegger 1962). It is this understanding which Heidegger thought enabled human beings to cope with the day to day living without having to constantly think about it (Heidegger 1962). How each person does this depends on their encounters as experience of being in the world develops and shapes their meanings and practices.

Hermeneutical phenomenology based on Heidegger's understanding permits the investigation and analysis of experience. Direct experience relates to our relation with things and includes not only material objects but also the relationship to those objects, including abstract entities like emotions, memories, thoughts and past experiences. Such an approach allows everyday living to be analysed by investigating the shared meanings and practices. This is achieved by tapping into lived experiences of human beings to produce descriptions. Lived experiences are always a reflection and recollection on experiences (van Manen 2003) and are those situations or things that matter to the individual. By tapping into these lived experiences descriptions can be achieved which can then be interpreted. Lived experiences can be accessed through narratives (van Manen 2003). A narrative is a conversation or observation of actual everyday events or episodes. These become the material which is interpreted in an attempt to reveal and make known the often taken for granted common meanings in everyday living. This approach enables me to investigate the phenomenon of learning in clinical placement from the perspective of the student. Those situations or things that are important to student nurses whilst on clinical placement will be identified by tapping into their lived experience of clinical placement through the collection of narratives to produce descriptions. From the analysis and interpretation of these descriptions, common patterns and shared meanings can be revealed for the purpose of making them known.

As the literature review demonstrates, learning in clinical placement is a complex phenomenon. A key aim of this research is to uncover the common

patterns from this everyday experience to promote further understanding. A working hypothesis was that a greater insight and understanding of the nature of the experience of learning in placement of these students would help to inform my work as Placement Development Manager and pre-registration nurse education. Viewing the phenomenon in different ways could challenge current thinking of nurse educators, including my own, and influence curriculum development.

This approach allows this phenomenon to be viewed from the student perspective. This should provide new insights and enhance our understanding of this phenomenon as much of the research in relation to clinical placement in the past has not been from this perspective.

3.3. Research context

This research has been undertaken in one faculty within one higher education institution in England that is commissioned to provide pre-registration nurse education courses. This faculty was within a large university setting which had a large diverse student population. All the nurse education courses within this faculty are approved and validated and are delivered on the same site within the university. This faculty had two intakes per year of approximately 250 students annually for pre-registration nurse education adult branch. The demography of the student nurses undertaking the pre-registration adult nursing consisted of 82% white, 10% black African/Caribbean, 5% Asian and 3% other. The majority of the students were female, 95%, and 5% male. From my own experience of working with student nurses studying this branch of nursing they were beginning to raise some interesting issues which I wanted to explore and I felt this faculty would provide me with a diverse population of student nurses to draw upon for my study which ultimately would inform my future practices as placement development manager.

3.4 The researcher

Participating in conversation and dialogue normally through question and answer and negotiation facilitates understanding. The researcher is actively involved in the process. Understanding is not static and experience can change a person's understanding, influencing the meanings that are given to situations and events. This will influence how we see and interpret situations and events. This means that there can never be finality of meanings as it is always open and anticipatory. Thus, the research can never be complete; it is always evolving. Everyone will come to the study, researcher and participants alike, with their own personal and cultural histories. It is this which gives rise to pre-judgements and prejudices which will influence understanding. Individuals including the researcher understand and interpret in the light of their pre-judgements and prejudices (Koch 1994, Sandelowski 1986). Providing relevant information about oneself as the researcher can help the reader to see my pre-judgements and prejudices; however, accessing these is not always easy, making it difficult to provide the most appropriate information.

I am entering this investigation as an educator, nurse and mother. A woman who is white, middle aged, and who is in full time employment as a principal lecturer in higher education. This enables me to have the means to live a comfortable life now, although this has not always been the case within my adult life. I have gone through my nursing career with the view that nursing is a caring, compassionate and nurturing profession and it is this understanding of nursing that has featured in my teaching. I have taught many aspects of nursing but in recent years these have been focused around health promotion and ethics. However, today the majority of my time is spent in relation to enhancing and improving the quality of placement learning.

My conceptualisation of nursing as individualised holistic nursing care has been shaped by my personal experiences of nursing. Details of my nursing experiences have been included as Appendix one to give further insights into

my prejudices and biases which will influence what I see and my interpretations as a researcher.

One of my biases is my conceptualisation of nursing, and it was this that contributed to bringing to my attention the phenomenon for this study. I began this journey because I was encountering more and more requests from student nurses undertaking an adult nursing course to change clinical placements as they did not want to do the "vile work" of meeting the physical needs of the patients such as washing, dressing, mobilising eliminating and nutrition in the clinical placements allocated. The essence of nursing for me was caring for patients in a variety of circumstances, which included helping them to meet their basic needs in a dignified way when they were unable to do this for themselves. These requests to change placement not only distressed me but also challenged my conceptualisation of nursing as individualised holistic nursing care. I wanted to find out more and to understand why these students felt like this.

3.5 The research design

I have chosen a qualitative hermeneutical phenomenological approach as this would provide me with a framework to address the research question and objectives. The reasons for my choice are discussed in section 3.2. Van Manen (2003) has formulated a structure for hermeneutical research which provides a comprehensive guide for the researcher. This framework has been used to guide the design of this study. The activities within the framework include:

- Turning to a phenomenon which seriously interests us and commits us to the Investigating experience as we live it rather than as we conceptualise it
- Reflecting on the essential themes which characterise the phenomenon
- Describing the phenomenon through the art of writing and rewriting
- Maintaining a strong and oriented pedagogical relation to the phenomenon

- Balancing the research context by considering parts and whole (van Manen 2003 page 30)

3.6 The phenomenon

Some of the criteria for choosing a good phenomenon must be the ability to sustain attention and motivation. I have chosen a phenomenon which interests me and holds my focus. The phenomenon is:

> "student nurses experience of learning in clinical placement".

This still has the effect of exciting and motivating me even after all these years of study.

The reasons for my interest and choice of my chosen subject have already been discussed in section 3.4. I shall therefore not repeat these except, to reiterate that it is a phenomenon which I would like to have a deeper understanding of for the purpose initially of informing my own work, but also to generate new knowledge and understanding about this complex phenomenon. There is a plethora of knowledge already available on this subject but the literature available from the students' perspective is sparse and it is fragmented into separate pieces. Choosing this approach has enabled me to investigate this experience from the students' perspective to enrich the already available knowledge.

3.7 Investigating the experience

Phenomenological research strives to make known the basic experience of everyday living. The answers to this quest are to be found in the lived experiences of those who have had practice in the phenomenon being studied.

3.7.1 Sampling

It is recognised that not everyone in the population can be researched (Iphofen et al, 2009). Sampling is the process by which research participants are selected. In qualitative research sampling is based on quality not quantity with

the researcher looking for individuals who might offer rich and deep descriptions of the phenomenon under study (Crabtree & Miller 1992, Nicholls 2009a). Therefore one of the criterions for the sample was to have student nurses who had experience of clinical placement; as this study focussed on the clinical experiences of student nurses the sample for this study therefore has to be drawn from a population of student nurses who have been exposed to that experience. All pre-registration student nurses will be exposed to this at various times throughout their course as this is a requirement laid down by the Nursing and Midwifery Council for United Kingdom (2004, 2010).

Sampling in qualitative research requires boundaries to be set that take account of the time and means at the disposal of the researcher whilst at the same time ensuring that decisions are congruent with what the study is trying to achieve (Iphofen et al 2009).

This study is concerned with the way individuals (student nurses) give meaning to their world (clinical placement). This meaning will be different and unique for each person (Nicholls 2009a). Therefore decisions made regarding sampling had to reflect this. As the purpose of the sample was to collect in depth information a nonprobability sample is considered to be more appropriate (Iphofen et al 2009). A nonprobability sample of pre-registration student nurses was chosen from a university in England. As I wanted a sample that would provide me with opportunity to explore the way student nurses give meaning to their world of clinical placement, I felt this was the most appropriate choice. A drawback of using such a sampling method was the inability to generalise the findings to the population being studied as there is no evidence to suggest that the participants involved are reflective of that general population (Iphofen et al 2009). To do this I would have needed a sample that adequately represented the population. The numbers I would have needed would have detracted from what I was trying to do, the collection of in-depth information. However this study does not set out to represent variables possessed by the background population. Qualitative research attempts to build understanding and theory

which explains the phenomena and it is this theory which is generalisable to others (Nicholls 2009a, Silverman 1997). This study is therefore designed to bring to light the common meanings and practices of this everyday experience of student nurses which will provide further insights into the phenomenon, leading to a deeper understanding which can then inform and provide insights into this aspect of nurse education as well as identify further areas for research.

Criteria was developed for choosing the participants which included

- Pre-registration student nurses who were studying adult nursing as this corresponded to my own professional field and I felt that this would help me to make connections with the participants during the interview process
- Pre-registration student nurses who had experience of clinical placement
- Pre-registration student nurses who were willing to share their experience of clinical placement and who were willing to share these with me
- Pre-registration students where there would be no possibility of my direct involvement with teaching and assessment

Being a lecturer and having chosen to recruit students raises ethical issues which will be discussed in section 3.7.3 as well as the problem of power which can affect the quality of the data being collected. Power is always present in interviews (Nunkoosing 2005). It can take many forms and can shift constantly throughout the interview between the interviewer and the interviewee (Nunkoosing 2005). This is important as power should not be held by one party throughout the interview as this could impact on the data collected. As well as having power from the authority invested in me as the researcher I also had power from being a lecturer which could result in an overwhelming imbalance of power for participants who may feel more cautious about revealing their stories, affecting the quality of the interview and the data collected. It was felt that this would be more likely to occur in situations where the researcher was involved in

evaluating the students' performance on the course. Therefore I took the precaution of not including any students where there was any possibility of me being involved in teaching or assessing students during their course. There is still an assumption that the power balance will be skewed towards the teacher which will influence what information the students feel able to reveal. This is dependent on how the interview is conducted and the skill of the interviewer to attempt to minimise any power imbalances where possible. This is discussed further in section 3.7.3.

The sample was drawn using the above criteria. Sample size in qualitative research is not governed by rules as it is in quantitative research (Nicholls 2009b) making the decision dependent on other factors including the method of analysis to be undertaken within the research as well as available resources (Iphofen et al 2009). Phenomenological studies regularly use as few as 5-8 participants (Nicholls 2009a). Lincoln and Guba (1985) suggest that:

> "you should sample to the point of redundancy when no new information is forthcoming" (page 202).

Redundancy from participants' responses was identified after 10 interviews with student nurses. It was therefore determined that 10 was a sufficient sample size for this study.

Students were informed of the study through advertisements posted on the course website, course notice boards and notices given out in class by the module leader who was not the researcher. They contained information about the study, including contact details of where prospective participants could go to get more information regarding the research. Students were encouraged to ask questions regarding the study and their involvement. Students who were interested in participating in the study and left contact details were contacted, providing a further opportunity to discuss the research, in more detail. Students also received a pack containing written details of the research, including a welcome letter, an information sheet containing a sample of the prompt question

to be used at interview and two consent forms. A copy of the welcome letter, consent form and the information sheet are included as appendices two, three and four respectively. If students wanted to volunteer to take part, arrangements were made for students to attend an informal session at a place and time mutually convenient to the student and researcher.

The sample consisted of a diverse group of 10 student nurses who were all undertaking a course in pre-registration nursing, adult branch, at the same university. The sample was made up of two males and eight females and the age range of sample was from 20 to 50. The students were not asked to state their ethnicity. However, from the discussions, it emerged that one participant was of Asian descent and one originated from outside of the European Union, which broadly reflects the diversity of the population it was drawn from. I also enquired as to whether the students had previous health care experience prior to commencing the course. Six of the participants had previous health care experience and four had no prior experience.

At time of interview, participants were either in their second or third year of their programme of study. Three participants were in their second year, and seven participants were in their third year. All participants had been exposed to at least two clinical placements in their first year, one of eight weeks and one of 12 weeks duration. Those participants who had completed their second year had been exposed to two further placements, one of eight weeks and one of twelve weeks duration. All placements were drawn from a range of clinical specialities including medicine, surgery, older adult, community and high dependency.

These students chose to participate in this study. There is an issue of non response and the potential problem that those who do not choose to participate are different from those who do. This has to be taken into consideration when drawing conclusions from the study.

The information was available to all student nurses undertaking the adult branch of the pre-registration nursing course. In summary a total of ten students who met the criteria were recruited to the research study. All ten attended for interview at the agreed mutually convenient time and place and appeared relaxed to discuss their experiences of learning in clinical placements. The tape recording for one of the participants was damaged and therefore the data was not available for use. Although attempts were made to reschedule the interview with this student the appointments were not kept.

3.7.2 Data collection

As hermeneutic phenomenology characteristically requires the examination of descriptions of human experience a method was chosen which would enable such data to be collected. Descriptions can be achieved by tapping into the lived experiences of human beings which can be accessed through narratives which are conversations or observations of actual everyday events or episodes. An unstructured interviewing format provides opportunities for open conversation between the interviewer (researcher) and interviewee allowing for the sharing of thoughts, ideas, experiences and emotions which captures our relation to things including memories, thoughts and past experiences van Manen 1997). This type also allows the researcher to probe deeper into the views of the interviewees. It is hoped that by giving the participants sufficient opportunity significant information will be revealed by the participants and more profound levels of meaning, depth of feeling and emotion will emerge (Iphofen et al 2009). This will require time to allow each participant to express their views therefore the number of individuals who can be interviewed is restricted.

The success of this method to produce useful data rests with the interviewer's skill and how they present themselves (Iphofenet al 2009). Although I was a lecturer and had opportunity to interview students in the past I felt that research interviews required a subtly different set of skills if they are to be undertaken successfully. This is supported by Nicholls (2009b). I therefore needed to develop my skills further particularly in relation to phenomenological interviewing

in order to enable the students to tell their stories. I therefore attended two courses run at George Mason University, Fairfax, Washington USA which gave me instruction and practice in how to conduct such interviews. I learned how to commence the interview with a question that would help direct the students to the area under investigation and how to use prompts to probe for deeper meanings and understanding. However this is only part as the quality of the interview is also dependent on how the researcher sets up the interviews, presents and conducts them self during the process. The aim of the researcher is to draw from the participants genuine responses by maintaining a natural demeanour that encourages them to converse. It is therefore important to develop an approach which encourages this. The relationship between the researcher and their participants should be a natural one that develops trust (Holloway and Wheeler 1996).

Data were collected between February and June 2007. Students were asked to attend for interview at a date time and place that was convenient for them as well as the researcher. Although the students were given the choice as to where this could be held, all the students opted for a quiet interview room within the university. This venue was well known to the students which could be beneficial as Iphofen et al (2009) state that a familiar environment to the participant helps them to maintain a degree of normality in their conversation.

As I wanted the students to talk freely about their experiences in clinical placement it was important to make them feel comfortable and at ease prior to commencing the interview. To make the process less formal, the furniture was carefully arranged in advance to minimise barriers to communication. On days that I was scheduled to undertake an interview I took care with dressing so as not to appear too formal. At the start of the interview tea and coffee making facilities were on offer and myself and the student chatted socially before the commencement of the interview as a way of breaking the ice and putting them more at ease. These measures were taken to ensure that the environment was conducive to allowing the student to relate their stories as well as to minimise

any power imbalances. Students were again briefed as to the format of the interview and written consent was obtained at the start. However the difficulty with interviewing is to get the balance between clarity of role and relationship with the student without stepping over and becoming too friendly where the interviewees may be duped into revealing more about themselves than they would normally want to share .During these interviews I tried to maintain a natural demeanour without leading students on to believing I was their friend and made it clear to the students that they could withdraw from the situation if they felt uncomfortable or for any other reason.

It was also important that students participated in the interview. Participants were therefore briefed at the start of the interview that the process was informal and their participation would be welcomed. This is important as it can help with the creation of jointly built construction of meanings where both parties felt able to contribute (Chodorow 1989). This puts the onus on the researcher to ensure that participants feel comfortable to do this. A detached value neutral approach with pre-defined questions and answers would be an inappropriate approach as it puts participants in the passive role and gives rise to power issues as it can exert power over the participant (Denzin & Lincoln 1994, Gubrium & Holstein 2002, Silverman 1997). Helping students to participate will only be possible if the researcher does not portray oneself as being in charge of the interview or the knowing one Chodorow (1989). However the ability to generate this non hierarchical participatory environment will be down to the skill of the researcher to create. One of the most important aspects of the interviewer's approach is to convey an attitude that enables the participants to feel that their views are valuable and useful (Patton 1990). I attempted to do this by not interfering with how the students structured and framed their responses and by demonstrating that I was interested in their responses through my body language and by encouraging them to go on with their narrative. In this way I showed the participants respect and I feel I created conditions that made them feel empowered to take part. The interviews were in-depth and the length was under their control as they decided when to conclude. Each interview lasted a

minimum of an hour with some lasting much longer. This did not appear to pose the students any problems.

The data needed to be recorded which immediately introduced an artificial element into the situation. Writing the content of the interview down was not the preferred option as it would likely restrict the informal and spontaneous responses to the interviewees from the researcher and would not give the detailed responses required (Iphofen et al 2009). For these reasons the plan was to audio tape each interview unless objected to by the participants. The student's consent to this was sought at the beginning of the interview. The researcher was prepared to take notes in the event that a participant refused however this was not necessary as all the participants agreed to the taping of the interviews. Field notes were also kept of each interview to record any particular aspects of the interview that stood out including any particular physical gestures and expressions that would provide further data for analysis.

The interviews were all taped. Unfortunately there was a problem with one tape recording and the content was not available for transcription. I invited the student back and rearranged other times to re-record the session but the student cancelled. Transcription raises ethical issues, one of which relates to who is going to transcribe the data as involving others raises issues of confidentiality (MacLean et al 2004). I transcribed all the tapes myself. Before these were transcribed the data was anonymised. There is controversy over whether the tapes need to be transcribed in full. Poland (1995) believes that everything should be transcribed to prevent missing anything vital. I transcribed the tapes in full and when I had finished each tape I reviewed it with the original recording to check for accuracy and authenticity. It has been stated that having included these checks and having only one transcriber increases reliability (Iphofen et al 2009). The transcriptions were exactly what was said and each speaker and their turns were identified and indicators were also used where appropriate to convey more information about how the words were spoken. I took the decision to transcribe for the reasons described but also it is the first

step by which the researcher gets to know the data and as such is a key stage in the study.

3.7.3 Ethical considerations and approval

The research proposal was presented to and approved by the university research ethics committee of the higher education institute where the students were enrolled on the pre-registration nursing course prior to starting the data collection.

Participants can feel coerced into taking part in research depending on how they are recruited. This can also be made more acute as I was a lecturer in nurse education and they may feel their course is in jeopardy if they do not participate. To minimise these risks I did not approach the students in person. The information regarding the study was posted on the web site and also disseminated by colleagues. I also included information that the decision to take part rested with them and that they could withdraw at any time and I re-iterated that it would not impact on anyway on their course. I also decided not to include any students where there was any possibility of my direct involvement with their teaching and or assessing during their course as these students may have felt more at risk of feeling this.

Students had the right to feel free to choose whether to participate in the study and without fear of reprisals. The participants were informed of this right through the information sheet. This was again discussed with the participant before the commencement of the interview and before they signed the consent form. The consent form also contained a statement to the effect that they understood their right to withdraw at any time without any reprisal. None of the participants identified a desire to, or have pulled out of, being part of this research study.

Interviewing can give rise to ethical dilemmas which arise from how the interviewer acts and behaves during the interviewing process. It can be seen as being dishonest as the participants can be encouraged to view the situation as a normal interpersonal encounter where they feel they can talk freely and confess

their innermost thoughts and feelings. As we live in a society where we are encouraged to express and confess one's innermost thoughts and feelings (Nichols 2009b) this can only contribute to the problem. This can occur when the interviewer exploits the natural attitude too much and the participant views the interviewer as a new friend which can lead them to expose thoughts and feelings that they would not want to share. The dilemma is resolved by balancing intent (getting the data) with role clarity (Iphofen et al 2009). I maintained a natural attitude during the interview process without being overly friendly. I made it clear to the students prior to the setting up of the interview and at the start of the interview my intentions regarding the data I was seeking. I also informed them of the safeguards in place regarding the storage and use of data and their anonymity in that process. Statements, that they could withdraw from the study at any time and use of the data were included as part of the informed consent and in the information given to the student. These messages were re-iterated at the start of the interview before students signed their consent form. Copies of the information letter, information sheet and informed consent are included as appendices two, three and four.

Trust is an important aspect in the researcher /participant relationship. The foundation of trust grows from a respect for the person including their right to privacy and confidentiality and autonomy. It was important that anonymity and confidentiality be preserved throughout the study. Several steps were taken by me (the researcher) to protect anonymity. Firstly the participants' identity was preserved by changing their names along with any distinguishing details which could reveal their identity. However I did not change the account of what was being said. Although I have made every attempt to maintain the anonymity of the participants it is likely that they may be able to recognise themselves from extracts as well as the text. Students did participate knowing that the information collected would be used to produce a thesis and possible publications, which was part of the consent procedure. During these accounts, patients were discussed however names of patients were never usually included within these accounts which helped to preserve their right to privacy however as a further

precaution any distinguishing details were changed or removed. Practice placements and placement provider organisations were either not named or if necessary the names were changed to protect their identity. It is hoped by taking these measures anonymity is maintained however this cannot be guaranteed for the reason previously stated.

Confidential information including audiotapes, consent forms and any other information containing personal details were kept locked in a cabinet and I was the only person with a key. During the study, when confidential data was being used this was not left unattended and at all other times it was locked away as described. Research data which was stored on the computer was made secure by using a password and through use of firewalls installed on the computer to prevent unauthorised access.

Power imbalance was a particular issue for this study, made more acute as I was a lecturer and was interviewing students. Practical measures were taken to minimise power imbalances. These included paying attention to the preparation of the environment where the interview took place for example by having chairs at same height, arranging the furniture to remove physical barriers. To make the process less formal, tea and coffee making facilities were on offer. On days that I was scheduled to undertake an interview I took care with dressing so as not to appear too formal. These measures were taken to ensure that the environment was conducive to allow the student to relate their stories as well as to minimise any power imbalances. I did not pick up on or identify any particular problems. Students were sometimes nervous, which was relieved by social conversation. Participants were fully engaged during this process and revealed in-depth and insightful stories which suggested that this was not an issue. I was humbled that the participants felt able to tell their stories.

As a registered nurse I had a duty to follow my professional code as a nurse this meant that I would need to act on any disclosure in the interview that gave rise to serious concerns. This was explained to the students at the start of the interview.

The safety of the participants is of paramount importance. Their health and safety should not be compromised by taking part in this study. Students can be harmed by taking part as a result of various factors such as stress from taking part, or other psychological injury including loss of self-esteem (Iphofen et al 2009). Although having assessed the risk of harm to students as being low I ensured that there were information available containing details of the counselling service at the university where the study was conducted in case the interview distressed the students. This was not required.

3.8 Reflecting on the essential themes that characterise the phenomenon

The purpose of phenomenological research is to construct meaning from the experience under investigation which in this case is the lived experiences of student nurses in clinical placement. This involves commitment and time to the analysis of the data from the study. The following section explains the processes involved in order to arrive at the themes of the study.

3.8.1 Data analysis

Qualitative data needs to be dealt with in a productive and efficient manner (Iphofen et al 2009). There are various stages in the process. The first stage of the data analysis involved transcribing the interviews. The processes involved in transcription have already been discussed and will not be repeated. After the transcripts had been compiled and checked for accuracy a copy of their own transcription was sent to each of the participants for their comments on accuracy. The researcher did not receive back any comments.

The second stage involved interpretation of the data to construct meaning. Different approaches have been used to analyse phenomenological data, and my approach to making sense of the data was to use the principles of conducting thematic analysis by van Manen (2003). Thematic analysis examines the words and analyses of data units which are sentences or paragraphs which are then coded and examined further in more detail to produce categories, and then themes (Iphofen et al 2009). This approach was

taken as it fitted in with the overall study method chosen, it had been used for educational phenomenological research, was comprehensive and gave the researcher insight as to how to analyse the data. The purpose of the analysis was to construct meaning and identify the key themes from the data. Van Manen (2003) identifies three different approaches for isolating thematic aspects of the phenomenon. I chose the line by line approach where every single sentence or sentence cluster is looked at for meaning as there was less chance to err or to see meaning that is idiosyncratic (van Manen 2003).

Themes are developed to sum up and depict the data (Iphofen et al 2009). Theme however is a complex concept to understand. Van Manen (2003) describes a theme as:

- Phenomenological description and interpretation
- The experience of focus ,of meaning, of point
- The structure of the lived experience (page 87)

Themes provide a metaphorphical structure by developing a web upon which lived experiences are spun for the purpose of constructing meaning. Developing themes from the data is an involved process that involves identifying the thematic aspects. Before a theme can be uncovered from the data it is necessary to uncover the thematic aspects.

The process involves many stages before themes emerge. Initially it involved being submerged in the data by reading the transcripts over and over again and then writing a summary for each transcript. The next stage involved organising and indexing the data which enables the data to be identified and retrieved. This is usually referred to as first level coding. These codes are normally descriptions of the phenomena (Iphofen et al 2009) . The summaries were then read and broken down into the sentences and sentence clusters and sequentially numbered. Each unit of data (i.e. sentence or sentence cluster) was analysed for its underlying meaning. This involved looking beyond the words and providing a description heading that reflected my interpretation of the

underlying meaning as there is no one truth from qualitative data (Iphofen et al 2009). However the data examples should reflect the data interpretation (Iphofen et al 2009). The descriptive headings were collated in a table to show the sentences or sentence clusters under each heading. This was repeated for each transcript summary. A table of all the descriptive headings used was produced. A number of the descriptive headings were common to the transcript summaries. To ascertain the descriptive headings common among the transcript summaries a record of this information was contained within the table. These were then examined for similarity and then grouped into categories. A category is a group of descriptions of the phenomena that appear to be alike (Iphofen et al 2009). From the information from the tables, the sentences and sentence clusters were then organised under each category, which were then read and reread as part of the process of forming the themes. Themes are the structures of the experience and provide control and structure to the research writing (van Manen 2003). Themes are not just categorical statements or conceptual formulations but more about the notion which will help to understand the experience (van Manen 2003).

The last stage in data analysis involved synthesising the data to evaluate how the different themes interrelated in order to understand more fully the phenomena as a whole. Lave and Wenger's theory of situated learning (2002) was used as the tool to help with this process. Each learning theory has its own perspective containing underlying assumptions and beliefs about the individual, knowledge and ways of knowing. The Lave and Wenger theory is based on the understanding that individuals are social beings; knowledge is regarded as competence in valued endeavours; knowing is engaging in the world in pursuit of these valued enterprises and meaning is the outcome of our experiences (Wenger 2008). To summarise, situated learning theory conceptualises learning as a social activity which is linked to the ongoing activities and practices undertaken by a group of people through social interaction rather than by single individuals (Fox 2000). Thus, learning is always inseparable from its context and the social relations and practices that are part of experience (Mann 2011).

Learning from this perspective is seen as an activity that is shaped both by others and by the culture (Mann 2011). Therefore, for students to learn, they need to access and participate in experiences where this is happening.

Lave and Wenger (2002) use the phrase "communities of practice" to describe the structures where this occurs. Communities of practice are explained in more detail in the discussion chapter (section 9.1). However, the process involves the learner being given access to the community of practice where they can participate and engage in the practices of that community. Billet (2004) sees this as being essential for learning, as the interactions between the learning opportunities and how the individual engages with these opportunities are seen to lead the learner to co-construct meaning and understanding from their experiences which shape what they know and do. In this way, the process is transformative. Learners are transformed by this participation in the community, whilst this participation in turn transforms the community. Through participation and active engagement, the individual learns to understand, take on and attain the roles, skills, norms and values of the culture of the community, whilst learning how the community views and structures its world and how it functions to solve its problems (Mann 2011).

The purpose of clinical education in the preparation of registered nurses that emerged from the literature revealed three key functions: skill development; integration of theory to practice; and socialisation. Other theories of learning tend to focus on one or other of these functions, but not all three. Behaviourists' theories view the environment as the major influence in learning, whilst cognitive theories of learning explain the processes within the brain of the individual, to explain how knowledge is organised and stored, and how individuals make meaning of their experience. Situated learning theory by Lave and Wenger (2002) incorporates and integrates these three key functions. In situated learning theory, the socialisation and the development of professional identity are integrated as part of the knowledge and skills that individuals attain (Mann 2011). Work and learning are also enmeshed into one (Brown & Duguid 1991).

Together, these provided a framework to further interrogate, explain and understand the findings from this study, to comprehend and synthesise more profoundly the phenomena under investigation.

The very qualities of shared perspectives in a domain: trust; communal identity; long standing relationships within the community; and an established practice which builds an ideal for learning; can also be seen as barriers limiting its development (Roberts 2006). This particularly relates to the influence of power on the social organisation and control of resources within the communities of practice, which Lave and Wenger have considered within their theory but have not addressed within their case studies (Contu & Wilmott 2003). Lave and Wenger (2002) fail to examine or explore the implications of the distribution of power within the communities they cite, with the overall effect of directing the reader to interpret communities as being consensual and harmonious, when in reality, they can be weighed down with misunderstandings and disagreements. (Roberts 2006).

Power can promote or hinder access to and continuing membership of communities of practice (Contu & Wilmott 2003) which can enhance learning by facilitating access or make it more difficult and/or impossible when it is restricted or denied. Legitimate peripheral participation can also be a source of power or powerlessness in allowing or preventing exchange and interaction among communities of practice. Learners on the one hand need to participate and engage in the practice of the community in order to understand the practices and to move from the periphery to being more centrally involved within the community. At the same time, they have a vested interest in the community and its development as it will impact on their construction of their identity and their place in its future (Fox 2000). This can lead to dilemmas from conflicts of power (Fox 2000), the outcome of which is dependent on the social relationships within the community of practice, particularly between those in power and the learner (Fox 2000). Unequal power structures and relations can influence the meanings and practices within a community of practice, often with the effect of mirroring

those held by the dominant source of power (Roberts 2006). An understanding of such effects can help to make one aware of how tacit knowledge is created within the different communities of practice (Fox 2000).

Learning within communities of practice in the manner described by Lave and Wenger (2002) relies on the presence of a relationship of trust between its members (Roberts 2006). This involves individuals in the community being able to share a high degree of mutual understanding, based on a common awareness of the social and cultural context. According to Roberts (2006), trust and the developments of mutual understanding and familiarity with the social and cultural context, are the preconditions for the transfer and thus the learning of tacit knowledge (Roberts 2006). The presence of trust within a community of practice can facilitate effective knowledge transfer (Wathne et al 1996). This is not examined within Lave & Wenger's theory, and therefore its exclusion highlights a limitation to this theory that needs to be taken into account during the application of this tool.

A key component of Lave and Wenger's (2002) theory is developed from the notion that meanings are co-constructed and negotiated from experiences within the community of practice. It is assumed that changes to practices are also developed in this way. This notion however does not take into account Bourdieu's (1990) view of habitas, consisting of forms of thought which are unconsciously acquired, resilient to change, and transferable between different contexts (Roberts 2006). These can influence and impact on the knowledge and practices within the community. According to Roberts (2006), dominant predispositions within a community of practice will shape the knowledge and support the identity and current practices of its members. In this way, knowledge and practices can become static as knowledge that challenges identity and practices is more likely to be resisted, leading to institutionalisation within the routines (Roberts 2006). Lave and Wenger's theory does not explain in depth how communities of practice change their practice or innovate (Roberts 2006).

In summary, when using this tool, it is important to take into account these limitations, as communities of practice do not develop and function in isolation from power, trust and predispositions. The extent to which communities of practice are successful as a means of facilitating learning and the transfer of knowledge will depend upon the context in which the community of practice is bound (Roberts 2006). However, communities of practice do provide a vehicle to explore the transfer of tacit knowledge and its facilitation (Roberts 2006) and as such provides a useful tool to synthesise and evaluate the findings of this thesis. .

3.9 Maintaining a strong and orientated pedagogical relation to the phenomenon

Hermeneutic phenomenology is both descriptive as it pays attention to how things appear, and it is interpretive as all phenomena are already interpreted as the details of lived experience are always already meaningful, and the details of lived experience are described in language. Descriptions of the research data will always be brought to life through a certain interest and this interest defines where the researcher stands in respect to the study. As I am both a teacher and a nurse I will be describing the experience from this perspective.

3.10 Balancing the research context between parts and whole

Heidegger believed that human beings were already in the circle of understanding as they lived in a world that already had meaning which was buried in the language, skills and activities of the communities and culture in which individuals existed (Heidegger 1962). It is this understanding of the world that enables the person to cope in the world in a manner where the activities and equipment are taken for granted. However these become conspicuous when some sort of breakdown occurs making it noticeable to the user. At these times the practical day to day activity stops and the person stands back to observe and reflect on the situation. It is these gems which help to uncover the shared meanings and common practices. Each transcript will contain those

situations where some sort of breakdown occurred as it is these which stand out for the student.

Individuals come to situations with some familiarity developed through the background practices. It is this understanding that makes interpretation possible (Plager 1994). Interpretations of situations will develop from our experiences and give the person a point of view from which to interpret as well as expectations of what may be anticipated in an interpretation (Heidegger 1962). The students in this study will interpret their situations from their point of view and their biases and it is this which will be described and caught within the data and I as the researcher will interpret the data from my point of view. In Heideggerian phenomenology fore-structure is an integral part of the process of interpretation and should therefore be recognised for the possible influence it has on the interpretation process (Plager 1994).

For me to uncover the shared meaning and common practices of the student experience of clinical placement it was necessary to examine each transcript individually and collectively. This activity involved moving backwards and forwards between the parts that is between the transcript and the whole collection of transcripts. However it was also necessary to consider this examination in the light of the bigger picture of nursing and health care. This process according to Plager (1994) involves openness, sensitivity and scrutiny to ensure that the interpretation presents an understanding of the lived experiences.

3.11 Research rigour

Qualitative research must meet the expectations of rigorously conducted research and reliable information but must do this within its philosophical and methodological framework including being true to the underlying beliefs which include humans as self determining which means that we each interpret the world in our own unique way and multiple realities. Quality in qualitative research has been an issue over the last twenty five years (Rolfe 2006).

Researchers during that time have developed quality criteria but to date there is no agreed consensus as to what these should be (Rolfe 2006). This study has been guided by the criteria set by Lincoln & Guba (1985) and includes the criteria of credibility, dependability and conformability. However the decisions made have been taken in the light of the underpinning philosophical and methodological framework of this study. Each one of these will now be discussed in the following sections including a section on methodological congruence as this is also recognised as a criterion of quality (Burns & Grove 2009).

3.11.1 Methodological congruence

Methodological congruence requires the researcher to make decisions that are compatible with the underlying framework including the philosophy and methodology and has to ensure rigour when applying the procedures selected (Burns & Grove 2009). A summary of the decisions made during this research process have been included as appendix 6.

3.11.2 Credibility

Lincoln & Guba (1985) identified credibility as a criterion against which truth value of qualitative research is evaluated. Truth value in qualitative research is normally found in the discovery of human phenomena or experiences rather than in the verification of 'a priori' conceptualisations of those experiences. Some of the key strategies used for measuring credibility include member checking – where participants review the researcher's developing coding, categorising and theorising and peer review – sharing developing analysis with peers. Both these strategies assume that there is something within the data that already exists to be revealed. If it is believed that essences and categories of the phenomena are already embedded within the data then it makes sense to ask the participant or independent researcher to review with the expectations that they will confirm the researcher's interpretations of the data (Rolfe 2006). However Sandelowski (1993) argued that if reality is assumed to be multiple

and constructed then we should not expect either expert researchers or participants to arrive at the same interpretations as the researcher and believed that repeatability was not an essential or sufficient property of the things themselves (Sandelowski 1993). Such a move involving the conformity or artificial consensus of the analysis of the data can be seen to detract from the meaningfulness of the findings (Rolfe 2006). Sandelowski (1993) argued that these strategies are a threat to phenomenological validity and are hostile to the naturalistic / interpretive paradigm and rejected these measures as helpful in contributing to rigour. For this reason I did not employ either peer review or member checking.

A qualitative study is credible when it either presents such faithful descriptions or interpretations of a human experience that individuals recognise it from their past experiences or they can identify from their reading of the experience when confronted by it (Lincoln & Guba 1985). In these cases the judgement of rigour in qualitative research rests with the reader (Rolfe 2006). However the researcher has a responsibility to provide the reader with sufficient clarity and detail to enable them to make this judgement. For this reason one of the strategies that I have used is to present data from this study in sufficient depth to help the reader to recognise it, as a credible study. This is also important as it also demonstrates commitment to interpreting the text which is seen by Plager (1994) as contributing to the rigour of hermeneutic phenomenological research. Another strategy to help the reader decide on rigour is the inclusion of a summary of the decisions made through the research process and is presented as appendix 6.

With this methodology the researcher is seen as being an integral part of the data collection and central to the analysis process therefore credibility is also dependent on them (Patton 1990). Making explicit what the researcher brings in terms of qualifications, experience and perspective including prejudices and biases enhances their credibility (Patton 1990) and allows the reader some opportunity to make their own judgement regarding the credibility of the study. I

have included information in appendix 1 about me, the researcher, which helps to identify my qualifications, experience and perspective.

3.11.3 Dependability

Dependability refers to the stability of data over time and over conditions (Polit & Beck 2004). One method identified to assess dependability is stepwise replication. This involves two teams of researchers who review the data sources separately and compare their findings in order to confirm the findings. This method assumes that there is something in the data to be revealed and detracts from the belief that reality is multiple and constructed. Thus its implementation could impact on the meaningfulness of the findings and be in conflict with the underlying philosophy and methodology of the study. For this reason it was not used.

Dependability is also concerned with ensuring that the study is logical and the processes can be audited (Koch 1994). I have discussed how I have undertaken the study and the processes used in this chapter and have included a summary of my decisions as appendix six.

3.11.4 Transferability

The aim of qualitative research is to generate understanding and theories that explain the phenomena in the world. The theories that emerge must be transferable if they are to be of value to researchers, educators, practitioners and patients. The purpose of this study is to produce general themes which reveal the commonality of the experience which is applicable in situations other than the one studied (Searle 1999).

To be able to judge transferability to other situations and /or groups relies on the researcher collecting and making explicit sufficient detail from the data to enable the researcher and reader to make an informed judgement (Iphofen et al 2009). This is something that I planned to do to enable inferences to be made where relevant. In this way it is envisaged that the insights from the study will

be useful not only to the university where the study was undertaken but to other institutions undertaking similar courses as well as informing the discipline of nursing.

3.11.5 Confirmability

Confirmability is a criterion that examines and measures the integrity of the study including the processes undertaken are genuine, consistent and accurate. Lincoln & Guba (1985) propose that auditability be the criterion of rigour in relating to consistency of qualitative research. A study is auditable when another researcher can clearly follow the decision trail used by the investigator in the study (Lincoln & Guba 1985). I have therefore included a summary of the decisions made. Please see appendix six.

3.12 Limitations of the study

There are limitations with all research and this study is no exception. Although the findings from this study cannot be generalised as this study was undertaken within one setting and the sample size was small, which is a limitation. However interviews were undertaken until saturation was achieved. The students interviewed were volunteers and as such may have had a special reason for being part of the study which could influence the data collected. The study was also reliant on the participants being open and honest during the interviews which the researcher felt was the case. As this was a small scale study to be undertaken within a timescale it was decided to look solely at the lived experiences of student nurses. This meant that the study did not cover other perspectives e.g. the lived experiences of mentors and or link tutors. The rationale for choosing the lived experiences of student nurses in clinical placement was the lack of literature on this subject.

The findings from this study are context bound because only one site was used therefore the findings only pertain to the participants perspective in that environment. However there is no threat to external validity because the research situation and study findings display characteristics that are

represented in other clinical practice areas UK wide as determined by the literature reviewed. This is my interpretation of the students' experiences which are influenced by my prejudices and biases. This therefore is only one interpretation of the findings.

3.13 Summary

This chapter has described and defended the methodology and design of the study. It has explained in detail the processes involved and the reasons for their inclusion. The following chapters present the findings from the data analysis.

Chapter four

Introduction to findings, discussion and conclusion

4.0 Findings, discussion and conclusion

This study set out to investigate the lived experiences of student nurses learning in clinical placement for the purpose of having a deeper understanding of this phenomenon. It was triggered by my desire to comprehend why some students undertaking a pre-registration nurse education course in adult nursing did not want to attend clinical placements where they perceived that they would be participating in helping patients to meet their "physical care needs" such as washing, dressing, eliminating etc. which they described to me as "vile work". From their accounts it became clear that my understanding as to why students felt this way i.e. a mistaken choice of profession by the individuals concerned or a problem with recruiting students who did not have the attributes for nursing was naive and too simplistic. The stories told by the 10 participants of their expectations and experiences of learning in clinical placement showed that various factors including individual, interpersonal, contextual and organisational entwine to mould and shape their experience which in turn influences and shapes their learning and understanding of the practice of nursing and the work of the registered nurse. Their accounts have enabled me to produce a rich and colourful picture of the students' perspective of placement learning which shows the complexity and multi dimensionality of this phenomenon.

I have used social learning theory particularly Lave and Wenger (1991) as a tool to synthesis the data. Lave and Wenger (1991) define learning as a way of being in the social world which involves engagement and participation. They see learning as fundamentally an experiential and social activity. The individual during this engagement is involved in both the situations of their learning as well as the broader social world where these situations are created. It is through such encounters that the individual learns which shapes their identities as it

changes their ability to participate, to belong and to negotiate meaning. Where this activity is absent or reduced learning will be adversely affected.

The following section addresses the findings from the study and their implications for nurse education and the practice of nursing. Four themes have emerged from my interpretation of the findings. These include:

- Being on the outside
- Learning on the margins
- Identity crisis
- Human buffers

Each theme will be addressed in a separate chapter followed by a discussion chapter where the findings are brought together and debated in more depth. The final chapter will conclude by considering what these findings mean for nurse education and the practice of nursing.

Chapter five

Findings: Being on the outside

5.0 Introduction

Pre-registration nurse education involves a mix of "at university" and "on the job" training. By its very nature, it spans the world of both education and healthcare, as students will normally spend time between a higher education institute and health care organisations where they are exposed to a variety of clinical placements such as wards, nursing homes, clinics or health centres (Donnelly 2003). Each organisation will have its own organisational, culture, values and beliefs which students will be exposed to as they proceed through their course. Clinical placement is the aspect of the course where education and healthcare intersect, where students are most likely to experience the effects of this.

According to Lave & Wenger (2002) learning is a process that occurs in a framework of participation, not the individual mind. Learning, understood in this way, maintains that:

> "Learning, thinking and knowing are relations among people in activity in, with and arising from the socially and culturally structured world" (Lave & Wenger 2002, page 51)

This means that learning is a process which is mediated through the context of the learning situation, and the individuals' involved. Thus, context and co-participation are seen as integral parts of the learning process. To learn, the students need to participate in a community where social practice is occurring (Lave & Wenger 2002). This is a fundamental aspect of how a social practice is created. Thus, students need opportunities to engage in communities of nursing. However, participation is often fraught with difficulties (Becker 1972), particularly in relation to becoming part of a community of practice, and where this is problematic the students' learning is adversely affected (Lave & Wenger 2002).

Lave & Wenger (2002) believe that communities of practice are essential for the development of competence and the evolution of the practice within an organisation; however their presence and contribution often go unrecognised. Thus decisions regarding change to the organisational structure and the layout of the work setting do not tend to consider the impact and consequences on communities of practice.

In the past, students were employees within the National Health Service, usually within the organisations where they undertook the majority or all of their clinical placements. They worked in hospital wards making a substantial service contribution (UKCC 1986). The staff complement was calculated to include the students' service contribution. This meant that students made up part of the overall workforce needed to deliver the work. As the students were part of the workforce then, there was more likelihood during this time that they belonged to communities of practice, although there is no evidence to support this. It was argued however, that such a system produced major barriers to education for the students, as their time was spent focused on the work rather than the learning (UKCC 1986). Students themselves were disillusioned at the time with this system (UKCC 1986).

Employee status for students was removed in the late 1980s, and students awarded supernumerary status. As they would not be counted as part of the staff complement it was thought that students would be unshackled from the work place, freeing them to undertake the learning required to be a registered nurse. Students would be surplus to manpower requirements. Supernumerary status changed the perception and position of student nurses on placement. According to Edwards (2007), students were no longer there purely to carry out nursing work alongside members of the placement team, but also to observe and study the field of nursing in general. Students no longer had an allegiance to their place of work; their base during the three year pre-registration nursing course was the higher education institute. This led to students being seen as 'outsiders' where in the past they were on the inside (Edwards 2007). Students

were outsiders by virtue of the fact that they were not employees of the health care organisation in which the placement was situated, a change which was instigated to ensure priority was given to learning as opposed to the work. However, this now appears counterproductive by creating a new set of barriers which students have to negotiate before they can access learning

5.1 Students as outsiders

The students' accounts begin to expose what it means for them to be outsiders within the healthcare organisation and the issues that it raises for students and educators. From the students' accounts of their experiences of some clinical placements, particularly the general wards within hospital settings, there is no recognisable position for them in the hierarchy of the nursing team. It would appear that they live somewhere between the level of registered nurse and healthcare assistant. This leaves the students confused and unclear as to their position and status within the nursing team. Students found it difficult to see where they fitted in. This is illustrated by Ann's account:

> "They would split you into half – you'd have one team one side and the other team the other side, each would have a trained nurse and two health care assistants.The health care assistants knew what they were doing and they'd get on with it."
>
> (Participant 4 page 3)

Ann's description above identifies a model of work organisation that I recognised when I was a student nurse; teams were made up of registered nurses, auxiliary nurses and students. This model has been common since the 70s at least. It could be argued this is surprising for a health service that has gone through radical reforms and which emphasises new and innovative ways of working. In fact, on closer inspection there are some subtle changes. Ann's account suggests that the health care assistants are forming a group and going off and doing their work, indicating a further fragmentation and division of nursing. This is further illustrated by Ann.

> "They (the health care assistants) would get on with it and you'd be like, what should I do? You want to help but you don't know what you are doing. You're

> just standing there and they're walking by you and you're thinking what do I do. It makes you feel like you're invisible
>
> (Participant 4, page 3)

Ann describes how the members of the nursing team, each with their allocated work load, busy themselves leaving her to feel excluded and wondering where she fits into the structure as a student nurse. This is acute for Ann, as she describes herself as being invisible.

Further accounts by the students begin to give further insights into the structure of the nursing team and their difficulties with where they fit into the structure and where they belong.

> "You've got the trained staff doing their thing and the support workers go off and do their thing and you're stood in the middle
>
> (Participant 5, page 6)
>
> "On this ward I found it was very much 'them and us' sort of situation and I wondered where I fitted into that situation. I didn't really feel I fitted in anywhere because the auxiliaries resented me but the staff nurses were not sure of my capabilities."
>
> (Participant 9, page 9)
>
> "The care assistants are very much hands on. They will do the general work, all the observations, basically anything they can do, even down to identifying if there is a problem and then feeding it back to the qualified staff who will investigate it. So it's almost like two separate teams. This is what it is like for most of the general placements I've been on."
>
> (Participant 10, page 9)

These accounts further reveal greater understanding of the subtle changes to the nursing team, which in the past has been assumed to be a unified whole composed of registered nurses, support workers and students. From the students' descriptions we are beginning to see a team consisting generally of separate subgroups of registered nurses and health care assistants, each with their own identified nursing tasks and activities. Even when the team appears less fragmented into discrete groups, the team appears to work separately, each undertaking their own identified work, as described by Ann. This is also further illustrated by Sarah's account.

> "We were often short staffed and the way the ward was managed was to rota on an extra registered nurse to work as an auxiliary so that they were doing the washes, they were doing the basic care of the patient. Your staff nurses would do your drug rounds, they would do their obs."
>
> (Participant 9, pages 7 & 9)

The students' descriptions show the complexities of the inner workings of the nursing team and reveal how "fitting in" is an even more convoluted and difficult process which seems to involve having to gain acceptance not just to the nursing team per se, but to the separate sub groups of health care assistants and registered nurses which appear under the umbrella of the title "nursing team". Students appeared, in these situations to be living in no man's land. They did not appear to fit in or belong to either the health care assistants (HCA) or the registered nurses sub groups. The criteria of membership appeared to relate to the position of employment of members within the placement. Using Lave and Wenger's theory of situated learning to further analyse these findings, it would appear from the students' accounts, that there is confusion over the composition of communities of practice in nursing. From the students' descriptions there may be more than one community of practice within a placement to which they feel they need to belong namely to both the health care assistant and the registered nurse groups. Their accounts showed that access to communities of practice in some of the placements was extremely difficult, which will have an impact on their learning and the development of their identity, as learning is acquired by actually engaging in the process of legitimate peripheral participation. Without this engagement, learning is restricted or absent (Lave & Wenger 2002). Existing at the boundary can perpetuate marginality where separation is maintained. Although boundaries of practice can be a positive occurrence, the descriptions of the students suggesting separation and disconnectedness are not.

5.1.1 Being on the outside

As well as nursing being fragmented it would also appear that in some of the clinical placements the fragmentation has now infiltrated the nursing team, with

sub groups forming and operating under the umbrella of the nursing team. For many students in these circumstances, they struggled to see where they fitted in. This often left them feeling lost. As well as students being in a tenuous position within the hierarchy, the registered nurses and the healthcare assistants have their own day to day work activities to fulfill which can make the exclusion and rejection more acute for the students. The difficulties they faced are typified in the following accounts.

> "I would ask them if you could do a drugs round with them (registered nurses) and most of the time they would say "No, I'm really busy at this time." You might see them doing a drugs round but they were wearing this 'do not disturb jacket'.
>
> (Participant 10, page 17)
>
> "Perhaps you do a few injections but few and far between because it was quicker if registered nurses did them."
>
> (Participant 3, page 11)
>
> "You're asking other nurses what you should do and you feel like you're sort of hassling them and you shouldn't really be and sometimes I think they expect you to know what to do as soon as you walk in the ward."
>
> (Participant 4, page 3)
>
> "It feels like you're being ignored and I felt like "I wish I wasn't here"."
>
> (Participant 4, page 3)

5.1.2 Being excluded

From the student accounts above, the attitudes and behaviors of members of some nursing teams have left students feeling ignored, shunned, and even rejected. Leary (2001) has identified that these, along with the "silent treatment"; are forms of exclusionary behavior. Myall et al (2008) found that when students felt that they did not belong and did not have the support of the placement staff when working in the placement, they often felt as if they had been confined to the edge of the clinical team. Students who are confined to the edges will have difficulties in learning the nuances of the practice such as the language, symbols, artifacts, signs (Lave & Wenger 2002). In these circumstances, the experiences that the students have will influence and shape their identities and

influence their understanding and meaning of the practice. As the students move from novice to registered nurse, their understanding and meaning of their practice will be reflected in what they do and will thus shape the future of the practice.

Marginalisation has been described as the process of confining individuals, who inhabit two socially inaccessible worlds concurrently to the fringe where their boundaries meet on the basis of identities, associations, experiences and environments (Hall et al 1994). It is these intersections which play an important role in structuring and negotiating meaning. Being marginalised has been identified in the literature as an issue for newly registered nurses entering the world of work (Boychuk Duchscher & Cowin 2004), indicating that it is not something new to nursing. However, it would also appear to be an issue for pre-registration student nurses during their placement experience. Students appear to have difficulty becoming a member of the nursing team due to the composition of the identities within the hierarchy. All hierarchies work on the basis of membership criteria (Smyth 1988), and processes exist to maintain the separate identities within this structure. The maintenance of the hierarchy will be achieved through the use of power.

According, to Foucault (1979), a network of power exists within social structures of all organisations. Therefore, such networks of power will exist throughout the entire healthcare system and therefore will be present in the areas where the students are allocated to undertake their placement experience. Such power as described by Foucault (1979), was not in the possession of individuals, but was dynamic and pervasive to the organisation through the network of social systems. It is this network that ensures that the behaviour of members of an organisation is modified to the expected norms. However, those who are marginalised may lack the information about what these norms and expectations are, thus appearing to be deviant (Hall 1999). Their conformity will be achieved through being observed, disciplined, and by being punished as a means of ensuring that the individual learns the norms and expectations and

then conforms (Foucault 1979). According to Hall (1999) marginalised individuals will be moulded and shaped to conform to the expectations of the dominant culture which will be achieved through power. However the students' stories raise the question as to the nature of this dominant culture in nursing and whether there is only one.

One student was severely punished by being ostracised by the health care assistants. Ostracism is a form of social exclusionary behavior (Williams 2001). Sarah's story is a disturbing account of what one student had to endure during her clinical placement, and the courage she showed as she persevered to remove the barriers to allow her entry, to begin the process of "fitting in" and being accepted. It shows the lengths that have been employed to try and keep her on the outside. It does, however, raise the question as to what personal costs students should be expected to bear in order to become a registered nurse.

> "On my last placement I was ostracised by most of the health care support workers. They would organise break times so that I wouldn't go with anybody. I would be on my own the whole time and my first break would be 12 midday if I was on an early when they had all been and were ready to go on their second break. That was just one of the minor things they were doing. They would hide equipment knowing that I needed it. They would send me in directions to go and get stuff that was the wrong place knowing full well that it was the wrong place. They were trying to tell the staff nurses that I was sitting around doing nothing when the staff nurses clearly observed that I was doing more than I should've been doing and then when they realised they couldn't break me like they apparently had done to a previous student they backed down."
>
> (Participant 9, page 3)

Students had difficulty in fitting in and feeling a sense of belongingness. Human beings need to feel a sense of belonging and attachment to other individuals (DeWall et al 2008), as they are not by their nature solitary animals. Belongingness has been defined as:

"the deeply personal and contextually mediated experience that evolves in response to the degree to which an individual feels:

- Secure, accepted, included, valued and respected by a defined group

- Connected with or integral to the group
- That their professional and /or personal values are in harmony with those of the group"

(Levett-Jones & Lathlean 2008b)

Individuals who do not fit in or belong feel socially excluded. Social exclusion in general thwarts the ability to make the social interactions needed to address the drive to belong (Baumiester et al 2007). It also thwarts the learning of the social practice (Lave & Wenger 2002) as it reduces the opportunities to learn the nuances of the practice including the language, symbols and so forth. Ostracism is a form of social exclusion. Sarah was the victim of workplace ostracism which has been defined as:

> "the act of being excluded, ignored or rejected by one individual or group by another individual or group that hinders one's ability to establish or maintain positive interpersonal relationships, work related successes or favorable reputation within one's place of work"
>
> (Hitlan et al 2006 page 217).

As well as ostracism reducing feelings of belonging within the individual, it also decreases control, self esteem and meaningful existence (Zadro et al 2006).

5.1.3 Fitting in on the outside

Students have a strong desire to fit in and belong within the placement and therefore will find ways to help them achieve this. Students learned to cope with the experience of living on the edge in no man's land. For some students this meant having a foot in the camp of the registered nurse as well as the healthcare assistants. One student described this as building a bridge to help her manage the gap between the health care assistants and the registered nurses. This involved incorporating both aspects of the roles of health care assistants and registered nurses within the role of student nurse, which is illustrated by Sarah and Jane's accounts.

> "I sort of bridged the gap between the other staff nurses and the auxiliaries because I was able to do both aspects of the role. I didn't see myself as a staff nurse but I could do a lot of the staff nurse role and I didn't see myself as auxiliary but I did all the auxiliary role. It was nice to do both parts of it and show that it does work. The student had their own separate role."
>
> (Participant 9, page 10)
>
> "You've got the trained staff doing their thing and the support workers go off and do their thing and you're stood in the middle, because you know you've got to go with the trained staff to get certain things done but you can also see that the support staff need help with things so you kinda – walking the thin line – between the two."
>
> (Participant 5, page 6)

It would appear that for some students they were learning to cope with the situation they found themselves in. In these circumstances the students appeared to be brokers across boundaries. Lave and Wenger (2002) describe brokering as managing multi membership of groups. Thus the identity of the students will be shaped by this phenomenon.

5.1.4 Learning to compromise

Students were prepared to work hard at fitting in, which often involved them compromising their opportunities for learning in order to be seen to do the work, so that they would be seen in a more favorable light to assist with their drive to belong and fit in. Jane's story illustrates how she worked hard and complied and conformed in order to be seen in a favorable light with the health care assistants in order to fit in.

> "My mentor used to give me one drug to memorise and the next day she would test me. I was looking forward to being with her that morning. The health care support workers said they were a bit short. The support workers that were on were very strong characters. They designated when they went to break and what time they went to break and I thought "what shall I do", so I offered to work and go and do the washes on a bay on my own. I know I'm being weak in one way but you do it to kind of ingratiate yourself with them don't you? That's how you fit in. I only had to do it for a couple of hours then I went off and got my other bits done."
>
> (Participant 5, pages 9 & 10)

Jane had learned that she had to manage situations in a way that did not rock the boat.

> "'cause you don't want to rock the boat really in some respects when you're there do you. You don't want to be known as the student that was difficult".
>
> (Participant 5 page 8)

Rocking the boat for Jane meant:

> "You go in and they're all established and everybody works there. You want to be known as the one that's friendly and, you know, most of the time you are. You've staff who tolerate students whereas you know you've staff that are really great, come on learn this, you'll love this and I think they're the ones you don't really want to offend because you don't want to upset them .If they withdraw that little piece away.
>
> (Participant 5 page 9)

This student felt that if she rocked the boat she was in danger of incurring sanctions. These sanctions were the withdrawal of learning support by some placement staff. The perceived sanctions were seen by the student as potentially hindering their learning. The fear of such a reprisal was enough to ensure that the student worked at maintaining an even keel. Individuals who were more co-operative and harmonious were more likely to be accepted and included in the group (Poirier & McKee 1999).

The student demonstrated the lengths she was prepared to go to ensure that she did not upset the health care assistants who seemed to have some perceived power and control over what the students did on placement, particularly in respect to accessing learning opportunities. This situation clearly illustrates the dilemma facing students in practice between the "work" of the placement and "taking up learning opportunities" that present themselves, which will be discussed in depth in chapter five. When students are in clinical placement, it is registered nurses, in particular assigned mentors, who have the responsibility for directing and supporting students' learning on placement. However, in this particular situation, it was not the mentor who requested Jane to compromise her learning, but the healthcare assistant; the mentor did not appear to intervene to ensure that Jane accessed her learning opportunity to the

full. It would appear that the students are already being socialised to behave in ways that support getting the work done.

Another student Christine, she also did not want to "rock the boat", therefore she did not challenge her assigned duties:

> "I was paired up with a health care assistant rather than a nurse, although I was told "If you need help you can come to us". They would expect me to stay and do the jobs with the health care assistants and I don't like to upset people really."
>
> (Participant 7, page 9)

Such actions have implications on the construction of the identities of the students which will have implications on the future practice of nursing.

Braumiester and Tice (1990) proposed that in order for people to be accepted and not excluded they were prepared to conform, comply, obey, work hard and present themselves favorably as ways of seeking inclusion. This was no different for the students in this study. However, the threat of such behavior coerces unquestioning agreement, which could lead to the adoption of inappropriate conduct (Randle 2003). Clinical placements are audited for quality as laid down by the NMC (2004, 2010). Therefore there is an assumption that, where this has happened, the clinical placements operate at this standard. It is within these clinical placements that the communities of practice are to be found which are assumed to be good if the quality standard has been met, however the reality may be very different, as not all communities of practice are good (Lave & Wenger 2002). Mooreland and Levine (1989), in their study, showed that some students undertook nursing practices that were wrong in order to be included. Jane's account did not suggest that she undertook behaviors that were inappropriate. There was substantial evidence from the findings of my study to show that students were willing to speak out and advocate for patients when they came across inappropriate or poor nursing practice, even if it was at a personal cost to them. Speaking out is discussed in depth in chapter six section 6.4.2.

Hemmings (1993) found that integration of graduates into a ward within a healthcare organisation happened when they conducted themselves in ways that demonstrated their acceptance of the ward culture. Kramer (1974) in her study identified that newly qualified nurses were ill prepared from their nurse education for the reality of work as a nurse, which Cowan and Jacobsson (2003) put down to the incompatibility between education and healthcare regarding the philosophy of nursing care. This suggests that the theory of care espoused by education is different to the care practiced in the work environment, contributing to the theory practice gap. Such a scenario can give rise to unrealistic expectations among students and healthcare workers, which can develop from the different values and beliefs held between academia and healthcare regarding the practice of nursing, giving rise to conflicts and uncertainty about position and role for students. However it is not only students who can be affected. Boychuk Duchscher & Cowin (2004) found that registered nurses were caught in the moral dilemma of having to choose between "caring effectively" by providing care and comfort to their patients and their families or caring efficiently where the needs of the organisation are paramount. If students feel they have to comply in order to fit in with the placement they may also feel in a similar dilemma. Foucault (1979) argued that organisations are set up to ensure that the behaviour of those associated with them is shaped in order to be productive, which in this case is getting through the work of the placement. Pressure to conform and comply can lead students to adopt the values and standards of the work place without challenging and upholding the professional practice. To expect students to challenge in such a way places students in the role as agents of change, which poses its own ethical dilemmas?

5.1.5 Feeling stupid

Being rejected and excluded can adversely affect individuals, leaving them feeling that their existence lacks meaning (Twenge et al 2007). This can have a damaging effect on a person's psychological well being by increasing anxiety, depression and lowering self esteem (Baumeister and Tice 1990, Leary et al

1995).These effects have been shown to impact negatively on the students' learning, particularly if they are feeling anxious or afraid on placement (Levett-Jones & Lathlean 2008b). Many students in this study relayed their anxiety and stress as fear, particularly of making mistakes and saying or doing something that would make them feel and look foolish. Ann's experience exemplifies this:

> "The nurses kind of talk to you as if you know everything. Well some of them do and it's like, I don't know what you're talking about and you're just there nodding your head and you're too scared to ask a question 'cause you think they're going to think you're stupid
>
> (Participant 4 page 5)

This can have detrimental consequences for the patient and the quality of care they receive. Ann confided that:

> "A lot of the time I was doing the dressing by myself and I shouldn't say this, but a lot of the time it was just guesswork."
>
> (Participant 4, page 9)

To guess means to judge upon inadequate knowledge or none at all or to randomly surmise (Collins 2006). This was how the student made some of her nursing decisions in practice.

Ann did recognise that such actions could put patients at risk. She explains how she tried on one occasion to expose her lack of skill to undertake a dressing, but was still expected to do it after being told briefly what to do. What appeared to be missing from the instructions was the knowhow knowledge of how to do it for example how tight to make the bandage.

> "I was told to dress a man's' legs (he had skin grafts for leg ulcers). I think it was a type of compression bandage and I thought, I didn't know how to do that but the doctor went, "you just put on a bit of gela net and some balls on it and just put the bandage tight around it" and I thought, I don't know, if I do it too tight I might cut the blood supply off and I might just wreck all the work they've done. I did feel a bit out of my depth then."
>
> (Participant 4, page 10)

This shows that the student was trying to think through the problem but still felt very much on her own to deal with this situation. Knowing how Ann felt about

exposing her lack of knowledge and skill for fear of being seen as being stupid, this action must have taken courage. It is interesting to note that at no time did the student talk about getting help from the registered nurses, which gives some insight into the students' relationship with the registered nurse. The student felt she had to do the dressing; she did not have the confidence to say no, and therefore undertook the dressing to the best of her ability. This can leave students vulnerable and exposed, which can leave them, at times, feeling confused, frightened and alone.

These findings of stress and anxiety relating to clinical placement are consistent with the findings from the nursing literature (Brodie et al 2005, Kleehammer et al 1990, Lindop 1999, Lo 2002,Timmins & Kaliszer 2002). Anxiety and stress have been documented as being present in British students at the start of clinical placement (Brodie et al 2005, El Cock et al 2007, Levett-Jones & Lathlean 2008b). The cause of the anxiety was identified as fear of the unknown. However, Kleehammer et al (1990) found the cause of anxiety for American students included fear of making mistakes, clinical procedures, hospital equipment, talking to doctors and being late. High levels of anxiety have been shown to decrease learning (Eysenck 1970, Hunsley 1985, Yates ey al 1985), and have also been found to reduce a person's beliefs about their abilities to perform the requisite activities, thus impacting on their motivation to learn (Pelaccia 2009). Levett-Jones and Lathlean (2009a) state that unless this anxiety is addressed, students' needs for psychological safety and security will not be met. According to Maslow's hierarchy of needs, learning can be limited if the students' needs for safety are not met, as they will spend time in meeting this need before they can progress (Maslow 1987).

Lofmak & Wikbald (2001) found that in placements where the staff were unreceptive and did not facilitate learning, students' confidence and their ability to become actively involved in experiential learning opportunities, was negatively affected. In such situations, the students wanted to please the teacher, which according to Gillespie (2002), acted as a barrier to students

being able to synthesise knowledge from their clinical practice. Having staff on placement that are not receptive can affect the students' feelings of belonging. Baumeister et al (2002) found that social exclusion led to a drop in intellectual thought, which mainly impaired logical reasoning, extrapolation and other mental operations involving moving from one set of information to a different conclusion. These processes are related to the executive function of the brain which is responsible for understanding concepts, planning, abstract reasoning and problem solving (Jaeger et al 2008). Such impairments would impact on an individual's ability to problem solve and make decisions.

The organisation of work and the attitudes of the staff in some placements can appear to create barriers which prevent, or make it difficult, to provide comfort and support which would help students to feel safe whilst learning the role of registered nurse. This feeling of discomfort can leave students uneasy about asking questions and seeking direction and support for their practice learning from the registered nurses (Levett-Jones & Lathlean 2008b). Students felt alone in these placements.

5.1.6 Barriers to learning

Lave & Wenger (2002) believe that learning is fundamentally experiential and social, which transforms our identities. Such learning is facilitated through social learning structures, such as communities of practice. However for learning to occur,students have to engage and belong to these communities of practice. Lack of such engagement adversely affects learning. The need to belong in clinical placement was seen as one of the most important factors, and one which impacted on the learning experience in placement (Levett-Jones & Lathlean 2008b). Nolan (1998) identified that fitting in and being accepted is a pre-requisite for learning in placement. The feeling of belongingness made a big difference to students' motivation, whether they positively viewed the placement as somewhere they wanted to get up and go to or whether it was seen in a disinterested light.

David's story is an example of this. He describes one placement where his assigned mentor did not speak to him for two weeks.

> "For one, two weeks she (the mentor) didn't talk to me. She told me "I don't like students".

This had an effect on him during the placement.

> "It puts strain on you. If you have a bad day at work you go home and you're quite depressed, but you have to go back and put up a smile the next day and be jolly in order to meet your work outcomes and then come home and be depressed".
>
> (Participant 2, page 11)

Again this gives some insight into the lack of relationship which seemed to exist between the student and the registered nurse. A key factor in communities of practice is the relationship between the old timers and the newcomers, which in this case is the student and the registered nurse. Motivation to learn can be affected by placement staff behaviors and attitudes, and where staff do not appear receptive or accepting of students it can have a negative effect on their learning (Levett-Jones & Lathlean 2008b). They can become disinterested and less enthusiastic about their learning.

Although this did have an adverse effect on David's general well being, he did actively find ways around the problem to continue his learning on placement. This contrasted with the findings in Brown's study where students often felt passive about their learning when there was not a supportive person to direct and help them in their placement. Gillespie (2002) found that students were fearful, lacking in confidence and had their learning opportunities reduced in placements where there was no positive relationship. However, it is difficult to comment on the effects this had on David. It is important that students feel safe and secure during their placement experience as this should help them to be more confident, enabling them to speak out and be more questioning in their practice situations, which would be safer for patients (Levett-Jones & Lathlean 2009a). Although the literature recognises the importance of being welcomed, accepted and supported, and assumes this is important for a positive learning

experience, it is unclear from the literature what it actually means to belong on placement or how this is achieved in the complex world of nursing today. Lave & Wenger (2002) argue that this would involve students having access to, and participating in, communities of practice. Further research may help to establish how to bring this about.

5.2 Being alone

Placements are normally "a hive of activity" and yet the students strongly expressed their feelings of "being alone" in these environments. This was a finding that I was not expecting and which took me by surprise. Brown et al (2005) link this state to a lack of emotional support for students whilst on placement, and it may well be a symptom of what Brown describes as the disease of "not being accepted or feeling as if they do not belong". Being alone had a number of different connotations for students, exposing the complexity and multi-dimensionality of the concept. For many students, being alone equated to working on their own without another colleague, as described by Ann.

> "The first placement was pretty much working alone."
>
> (Participant 4, page 8)

However, Julie's account reveals another dimension to our understanding of being alone. It was more than just working on her own and being left to her own devices; it was also a sense of professional isolation and abandonment, of being alone without backup from the placement staff providing such support.

Julie describes how:

> "in general situations you're working pretty much on your own. You're left to your own devices. You're doing a task and you're helping a patient with everyday activities and one of the care assistants will come up and ask you for advice and you suddenly realise that you're on your own because everybody else has left, gone on break, or...."
>
> (Participant 10, page 3)

> "You don't know where the trained members of staff were, particularly if it was a location that's got loads of, lots of different rooms or side rooms. They could be anywhere."
>
> (Participant 10, page 5)

Julie's account shows the complexities involved in clinical placement, where she is key to preventing others from feeling at a loss whilst she at the same time is feeling alone. Being alone does not only appear to be associated with being physically on your own, but is also a psychological feeling associated with separation, loss and isolation. Julie felt disconnected from the group of people who would supposedly provide her with emotional support during the placement experience, whilst at the same time she was expected to provide support to other staff on the placement that are looking to her for their direction and support.

> "You've got people asking you questions like care assistants and you'd try and help them. I'd suggest doing this for now but I will go and find out for you."
>
> (Participant 10, page 5)

According to Lave & Wenger (2002), the layout of the work setting can have an important bearing on learning. In the experiences described by the students there was a separation that prevented them from observing others and being observed; activities which can enhance learning (Bandura 1977).

Separation and loss can also be felt even in the presence of those providing support, as illustrated by Elizabeth, suggesting that the solution is more than the supporters being present. It appears to be more related to how they provide this support to make the person feel safe and secure. Elizabeth described, whilst on placement within intensive care, how she felt when the staff went to coffee break.

> "Basically you're a bit scared especially if they go to coffee break and leave you there on your own. I mean you have got lots of nurses but it looks like you're not doing anything."
>
> (Participant 3, page 7)

Although there may be staff nearby to call for help and support, as in the case of Elizabeth and Julie, students perceived they were on their own and at times felt abandoned.

For other students, being alone related to being excluded and isolated from the placement staff,a perception which the students picked up from the attitude and behavior displayed to them during their placement experience. Jane describes how staff on the ward would ignore them, leaving her feeling alone.

> "You either ignore me or you fall over me - because you are so busy."
>
> (Participant 5, page 6)

Ann also had similar experiences which left her feeling invisible as if she did not exist in their eyes.

> "You're just standing there and they're walking by you and you're thinking 'what do we do?' It feels like you're invisible. It just feels like you're being ignored."
>
> (Participant 4, page 8)

David also had an experience of being ignored which is described in chapter seven,section 7.1.

The students' accounts have given insight into what it means to them being alone in placement. To summarise:

- Being invisible (not being seen)
- Being isolated (working on your own not with another colleague)
- Loss and separation (lack of emotional support from placement staff)
- Being excluded (not being accepted into the social grouping of nurses)
  Psychological feeling of being alone, even in the presence of others
- Loneliness

The students' descriptions suggest that they had difficulties belonging to communities of registered nurse practice, and that the feelings they have described regarding being alone may be a symptom of this. If this is the case

then such exclusion will affect what and how they learn the practice of nursing which will ultimately impact on the students' overall meaning and understanding.

The behavior displayed by the staff appeared to be in response to being busy and needing to get the work done, which implies that they had some sort of deadline to deliver to. Timing is a mechanism that Foucault (1979) believes is used to control activities of the worker to ensure their effectiveness. If staff are being watched, disciplined and punished through the systems and mechanisms employed by the healthcare organisation, then it is not surprising that their behaviors conform to the expectation that getting the work done is the priority. In some placements the ward organisation, as described by the students, also appeared to make it difficult for nurses to be with the students.

In those placements where the work was fragmented and demarcated between the different group members, a physical type of barrier existed between students and registered nurses as the tasks and activities undertaken tended to be different. Registered nurses in these areas tended to be associated more with managing, supervising and coordinating, with less opportunity for them to be involved in the direct care of patients except for the more technical aspects such as drug administration. In these settings there was an assumption and expectation that students' time should be taken up with caring directly for patients, making it difficult for students and registered nurses to easily work together.

This appears strange, as the students' descriptions suggest that they do not appear to be exposed to the opportunities to learn the practice from registered nurses. Lave & Wenger (2002) found that particular forms of apprenticeship can hinder, rather than facilitate, learning. They describe how the theory and practice of meat cutting do not always correspond; learning the theory of wholesale meat cutting conflicts with the cuts used in supermarkets (Lave & Wenger 2002). They also identify how the apprentices allocated to placements in supermarkets are trained to perform a task or tasks which, if they can do competently, are left to continue to do as the division of labour amongst the

workforce leads to efficiency. Such efficiency is demanded through the need to meet the targets set by the organisation for the butchery department. The implication for these learners was that they did not get opportunity to work with the butchers to cut the meat. As this activity took place away from the shop floor, the apprentices could not even observe the butchers at work. There are similarities with nursing. Health care organisations also have targets and objectives that they have to achieve. The work is broken down into constituent parts and distributed between the workforce in a way that is supposed to deliver efficiency and effectiveness. Thus, the students of nursing in some placement areas appear to be required to undertake tasks where they can be useful, contributing to the overall efficiency of the service. The registered nurses, at the same time, are off doing other aspects of the work which are often out of view of the students who therefore cannot observe them. The major difference between the meat cutting and nursing is the product; nursing involves vulnerable human beings, not consumables. Therefore, the consequences of these actions are likely to be more profound in health care. If the organisation does not recognize education as being important, and therefore does not factor it into the work and the work schedule timings, one begins to have a better understanding as to why staff may respond in the way that has been described. The priority for staff is to get their work done. Students who challenge this with their own needs can be seen as hindering this goal.

5.2.1 The concept of being alone

Being alone is a difficult and complex concept to understand, which is made even more confusing as there are a number of other important concepts which are closely related. Kileen (1998) has illustrated the different concepts and where they lie in relation to society's view of their effects:

Negative.....continuum.....Positive
Alienation Loneliness Social Isolation Aloneness Solitude Connectedness (Kileen 1998).

A number of the concepts towards the negative end of the continuum have been identified by the students in this study, especially loneliness, social isolation and aloneness. Aloneness is described as the perceived objective experience of being separate from others (Rokach 2004), which can be viewed as a temporary state when one is just not with anybody, when one is on their own for a brief time. Although aloneness can be seen in a positive light and does not necessarily imply feelings of unhappiness, the students' descriptions of this were associated with negative rather than positive feelings.

Human beings have a basic need to be with others (Rockach 2004). People need intimacy, warmth and a sense of self worth, established through human contact, which also helps to reinforce their identity. The students' accounts of being alone seem to identify different situations where there was a lack of connectedness and companionship. Loneliness is a state of being alone or remote from others where there is a desire for companionship, which does not necessarily always arise from actually being on your own (Younger 1995, Ryan & Patterson 1987). This relates to the experience conveyed through the students' narratives. They felt alone even in the presence of others. Acorn & Bampton (1992) believes that this is more prevalent in women than in men. However, one of the men described being ignored and excluded, which had an effect on him, but did not relate his experience to being alone.

The findings from this study show that students felt very much alone, and lonely, at times during their placement experience. As a feeling which is potentially always present, and which can present in different ways, loneliness has been described as the painful agonizing longing to be connected to others and to be accepted and valued (Rokach 2004). Loneliness is also associated with lack of emotional support from others to help and comfort the individual (Rokach 2004). According to Baumeister and Leary (1995), individuals experience loneliness when their need to belong has not been met. Belongingness relates to individuals connecting with one another which make them feel accepted, cared for, valued and respected by others, which are reciprocated back to the

individual or group. Therefore, social contacts alone will not be sufficient to meet the need to belong. Baumeister & Leary (1995) found a correlation between self reported loneliness and the degree to which individuals felt included and accepted by others. According to Rokach (1998) being with others and yet not being able to connect to them can evoke not only feelings of loneliness, but also self doubt, anger and shame.

Kileen (1998) states that caring can help to alleviate loneliness in patients. The nurse does not necessarily have to do anything except to be there for the patient. It seems plausible that caring could also help pre-registration nursing students alleviate their feelings of being alone. This would help to convey to students that they were valued, cared for and respected, which according to Levett-Jones et al (2007), are necessary to foster the sense of belonging. This would require the staff on placement to demonstrate caring values through their attitudes and actions, which may lead students to feeling more valued and accepted by the placement team. Students could benefit from the knowledge that the staff are there for them, giving them the feeling of psychological safety and security. This, however, may conflict with the business values of the healthcare organisation. There is evidence that caring values appear to be lacking in some health care organisations, as highlighted by the recent reports on the lack of dignity shown to elderly patients and the report identifying the shortfalls in North Staffordshire hospital (Parliamentary & Health Service Ombudsman 2011, Health Care Commission 2009). It is clear then that nurses and students may be exposed to apparently contradictory organisational messages in practice.

5.3 Living with confusion

As well as students in the study feeling alone in placement, they also felt confused. This confusion related to not knowing what the role of the registered nurse was, particularly in placements where students had less opportunity to work alongside registered nurses and observe what they do. The students in

this study indicated their difficulty in working with registered nurses, which is illuminated by Christine who talked about her experience on a surgical ward.

> "I was paired up with a health care assistant rather than a nurse, although I was told "If you need help you can come to us". They would expect me to stay and do the jobs with the health care assistants and I don't like to upset people really."
>
> (Participant 7, page 9)

Julie states how:

> "you could go and find a member of staff (registered nurse) if you tried hard enough, if you waited long enough, but it's a case of waiting if they are available, waiting for them to finish a drugs round or something like that. They are very, very busy."
>
> (Participant 10, page 4)

Students describe how the work of the registered nurse was hidden from their view in these settings, making it a mystery, exemplified by Christine's experience:

> "You need to get more in the paperwork side of things and work, the things you were going to be doing once you qualified."
>
> (Participant 7, page 8)

However, Christine could not elaborate upon what the paperwork involved or the things that related to the work of the registered nurse. She remained in the dark, although she wanted to rectify this by being exposed to learning opportunities which would help her to understand. Elizabeth also demonstrates her lack of understanding of the role of the registered nurse, but her lack of clarity led her to believe that the registered nurses were lazy.

> "It was there that I learned that trained staff does nothing. They would go and sit in the office most of the time and they hated coming to help you to do the basic care."
>
> (Participant 3, page 11)
>
> "They were on the 'phone to somebody or taking 'phone calls from the wife. I am sure they did do a bit of paperwork but that is not how it appeared and this is not what the other health care assistants used to tell us. Me and the other student

> thought this would be a 'cushy' number when we're qualified. But no, I wouldn't want it."
>
> (Participant 3, page 11)

In a diverse, complex health service, it is impossible to present a common definition for the role of the registered nurse (Ousey & Johnson 2007), which is not surprising as the role has to accommodate the work associated with the work setting. However, such variances make it more difficult for student nurses to have an understanding of what the role entails, and the knowledge and skills they need to perform it. In settings where the nurses are not involved directly with delivering patient care, students are not normally working directly with registered nurses except for certain tasks or activities, making it even more difficult for them to know and understand the registered nurse role. This is made even more acute as the work of the registered nurse in these settings often takes place out of view of the students, and the students find it difficult to get opportunities to observe them or work alongside them, which would enable them to better conceptualise the registered nurse role. Lave & Wenger (2002) believe that the opportunity to observe and be observed is an important aspect of learning.

Learning involves the ability to negotiate meanings. The students' descriptions began to uncover what they understood by the role of the registered nurse, and their descriptions show that they were having difficulty constructing the meaning of this role. Experiences help to shape meaning and understanding, which in turn will transform their identities. Ultimately this will influence how they practice nursing, and how nursing is practiced.

Students did highlight the difficulty they found, at times, in being able to find registered nurses to work alongside who would guide and support their practice. They found this support from health care assistants and other student nurses or other healthcare professionals. Ann's account illustrates this:

> "I was asked to do a dressing and I didn't know how to do it, you'd ask a health care assistant and they'd show you but it wasn't an aseptic technique. A lot of them didn't do it like that and I thought, hold on, you're meant to wash the trolley

> down, you're meant to put all your bits and pieces on it and they weren't doing that and I just thought, am I doing it wrong?"
>
> (Participant 4, page 6)

Ann's description raises the issue as to the quality of the guidance that is available to the student. This was Ann's first placement experience and she was left confused as to whether what she was being shown constituted safe practice, as she recognised that it was not the same as she had been shown at university, leaving her feeling vulnerable and exposed. Such a situation can also have serious consequences for the patient in relation to their quality of care and can expose them to unacceptable risks.

The students found that it was easier to understand the role of the other health care professionals rather than that of the registered nurse, as they could see what they did. It was more transparent, as explained by Julie:

> "I could tell you pretty much what all the other professions do but I couldn't tell you what the nursing staff, the qualified staff, do."
>
> (Participant 10, page 16)

The students also had opportunity to observe the other health professionals at work by tagging along with them whilst they practiced, which also helped them to formulate their understanding of what they did, and how their role fitted into the multidisciplinary team. The biggest barrier to students being able to work with other health care professionals was time, as illustrated by Julie:

> "If there was time you could go and work with another professional."
>
> (Participant 10, page 17)

However, the opportunity for Julie to work with a registered nurse was denied to her:

> "I asked my mentor (registered nurse) if she wouldn't mind if I worked with her and shadowed her for the day and she said, "I will write it down for you, I'm far too busy to work with you, I haven't got time"".
>
> (Participant 10, page 17)

Julie didn't get a written response. Although she had some understanding of the other professionals, she was still ignorant in relation to the role of the registered nurse, which left her with an incomplete picture of how the role of the registered nurse fitted in with the other health care professionals to deliver the care for the patients on that placement.

Ousey and Johnson (2007) state that the role of the registered nurse is constantly evolving; this has led to more registered nurses being removed from "bedside nursing" to undertake more supervisory, managerial and administrative roles. In these placements it would appear that the expertise of registered nurses relates more too managerial and co-ordination skills rather than the expertise in directly caring for the physical needs of patients. As part of their role, registered nurses also perform some technical skills; however, opportunity for students to be taught these skills also appears to be limited.

5.3.1 Being with registered nurses

The student descriptions seemed to suggest that there was no single role of a nurse; it changed according to the placement setting. In departments like Accident & Emergency (A&E) and Intensive Treatment Unit (ITU), the nurse appeared to be involved in the direct care of patients, undertaking more technical skills which often enabled the student to work alongside the registered nurse to learn the practice of nursing. In these situations the students could see what the nurse was doing and their accounts of such experiences were positive, as described by the following excerpts:

> "I think my best placement has to be Accident and Emergency. My mentor, she had me on the same shifts. She'd go round each patient and I'd go with her and she'd introduce herself and me and she would say, "This is the student nurse and she will be with me and she will be looking after you." I learned such a lot."
>
> (Participant 4, pages 6 & 7)
>
> "The only time I've felt really comfortable within the team was in A & E. The team works so well there."
>
> (Participant 4, page 22)

> "I went to coronary care unit and I was so spoilt. There were at least five registered nurses working, at least three senior nurses for twelve patients.I was the only student so if one hadn't got something to do, the other one had and if that one hadn't got something to do, two or three had but whoever had it they'd got me. They were quite happy to take me even though I had one mentor while I was there they all saw me as their student because I was the only one, so I was very, very spoilt."
>
> (Participant 6, page 6)

In these situations the role of the registered nurse was more overt as the students had opportunity not only to observe but to work alongside registered nurses learning what they did, thus enabling students to have some insight into their role. In these situations the student normally felt supported by the registered nurse. An example of this is portrayed in Ann's account during her placement in A&E:

> "They (registered nurses) were always there, even simple things - even though at times when I didn't know and felt stupid but they were always willing to tell you over and over again. They were willing to teach you".
>
> (Participant 4, page 6)

Ann found that just being with her mentor made such a difference. The mentor had Ann on the same shifts as her and they both worked together.

> "I learned quite a lot from her - just learning about how to deal with patients."
>
> (Participant 4, page 7)

From Ann's description of her experience, the registered nurses were on hand to watch, guide and direct her through her practice, providing her with some security whilst learning.

Schön (1991) believes that fledgling performers can be helped to learn a professional practice by assisting them to frame and re-frame a challenge or challenges in practice and to plan and act out solutions. According to Schön (1991) the professional, in their day to day work, is required to conceptualise, frame and re-frame problems as well as find solutions to deal with ill defined situations which occur regularly in the work setting. This involves professionals drawing on their own practical experience in an intuitive manner whilst reflecting

at the same time on what they are doing. Schön (1991) calls this reflection-in-action: it is the way that such a challenge is framed and re-framed which is important, as it affects what can be seen and eventually what action to take. Schön (1991) believes that it is important for the performer to be able to develop a range of ways of seeing. Hence the framing and re-framing of challenges, involving reflective practice, is key to its successful application. Effective reflective practice, according to Cranton (1996), can help to uncover and make available the professional knowledge base which demonstrates the inter relation between theory and practice, rather than the "normal" dichotomous view.

A key factor in learning a professional practice appears to be linked to the development of craft knowledge, the knowhow of a professional practice (Korrhagen & Kessels 1999). It is difficult for this knowledge to be put into words as it has no underpinning rationale (Drefus & Drefus 1986). This means that it cannot be articulated or taught. However, it is assumed that this can be learned. It has been thought that the learning of craft can be passed on to students by their being in the presence of a practitioner who possesses this knowledge, but how this happens is still very much debated. This does, however, raise serious issues for nurse education as to how students are learning this in those placements where the students have indicated that they are spending less time with registered nurses, as it is assumed that it is this group who are proficient in the craft of nursing.

In nursing, it is assumed that the most logical choice to help student nurses to frame, plan, and act out solutions arising from practice situations, would be practicing registered nurses. However, in some placements described by the students, the organisation of the placement presents barriers for this to easily happen. According to the findings, the student nurses describe spending a large proportion of their time assigned to caring for the physical needs of the patients, whilst registered nurses spend more of their time supervising, managing and coordinating care. In reality, this means that student nurses and registered nurses have limited opportunity to work together as the nature of their work is

different. If practicing nurses have minimal involvement in the tasks and activities undertaken by students, when will they have opportunity to cue student nurses into seeing and recognising the problems and solutions that arise from practice and do they have the expertise to do so if their day to day exposure is limited? Scholes et al (2000) found mentors did not cue students into higher order skill opportunity, for example assessment and evaluation, when undertaking tasks such as bed bathing. According to the students, the registered nurses are under too much pressure and therefore do not have the time to do this.

5.3.2 Who is the expert and expert in what?

Students mainly highlighted the lack of opportunity to work with registered nurses, but on the occasions when they worked alongside registered nurses to undertake the physical care for patients, they raised concerns regarding the standard of care that was delivered. This raised questions in the students' minds as to their authority to teach this aspect of care. This is demonstrated by Linda who talked about working alongside a registered nurse of senior rank to undertake a bed bath for a patient:

> "I was absolutely appalled at what was offered to the patient. As she pulled the covers up and I knew she was ready to go and as she walked out of the door I just said to her "I'll stay and do the mouth care then and do his hair" and I said a few other things and she just looked at me and said "whatever".
>
> (Participant 6, page 8)

Jane also described a situation where she was working with a registered nurse to give physical care to a patient.

> "A new patient came in with sacral sores. He had been incontinent. I dealt with it on my own as the staff nurse with me kept gagging and, on my suggestion that his dressings needed changing as they were very soiled, she left me to clean

him totally. She didn't return and when I tried to find out where she had got to I found her at the nurses' station about to leave".

(Participant 3, page 2)

Some of the students in this study began to question the authority of registered nurses in relation to this aspect of care and began to compensate by other means in order that they were prepared for such eventualities. This led them to be wary as to whom they could trust in placement to teach them this aspect of the practice of nursing. Linda describes how:

"I would never do anything without having a bit of underpinning knowledge. It's not that I don't trust all nurses but all nurses aren't that good either".

(Participant 6, page 8)

Expertise in nursing, according to Benner (1984), is a developmental process consisting of 5 stages. Her work which was based on the work of Drefus and Dreyfus (1986) who challenged the longstanding premise that beginners start with the individual cases and move through to expertise by abstracting more and more sophisticated rules. They believed that skill acquisition moved from abstract rules to individual cases. The experienced performer not only sees what needs to be achieved but also how to achieve it, as they have the ability to make more subtle and refined discriminations using a perceptual knowledge base and pattern recognition built up from their vast repertoire of experience (Eraut 1999, Luntley 2003). According to Drefus & Drefus (1986) the brain of the expert can classify these situations into classes and sub-classes which allows them to use pattern recognition. It is this which allows the expert to respond in an intuitive way. If nurses' experiences of direct patient care are limited, how do they develop their expertise in this aspect of nursing?

5.3.3 The roles of the registered nurse

From the students' accounts, they found that in the majority of general wards the general nurse's role was more akin to a care co-coordinator involving supervising, managing and coordination, rather than giving direct care to patients, except for some technical skills such as drug administration. In

specialized settings including A&E, coronary care and ITU, the registered nurses' role appeared to involve more direct nursing care. Each of the different roles had elements of management and technical skill; however the emphasis varied according to the different settings where care was delivered. This led me to question what I understood by the role of the registered nurse and its purpose and function within health care today, along with colleagues' understanding, and it seems that we are as confused as the students. I found this a shocking revelation. If we do not know what we are preparing registered nurses for, questions should be raised about how we can educate them appropriately.

5.4 Summary

Students are being allocated to some placements where they feel they are being confined to the edges, which is having a detrimental effect on their sense of belonging. This has been shown to impact negatively on the ability to learn. Students found it difficult to fit in and be accepted, leaving them on the outside where they felt alone and confused. Students felt short-changed at the lack of time they spent with the registered nurses, and confused as to what this role entailed, as well as confused as to their purpose within the placement.

Preparing students for their role as a registered nurse fit for purpose is a key priority for pre-registration nurse education. Purpose, according to Edwards (2007), has not been clearly debated, defined or articulated. This would require questions to be raised and answered regarding knowledge and understanding of the goals of healthcare and what makes a good health care professional (Edwards 2007). Having a clear understanding of what we are preparing nurses to do at the point of registration would ensure that pre-registration nurse education was planned and developed to take account of this. Lack of a clear understanding of what fitness for purpose means leads to difficulties in preparing students with a clear understanding of what the role entails. However, this raises further questions as to how nurse education should be preparing students for their future employment: as the work is diverse, there may be issues to resolve concerning the preparation of students for the professional

practice of nursing which they can apply in different settings, and the practical realities of care delivery in the NHS. It is assumed that fitness to practice and fitness for purpose concur, but this is not always the case as highlighted by the students' accounts in this study. Students were left feeling frustrated as they were continually compromising their time between what they saw as the work of the placement, and the learning opportunities they felt they needed. This is explored in depth in the next chapter to uncover what it is like to learn on the margins.

Chapter six

Findings: Learning on the margins

6.0 Introduction

The previous findings chapter began to uncover how students can experience being outsiders in clinical placement. The insights this showed were a revelation to me as it was not what I expected to find. Although it began to give me more insight into student experiences on placement, it did not fully answer the question, namely why students found participating in the physical care of patients to be "vile work", which I was on a quest to answer.

This chapter will continue the quest by unravelling what it is like for students learning on the margins and why they do not see the physical care of patients as part of the learning experience required to become a registered nurse. The chapter will use the accounts from the students to show how they view work and learning as separate entities, their battles during the placement experience to free themselves from the work to undertake the learning that they see as necessary to meeting their needs, and how they felt "used", particularly as they were led to believe they were supernumerary in placement and how that affected their learning.

6.1 What to learn? The communicated signals in clinical placement

Motivation is what drives students to obtain, convert and use knowledge (Groccia 1992). According to Cole (1993) the processes involved are both instinctive and rational. One of the key identified determinants of motivation is the perceived value of the task, which relates to the importance that the individual places on the task (Pintrich 1991). Two key areas which appear to influence what students see as being important to learn have been identified from the students' descriptions.

These include:

- The learning outcomes
- The role of the registered nurse (what the registered nurse does during their clinical placement)

6.1.1 The learning outcomes

Nurse education is built on premise that knowledge can be deconstructed and broken down into its constituent parts which students can then learn and apply to practice. This is then translated into a series of learning outcomes or objectives by which to test the student. Each placement or group of placements has a set of discrete learning outcomes which students will be measured against. The learning outcomes are derived from the pre-registration nursing curricula which have to conform to the standards laid down by the Nursing and Midwifery Council which include the structure, content and delivery of the course. The NMC (2004) education standards shaped the course undertaken by the students in this study. These outcomes signal to the student what is important and what they need to learn, as it is these that the student will be assessed and measured against. Failure to achieve the learning outcomes normally results in the student being referred or failed in any given component of the course, which can jeopardize their goal of becoming a registered nurse. This is a strong motivating force for students. Students therefore normally want to be exposed to learning opportunities and to staff who will help them to meet these outcomes, which are reflected in the following accounts by the students.

> "I had to meet the outcomes so I had to find people that were willing to help me to meet those outcomes".
>
> (Participant 2, page 10)
>
> "Can I do this? Will you sign this off for me?"
>
> (Participant 4, page 21)
>
> "You're aware of what you need to learn".
>
> (Participant 6, page 3)

"You learn what you need to do, you achieve it, you get it signed off, satisfaction, and I think that's a good way of achieving a learning outcome".

(Participant 6, page 4)

"It's about doing your actual competencies and learning from them".

(Participant 5, page 8)

"I try to learn everything a lot of. I'm always asking the nurses or my mentor on placement what can I do today? We always sit down and I always make sure I can do things. The plan in the skills grid and I always try and stick to it".

(Participant 8, page 5)

"It's really a case of having to fight to actually achieve your goals, you know, on the grids (assessment of practice documentation). To actually put pressure on them, the trained staff, to actually say, I really need to learn this".

(Participant 10, page 10)

Curricula are shaped by the underpinning knowledge base. According to Kitson (2001) the government has focused its interpretation of new knowledge in a narrow, reductionist manner favoring propositional knowledge. This is reflected in the underpinning knowledge base of the professions including nursing (Kitson 2001). This knowledge type, emphasising objectivity and detachment favoring the third person perspective, yields generalised findings using clearly formulated publicly agreed procedures. It ignores the human context of any situation (Dunne 2007), and reduces and fragments the knowledge into competences, standards, outcomes and theory and practice. This fragmentation is reflected in the learning outcomes reducing nursing into a series of skills or activities which favors technical instruction and competence, which prescribes how nursing is structured, labeled and perceived (Kenny 2004). Such a view negates the influence of the context and human elements associated with teaching and learning. Seeing the world of nursing in this de-contextualised way detracts from the social nature of nursing, including the context and social relations, and will impact on the shape of the profession as it will direct and shape the practice experience. Being prescriptive about practice and the form it should take pre-empts the participation which, in turn, will produce a practice different to the one expected (Bourdieu 1977).

The practical know how of nursing is not emphasized within the curricula. This is difficult to articulate due to the nature of the knowledge, but it is not signaled as an important part of learning for the placement experience. It is thought that it cannot as such be taught as it cannot be articulated, but it is thought that students could learn this from working alongside practitioners who possess it (Schön 1991). This would mean student nurses working alongside registered nurses. It is through the process of working alongside practitioners that students can begin to learn the practice of nursing which, according to MacIntyre (1985), involves learning to identify and recognise the internal goods of a practice which reflect the requisite virtues, whilst pursuing achievement of the standards of excellence which are appropriate to, and which define, this form of activity. Emphasis on this type of knowledge would give a different perspective to nursing. For example, in meeting the hygiene needs of a patient, the emphasis would not only be on the wash, but also on how the activity was carried out in a way that reflected the internal goods of the practice. This would mean not only learning to be technically competent to undertake the skill (the wash), but also to learn how to deliver such care in each unique situation in a way that reflects the values of individualised holistic nursing care. This is in direct contrast to the rules and procedures in propositional knowledge that can be generalised to any situation and where the context and human element can be seen as irrelevant.

The practical knowhow emphasises the artistry of nursing whereas propositional knowledge emphasises science. Today, the competence approach to pre-registration nurse education emphasises technical skills. The educational policy can influence the students' perceptions of nursing, as supported by the studies of MacLeod Clark et al (1997) and Mannien (1998). It is therefore plausible that students are being directed to see nursing as a set of skills and tasks; however it does not explain why students do not see the skills within physical care as offering them the opportunity to learn about nursing.

6.1.2 The role of the registered nurse

The role of the registered nurse entails elements of technical skill, co-ordination, supervision and management (Carr 2008). However, the balance between these elements can and do change. Over the last few years the functions, roles and work tasks of the registered nurse have changed to take account of the blurring of professional boundaries, leading to registered nurses taking on some of the work tasks and functions of the medical profession whilst at the same time devolving some of their work tasks and functions to health care assistants, which in some cases includes the physical care of the patients. However, how this has been achieved varies. Read et al (1999) have identified over 3,000 roles for the registered nurse. Understanding of the role of the registered nurse is made more difficult for the students due to these variances. This can leave the students feeling confused as to what the role entails and what they need to learn in order to perform it. This was discussed in chapter five section 5.3.

In a number of placement areas where the work is fragmented into tasks and activities, the physical care of patients is not normally undertaken directly by registered nurses. According to Davies (1995), this practice of nursing, of being broken down into a series of tasks which have been delivered in the past by a variety of people including nurse apprentices whilst registered nurses supervised and managed, has been occurring at least for the last 15-20 years since 1995, and this trend appears to be continuing.

6.2 Work versus learning

Lave and Wenger (2002) believe that the context as well as the knowledge is integral to the process of learning, therefore the social institutions which students are exposed to will shape what they learn. Thus to fully understand the learning process, it is necessary to examine the social institutions where learning takes place. As nurse education is split between theory normally delivered in the university setting, and practice within clinical placements, students are therefore exposed to a variety of social institutions during their pre-

registration nursing course, each with their own contexts. This is further complicated as the theory of nursing being taught does not always reflect the reality of the practice situation. For example students are taught the theory of individualised patient care which is challenging to apply to practice settings where the organisation of the work centres on task allocation. Lave and Wenger (2002) assert that learning opportunities are shaped by work practices more so than by the master / apprentice relationship. The practice of the community generates the potential curriculum for learning (Lave & Wenger 2002). Thus the experience students have within clinical placement influences their knowledge and understanding of nursing and the role of the registered nurse. In placements where nursing tasks and activities are broken up and distributed between the team members as described by the students in chapter five section 5.1, students have fragmented their experience into work and learning which they see as separate entities impacting on their learning experience. This is reflected in Christine's comment:

> "It is nice that the patient feels comfortable after a wash but I'm not learning anything".
>
> (Participant 3, page 18)

Christine implies that the physical care of washing a patient does not provide her with any opportunity to learn.

Students come to clinical placement with some notion of what they should be learning. The students in this study emphasised not only what they wanted to learn, which reflected the technical skills such as drug administration and wound care, but they also had strong views regarding what they did not want their time in placement to be taken up with, which was the physical care of patients. Students did not see this as providing them with learning opportunities which they saw as relevant. They saw this activity as the work of the placement. This is reflected in accounts by Elizabeth and Christine.

> "I know washing and helping patients is part of nursing but when you are a student you expect to be able to do drug rounds and be called when there is anything interesting going on".

(Participant 3, page 2)

> "I found on the wards more than anything, other than the occasional drugs round and seeing an investigation, you are used mainly as a health care assistant, getting people up. I appreciate it's an important part of the job but you need to get more in the paperwork side of things and work, the things you were going to be doing once you're qualified. I love helping people get ready. I can't think of anything worse than lying in a hospital sweaty bed. I'm quite happy to make people fresh but not all the time. You need to learn".

(Participant 7, page 8)

In a number of clinical placements, as reflected in the students' accounts within chapter five section 5.1, the tasks and activities associated with the physical care of patients have tended to be devolved to non-registered nurses, the health care assistants, who perform these duties. Thus, the messages that are being sent to the students are that this element of physical care within nursing is of low status and importance as it has been devolved to non nurses. It also sends messages to students that physical care is not normally part of the role of the registered nurse in these placements, which can indicate to students that it is not important for them to learn about this. In contrast, however, the technical skills of nursing are signaled as being important as it is these that tend to be emphasised within the learning outcomes to be achieved during clinical placement(s), and which are normally aspects of work undertaken by registered nurses. It therefore seems reasonable for students to question why they should be spending a large proportion of their time undertaking the physical care of patients and questioning why these activities are important or relevant. Some students have difficulty in seeing their relevance, which is summed up by Elizabeth, when she said:

> "A wash is a wash, is a wash and it's nice that they feel comfortable but I'm not learning anything."

(Participant 3, page 18)

For Elizabeth, the context within which 'the wash' is occurring, and the patient involved, are irrelevant because learning is directed to achieving the task or skill and not the practical knowhow involved in doing it. Therefore, the opportunity to use such an experience to see beyond the task to the context of the situation is

lost. The majority of the students in the study described how, in some placements, they were on the margins of the community or communities of practice, and as discussed in chapter five were either working alone or alongside the healthcare assistants which meant that they were not usually cued into the richness of the learning opportunities offered by each potential practice situation, which activities such as "the wash" offer. Students did not see these activities as being of value or offering learning opportunities. Scholes et al (2004) also found in their study that students did not find participating in meeting the physical care of patients as being relevant or important for their learning. It is therefore plausible that the ward organisation plays an important part in the placement experience for students and contributes to what they value as learning experiences to become registered nurses, as it will influence the students' participation in practice. As participation shapes what they know and understand, and what they become (their identity), such experiences will help to shape their understanding of their conceptualisation of nursing which will impact on the future practice of the profession.

6.2.1 Being used

Students in this study perceived that the majority of their time on some placements was neither spent in having opportunity to meet their learning outcomes, nor in opportunity to learn the tasks and activities of the registered nurse. They felt they were being used in placement to fulfill the requirements of the work. Students mainly described this feeling of being used within two phrases: "used as pairs of hands" or used as "healthcare assistants". The following examples of students' accounts show what being pairs of hands means to them.

> "If they are short staffed they need you as a pair of hands then, No, you can't do that (get the time to fulfill the learning you've identified). You're actually needed there to physically give care, which I'm not saying is a bad thing. I mean that's what we're there for".
>
> (Participant 10, page 6)

"I was going off the ward with the bed manager that particular day and she came to collect me from the ward and they said, you can't go, we're short staffed, and you need to stay here ..... I was a pair of hands".

(Participant 5, page 4)

"You just felt like you were an extra pair of hands as opposed to being able to learn or observe different things. Instead of being a student whose supernumerary, which I know doesn't work in quite the way you'd like it but, it was more, let's get all the work done, so we'll utilise everybody we can find and just, you know, so that the basic care of the patients was obviously the primary focus and like I say, on a number of occasions that was my main duty for the day would be to get your patients up, get them bed bathed or help the system with washes, assist in the daily care and make sure the paperwork, you know, all the documentation, food chart, fluid balances and all that were complete, which is everybody's role but is primarily taken over by health care support workers and auxiliaries, and therefore that's the type of things I was doing. I was escorting patients to CT or X-ray a lot, or down to the path lab for blood tests because they had missed the phlebotomist that day so I had to take them down. You just felt like you were an extra pair of hands as opposed to being able to learn or observe different things".

(Participant 9, page 8)

Being pairs of hands is a striking and descriptive term that the students use to portray how they felt. The descriptions imply that they saw themselves as being viewed as resource objects instead of human beings. Heidegger believed that a culture driven by efficiency, where the main concern was to use time more and more efficiently for the sake of efficiency was in danger of becoming meaningless (Magee 1987). This meaninglessness, Heidegger believed, would lead to objectification with the effect that it would create a one dimensional existence where human beings would be viewed as objects (Magee 1987).

Some students, rather than use the term pairs of hands, described themselves as being used as a health care assistant.

"I found on the wards more than anything else, other than the occasional drugs round and seeing an investigation you are used mainly as a health care assistant and getting people up, and I appreciate it's very important part of the job but you do need to get more in the paperwork side of things and work, the things you were going to be doing once you're qualified".

(Participant 7, pages 6 & 7)

"It is an extra pair of hands really. I know washing and keeping patients is part of nursing but when you are a student you expect to be able to do drug rounds

> and be called when there is anything interesting going on, and when they are short staffed, which most of them are, you just don't get to do that. You're a health care assistant".
>
> (Participant 3, page 2)

The health care assistant role is designed to provide support to the registered nurse by undertaking a set of devolved tasks and activities within the nursing domain. Health care assistants are not nurses, nor are they members of the profession of nursing. However, they participate in the practice of nursing but are not afforded the title of nurse. From their descriptions, the students feel that they have been assigned to undertake the tasks and activities of the work associated with the role of the health care assistant. They feel that they are used in this role to support the work of the placement rather than to learn to become a registered nurse, which the comments by Julie and David reflect:

> "Being counted as a member of staff to the level where you're needed there. You're part of the team and if you weren't there things wouldn't get done. You're actually replacing agency workers but unofficially".
>
> (Participant 10, page 6)
>
> "It was so frustrating because the staffing levels they were - people were going off sick and we thought, we jumped from starters to filling part of the ward's working force".
>
> (Participant 2, page 3)

Students had expectations of learning the tasks and activities that registered nurses participated in, for example, drug administration, wound care, investigations and paperwork, and of having opportunity to do this as they were supernumerary and not counted as part of the staffing establishment of the placement. In reality, students saw themselves being 'pairs of hands' to do 'the work' required on the placement, which they saw as impacting on their ability to learn as it prevented them from accessing learning opportunities that they perceived as being important.

Students did not expect to spend the majority of their time in placement caring for the physical needs of patients, and became frustrated when their expectation of learning the technical and administrative aspects of nursing was not the focus

of their learning during the placement experience. There was an expectation on the part of the student that they would be doing more of the technical aspects of nursing, such as drug administration, and also some of the activities that registered nurses were undertaking including the administrative tasks associated with their role rather than basic nursing care. This finding concurs with anecdotal evidence I encountered from students when they came along to my office asking for a change of placement in order to avoid doing this aspect of care. This surprised me as basic nursing care has always been integral within my conceptualisation of nursing.

Many students' accounts reflect how they felt that they were being used to undertake the work of the placement in preference to their learning. They found it difficult to understand why this should be so, as they had been informed that whilst on placement they were not part of the staffing compliment but would be additional to placement staffing establishments. Students had an expectation this would mean they would be free to access learning opportunities that arose in the setting. However, there appears to be a discrepancy in the meaning of supernumerary status between the students and the placement staff. Students interpret supernumerary status as enabling them to be free from the constraints of the work to pursue their learning without the work getting in the way whilst on placement. This emphasised to students the importance of learning within the placement, as well as the expectation of the time to do this. However, this understanding of supernumerary status is not always shared by placement staff. If registered nurses were also of the understanding that students had to learn to care for patients' physical care needs, then it is logical that registered nurses would assign students to this aspect of the work, even though they were involved in other aspects of nursing. From the students' accounts it would appear that in some placements, particularly the general ward settings, they felt that they spent most of their time in meeting the physical care of the patients with less time allocated to other learning opportunities. It raises the question as to why students are spending large proportions of their time in clinical placement

on this aspect of nursing if, as registered nurses, they are not going to be doing this within their everyday work.

If the organisation of the work of the placement through the distribution of the work activities leads to different tasks being given to students than to registered nurses, then the facilitation of the students' learning is made more difficult through the physical barrier of separation. Marshall (1972) described the experience of students learning the practice of meat cutting and how this was influenced by the layout of the work setting and the organisation of the work. He found that the work was being divided amongst the workforce to ensure efficiency, and that this affected what the students did and what they were able to observe and be observed doing, which Marshall (1972) believed were important aspects of learning a practice. In the placements described where students undertook the practice of meat cutting, the layout and the work organisation separated and prevented the students from being able to observe the mature members of the practice cutting and sawing the meat. This separation made them feel out of place and lacking in knowledge and understanding of the practice of meat cutting. He surmised that in these situations the students rarely learned the full array of tasks and skills associated with their practice (Marshall 1972). This will obviously have an impact on the future practice of meat cutting. If the layout and work organisation of placement precludes student nurses from observing registered nurses and being observed themselves, then it is possible that student nurses are also not learning the full range of knowledge and skills necessary for the practice of nursing. This will impact on the students' identities and understanding of nursing which will have implications for the future practice of the profession, as it will change to reflect this and will impact on the care being received by patients.

There is no recognition given to registered nurses or support workers of the time required to facilitate and support students in their learning. This is subsumed in their identified workload. Registered nurses who spent time with students away from their identified work tasks and functions could be seen as less productive,

making them vulnerable to being seen as less efficient and effective. In a health organisation driven by efficiency and effectiveness, a fall in productivity would be less likely to be tolerated.

In the past the term "nursing team" has been all encompassing to include registered nurses, students and auxiliary nurses. However the students' descriptions would suggest that nursing teams today are fragmented into discrete parts made up of healthcare assistants and registered nurses. This fragmentation is associated with the organisation of the work. A community of practice forms from the relations of the mutual engagement of participants which is organised around what they are there to do (Lave & Wenger 2002). This raises the question as to whether there is more than one community of practice within a placement and raises issues about membership. Students wanted to be part of the community of practice of registered nurses, but in reality their work experiences aligned them more to the community of practice of health care assistants. Although the students participated in both in some placements, they felt that they were not accepted into either (see chapter five section 5.1.1). This impacted on their opportunities to learn.

The majority of the students did get some access to other learning opportunities to meet their learning outcomes or quench their thirst for the technical skills. However, this depended on the placement. One student on placement had extreme difficulty. Julie describes:

> "I had a mentor who thought student nurses were there as care assistants. Didn't want, didn't involve you at all, didn't see it as relevant to do a drugs round, wouldn't let you get involved in the paperwork. It was hard work to try and gain any experience".
>
> (Participant 10, page 8)

This student had to work hard at trying to access opportunities which she thought she needed.

In other placement areas, such as the specialist areas, there appears to be more opportunity for the activities of the registered nurses and students to

coincide allowing the student and registered nurse to work alongside one another, making the potential for facilitation of learning more attainable. This will be discussed later in this chapter (section 6.3.1).

The students' accounts began to uncover some of their rationales for their choices of what they wanted to learn on clinical placement. It should not be surprising, given the messages being sent to students regarding the value and importance attached to technical skills and administration compared to the lack of worth given to physical care, that students want to learn the technical skills of nursing.

6.2.2 Tug of war

The findings from this study are beginning to reveal that what the students thought they should be learning, and were expected to learn in placement, did not always correspond to what the registered nurses and placement staff thought they should be doing. Often they were assigned work activities (mainly the physical care of patients) which they did not see as being relevant for their learning needs. For students, this gave rise to a constant battle between the opposing forces of work and learning, which left them feeling as if they were being pulled and tugged in different directions. The visual image that the students' descriptions conjure up is one giant imaginary tug of war. This is typified by Julie's account:

> "I asked if I could set up a lumbar puncture trolley and actually assist with it so I could actually observe and it was a case of, No, we're far too busy, we need you to go and do, go and shower this patient".
>
> (Participant 10, page 19)

They feel they are being pulled into doing the work, which they don't see as providing them with the necessary experiences to prepare them to become a registered nurse. Julie describes a typical day on the ward:

> "You would go into handover and from then on you would go out and would do all the washes of patients ..... if you had finished all those by the time the drugs round started, if nobody needed any help or assistance, you may get the opportunity to go on part of the drugs round until somebody did need

> assistance, in which case you would be obliged to go and assist the patient rather than continue on the drugs round. It's really a case of having to fight to actually achieve your goals, you know, on the grids (practice assessment documentation) To actually really put pressure on them, the trained staff, to actually say, I really need to learn this.....
>
> Participant 10, page 9

Normally the structure of work and the structure of an apprenticeship system do not always coincide, raising complex implications for learners in understanding the deepening and changing nature of the practice, which is ultimately relevant for all members of that community, including the newcomers (Lave & Wenger 2002). Becker (1972) believes that the constraints in work organisations can limit or extinguish the full array of activities and thus what is required to be a master of that practice. It would appear that in some placements described in the study, the organisation of work is having an impact on how students experience the practice of nursing, with a schism between work and learning being constructed, creating a major challenge for the students in placement.

Interacting with, and being accepted by, mature members of the community of practice makes learning for the student legitimate and of value (Lave & Wenger 2002). Although learning the skills and knowledge are important, out of context the focus is narrow. Thus student nurses need to have the experience of working with registered nurses as the technical skills and knowledge are not separate from the cultural practice and social organisation which it is embedded in. Students can only achieve this by being given access to communities of practice where registered nurses are members, as students will have more opportunity to achieve a deeper sense of value by becoming part of the community. Being denied opportunity to legitimately participate in the community of practice can be disempowering (Lave & Wenger 2002).

Shared participation is the opportunity by which old timers and newcomers interact and exchange the known and the unknown, and act out their differences. Therefore conflicts between masters and students are not unusual occurrences in every day practice (Lave & Wenger 2002). However, this can adversely affect the student by making them feel overpowered, intimidated and

overworked (Lave & Wenger 2002). Some student descriptions suggest a more complex involvement between the different communities of practice of health care assistants, registered nurses and the students' involvement with both, which has given rise to tensions and conflicts. The tug of war appeared to be a feature of some placement experiences with the students trying to access the learning while the placement staff continued to pull them back to do the work. It would appear that students have to manage the tug and pull between the different members of the placement team each, with their own agenda for the student.

6.2.3 Tactics

Access to the learning opportunities that students perceived they needed was at times in part due to their resilience and ingenuity. Those with less resilience and less ingenuity appeared less able to fight for the opportunity to access and maintain the learning opportunities that they viewed as being important. However, they learned how to cope and manage in these situations, some better than others, by employing a variety of different tactics that they used in order to counter the pull of the work in order to free themselves to pursue the learning.

An example of a tactic is described by Julie:

> "you have to make sure you're on a late when you know it's going to be quieter, or make sure you're actually working a weekend, on a late shift so you can actually say to them, I need to do this, have you got time to do it, and if you're lucky you can do it or actually stay behind on your own time or go back in your own time and do it when you're not actually there as a member of staff".
>
> (Participant 10, pages 9 & 10)

Julie, in this situation, had learned when there would be more opportunity for her to be free to access the learning opportunities she felt were important. It also shows the commitment the student was prepared to give in order to have a chance of being exposed to the learning opportunities she felt she required. The tactics are considered to be successful if the student manages to access their

perceived learning opportunities. Another example of a tactic was where students were able to be assertive and stand up to the placement staff in order to access their learning opportunity. This is illustrated by Jane whilst undertaking a social work referral:

> "The support workers tended to look at you and think you are not doing anything - you can come with me and do this commoding, you're sitting at the desk, and I said, look, I'm actually doing a social work referral, I'm on the phone now, you know, and they were fine, but Jo (the other student), Oh, I'll be there in a minute. She would stop what she was doing and go and do that and rush back".
>
> (Participant 5, page 5)

In Jane's case, her tactic was successful and she was able to continue. However, her successful outcome relied on her being able to defend herself and argue her case. Not all the students have the confidence or the skill required to do this, and can miss out in accessing such opportunities. Some students also felt pressurised into doing the work, which did not leave them time to learn from the opportunity experienced. This is alluded to in Jane's account. Other students felt that they had to be given permission before they could access learning opportunities. This is discussed in more detail in chapter eight, section 8.5.1.

However, for some students it was not enough just to access the learning opportunity; they needed the time to assimilate their learning. Again, this time was not available as the students were pulled back into doing the work. Christine describes how:

> "You need the time to be able to sit down once you do a drug round and go over the drugs that you don't know, have a look at the side effects and contra indications. There wasn't the time to do that. I"d do the drug round and then it would be dinner time so I would be helping the HCA's (health care assistants) and I think that was staff shortages more. They were using me for what they could get out of me".
>
> (Participant 7, page 8)

Becoming a member of a community of practice requires access to an array of ongoing activities associated with the technologies of everyday practice, the members of the community including the old timers, information, resources and

opportunities for participation (Lave & Wenger 2002). The social organisations of which a clinical placement is one, can either promote or preclude access to the community of practice and thus legitimate peripheral participation. Not all placements facilitated access to communities of practice. In these placements the students developed and learned to use a variety of methods and skills that enabled them some access to the community of practice they wanted to belong to.

6.2.4 Doing the work

All these accounts show that students were continually being pulled into what they perceived as the work of the placement. The emphasis was on students doing the work. Nursing has had a tradition of being seen to be working and doing something, which seems to be ingrained into the culture of nursing (Melia 1987). It has been argued by Farrell (2001) that nurses have control over their working practices and therefore have the ability to change these. However, this may not be so easy or straight forward as Farrell asserted, particularly in light of Foucault's analysis of organisations and how they operate. Placement staff are employees of health care organisations and will have been socialised into the values and beliefs of that organisation. One of the most important values in today's health service is efficiency and effectiveness leading to productivity. Foucault (1979) argued that productivity is achieved through an elaborate covert system of discipline and punishment which shapes and moulds the behavior of the employees. One of the techniques used to control such activities is timing and the use of time. Time is continually monitored to ensure that staff are being productive. Nurses are expected to be 100% productive (St Pierre & Holmes 2008). Wasting time is not acceptable and is usually punished. Therefore nurses are under pressure to perform and are moulded to do this through discipline and punishment. Students on placement are being socialised into the values and beliefs of healthcare organisations and therefore it is plausible to assume that they also need to learn to be productive, and that this learning starts during the placement experience. This may explain why the students are continually being

pulled into the work, which in some placements aligns students more with health care assistants than with registered nurses. Students also learn the importance of being seen doing the work, as a means of fitting in, through which they are perceived as adopting the culture of the placement. Ken describes:

> "If I know how it works I can go and do without having to ask anything, you know. I'm not wasting 20 minutes looking for it and they don't say where have you been today?"
>
> (Participant 8, page 17)

In the past, when nursing students were employed by healthcare organisations, they were entrenched in the traditions and hierarchy and this is what shaped their participation and therefore their identity. However, this changed when nurse education moved into higher education in the late '80s. Students were now being exposed to the values and beliefs of the education institution. Students on placement have to assimilate the values and beliefs of the higher education institute which they have been exposed to and which will help to shape their expectation of placement as well as the values and beliefs of the placement and the health care organisation. Often these forces are opposing and have different priorities: the healthcare organisation has its focus as health care work reflected in its numerous healthcare targets, whilst higher education has its focus on meeting the educational targets set. Students in placement will have to juggle the dual roles of care worker and student. It would appear from the students' accounts that they have difficulty in reconciling and merging these two roles, and see them as separate, which is having an impact on how they see and use their experience in placement. Students are being focused into the importance of achieving technical competence which is translated through their assessment strategy and the expectation that they will be afforded the time to do this, whilst the placements are required to continue to deliver on the work without recognition of the time required to support learners. This appears to be setting up a schism in the students' minds, leading to cognitive dissonance which will be discussed in the next chapter.

6.3 When work becomes learning

Registered nurses, in particular mentors, can influence how students see their learning in clinical placement particularly in relation to the value they place on a task or activity, and their confidence and control to undertake it. The experience of one student in one placement illustrated how the learning experience can be facilitated to help students see potential learning opportunities, where in the past they might have been blind to their presence. Christine describes this experience:

> "There was a specific task for the day whether it was the drug round or changing a stoma bag you had to get done with everything else. You always came away from that shift feeling, I've learned something new today instead of the same thing day in day out which can happen a lot of the time on placement. Then she'd (the mentor) go what have you done today. Do a little bit of a write up for me. Just say what you've felt you've learned and how you are going to use it in the rest of your placements and we'll go over it tomorrow and she'll say if you want any more information and she'd get everything. It was very organised and you learn what's different with the case even down to the extent of changing a catheter bag from a normal daily one to a night one".
>
> (Participant 7, page 7)

According to Pelaccia (2009), the value of the task is higher in students who can see the relevance of the task and can see how it fits into their goals for learning. In Christine's case, the mentor helped her to see this by directing and focusing her learning, allowing her to see the potential learning opportunities whilst being empowered to act on them. Deci & Ryan (1985) believed that if the student had control of their learning then they were more likely to engage in the learning opportunities. Also students are more likely to participate in tasks they feel confident to do. In Christine's situation, the tasks and activities did not appear to cause her difficulties, and the mentor, by directing her to undertake them, reinforced to Christine her confidence in her ability to perform them, thus helping to boost Christine's confidence.

6.3.1 Being cued in

Students appeared to be more satisfied with clinical placements where there was congruence between their expectations of learning and the reality of the

learning experience. These were normally in settings where more technological nursing care was carried out such as A&E, ITU and coronary care (CCU). In these settings the registered nurses undertook more direct patient care, which is reflected in the following accounts by Ann describing her experience in A&E:

> "The first couple of days (in Accident and Emergency) I was just shadowing my mentor and watching what she was doing. She showed me the dressings that they did in minors and I found that afterwards, I mean it took me a couple of tries I kind of mastered it. I was asked to do a neighbor strap and I thought I don't know what they are and I looked at my mentor with a completely lost look on my face and she said I'll show you and she did.
>
> (Participant 4, pages 5 & 6)

Ann describes how, on that placement, she normally worked alongside her mentor and was never left alone:

> "She'd (the mentor) always take me along and show me what she was doing, so I was never left alone, which was quite nice on the A&E
>
> (Participant 4, page 8)

In these placements, where students described how they worked alongside their mentors or other registered nurses in the delivery of nursing care, the schism between work and learning was less noticeable. In this example, the student appeared to be accepted into the community of practice as a fully participating member giving them the opportunity not only to observe the registered nurses at work but also to participate in that work. Lave & Wenger (2002) believe that for the apprentice to understand the master's performance they have to engage in the performance in similar ways which gives the apprentice opportunity to learn the knowhow knowledge of the practice including the culture , the language the artifacts and so on. The skill of the master is in their ability to manage this participation in a way that promotes and provides opportunity for the apprentice to grow and develop (Lave & Wenger 2002). In these placements the work and the learning appear to complement each other as students appeared to be assigned similar tasks and activities as their mentors, facilitating opportunities to work alongside each other, which students appeared to value. Ann's description describes how the mentor helped her to learn new skills.

According to Schön (1991), fledgling practitioners need to be helped, to be cued into seeing, by professional practitioners. Schön (1991) believes that the nature of the day to day work requires professionals to frame and reframe problems as well as find solutions to deal with the ill-defined situations which occur regularly in the work setting. This requires practitioners to deconstruct and then reconstruct practice for the students, in order to assist them to frame and reframe a challenge or challenges, and to plan and act out solutions. It is not always easy for professional practitioners to do this to enable students to learn, which is exemplified by Ken's experience when he asked a registered nurse if she could tell him how to regulate an intravenous infusion:

> "Rather getting it from a trained nurse 'cause you say, how do you do that? you just know, we can walk up and put it on and we can judge it, you know".
>
> (Participant 8, page 8)

This did not help Ken, although he was helped by another student. However, one student describes a situation where they were helped by their mentor:

> "We (the student and her mentor) were talking about an M.I. (myocardial infarction) and she was telling me how surgery can affect people, the effects that morphine and everything has on your system and on the cardiovascular system. She had been teaching me about silent M.I's and how after surgery it's not common but it can happen and it should be looked for. She was telling me about signs and symptoms. Well the very next day we were in the enhanced care unit. She sent me off to do somebody's obs (observations) and I'd been watching this woman all morning 'cause she'd been given to me. I'd got one patient. I mean they give you a patient but you can't go off and just do anything..... I'd done this set of obs which I was able to do on my own. This lady had been looking pale all morning and I said "How are you feeling, because you're really quite white" I said "and you're still a little bit sweaty around the gills" and she said "I keep getting this pain here" and I thought, oh we were talking about that yesterday. I said, "right", not to worry about it, we'll see what we can do about that, we'll see if we can get something for you". I went straight to my mentor and I said, "I've got a classic case here of just what you were talking about yesterday". They got the doctors in and this woman had had a silent M.I.".
>
> (Participant 6, page 10)

This text shows how the student was being cued into what to look for by her mentor, which helped her to see what was happening in practice. The low frequency of such descriptions by the students in this study does not mean to

say that it is not happening, however Scholes et al (2004) found that students were not being cued into practice situations by registered nurses particularly learning opportunities associated with basic care (meeting the physical needs of patients) . The ward organisation of some placements may make it more difficult to have the opportunity to do this.

Students need to construct their own schemata from individual practice situations. However, as discussed in the previous chapter, students are often working alone or with health care assistants; therefore opportunities to be cued into the practice situations they encounter are limited, and where there is an assessment strategy that favors technical competence, the registered nurses might not be aware that this was important.

6.3.2 Ways of seeing

Some students were beginning to see and interpret situational practice instead of just seeing the tasks and activities. This enabled them to see learning opportunities by participating in direct patient care, including undertaking the physical care of patients, and helped them to recognise the chance to make connections with the patient. In these instances the students appeared to have a different perspective of viewing practice, one which integrated and encompassed the context and the human element within the practice situation. They did not just see the task at hand, for example, the wash. They saw a more holistic picture which involved the individual and the context and the uniqueness that each practice situation offered.

> "I don't mind doing washing because it means you're interacting with the patient and you can just pick up stuff like pressure areas and stuff while you're washing them".
>
> (Participant 4, page 12)
>
> "I love washing patients, I do, I love toileting, that's when you get to see the skin and they talk to you and everything else".
>
> (Participant 5, page 10)

> "If you're going to provide holistic care you can't just concentrate on a window of a patient's journey"."How they are as a person is going to make an impact on how they get through what they have come in for and then it's really good to know your patient. To know what you've got to watch out for. To see them through it. See them come out the other side, hopefully successfully having done and then being able to look at the discharge and you know, making sure they're going back to either a good life or making it better to go back to where they've come from".
>
> (Participant 6, page 16)

The literature suggests that student nurses enter nursing with some identified construction or mental image of an ideal nurse (Price 2009, Spouse 2000), usually focused around the notions of caring, nurturing and compassion (Price 2009). Images appear to be developed from various sources including past experiences as well as the media. These include experiences such as previous health roles or direct interaction with nurses, and it is these rather than the media which are thought to give a more realistic and deeper level of understanding of the demands of the nursing profession (Andersson 1993, Gregg & Magilvy 2001). Calderhead (1991) suggests that it is these mental images which cue students to pay attention to particular aspects of their program as well as providing a framework on which to organise their practice. Many theories of nursing emphasise holistic individualised nursing care, for example Lenninger (1988) and Watson (1989), which may be why some of the students are cued into seeing practice in this way, as they had this taught to them whilst at university. This is exemplified in Sarah's story, where she describes how she used the time whilst escorting patients for investigations or blood tests to her advantage, as it gave her time to talk to her patients more.

> "We'd had a patient who was in her late 80's and she'd attempted suicide. People treated her professionally, they weren't unprofessional towards her but they were unsympathetic, and she needed to go for a blood test.I volunteered to take the patient down to path lab. I took her down and we were chatting through the corridors as I wheeled her through and while we were waiting for her to actually have her blood tests taken I found out that she had a five year old granddaughter who's got some sort of leukemia and basically it's not a positive prognosis. She will die regardless of the amount of treatment this child is going to have and this child was so happy and bouncy it was killing her to watch this grandchild and that's why she wanted to die. She couldn't watch any more. No-one had taken the time to speak to this woman and find out what was going on. As time went on during my placement I got quite a good rapport and every time

> I left my shift I waved to her and one day she said, "Can I have a hug off you" and I said "yeah". So I gave her a hug and she said, "you know", you're like another grandchild to me". It's lovely and I thought that was really nice and then as time went on she told me that she never used to go out without her lipstick on. Well I'd an old lip gloss in my bag. I hadn't any lipstick but I have got a lip gloss. She put it on. She looked so beautiful. It was funny. It just made the whole difference to her face just having this extra bit of colour to her face. I said "you can have that one". So every day from then on she had this lip gloss on. She looked so glamorous and she actually sent me a thank you card, you know, to say how I'd gone, I guess in her words, above and beyond my call of duty, but I see it as, how would I want my family treated? How would I want to be treated? and therefore I'll treat them that way".
>
> (Participant 9, pages 8 & 9)

These examples, particularly the last example, resonate with my conception of what I believe professional nursing practice means. They reflect care as compassionate as well as competent. However, according to Holden (1991) and Muxlow (1995), this humanitarian element is being lost to nursing in response to the emphasis being given to professional and technical issues. This will influence the experience students have during clinical placement, which has the potential to change how students view their practice, as these images, according to Kosslyn (1981), do not remain static but develop incrementally over periods of time and can be reshaped and modified according to perceptions of experience. This in turn will shape and change the individual formulating their identity. Lave &Wenger (2002) believe that identity is constructed through participation in social settings. Thus each practice situation has the potential to offer the student a treasure trove of learning experiences which will shape and mould their identity as well as providing them with opportunity to deepen their understanding of their practice by developing their knowledge, meaning and understanding. The identities being shaped through social practice will be influenced by the experience within the social institutions of education and health care where care as competence is becoming more evident (Day et al 1995), which will have ramifications for the future of the practice. Constructing identity is an ongoing process which will be discussed in the next chapter.

6.4 Changing conception of the nature of nursing

The embodiment of propositional knowledge as the foundation of a professional practice can impact on the nature of a profession and its practice (Standish 2007). Propositional knowledge is the knowledge base favoured by professions; the nursing profession is no exception (Eraut 1999). Such a knowledge base encourages nursing to be fragmented for the purpose of developing generalised rules and formulae which it is thought can be applied to various situations in practice to solve the problems which arise. This can help to demystify a profession and opens up opportunity for those outside the profession to undertake the work, as they can follow the rules. Such an approach allows for professional boundaries to be deconstructed and become blurred, which has been occurring with health care professionals. As a result of this, nurses have taken on tasks and activities previously undertaken by doctors, such as prescribing of drugs, whilst they have devolved some of their tasks, including the physical care of patients, to health care assistants. The assumption is that the general rules, principles and formulae can be applied whilst having a robust system to maintain the standards and minimize the risk.

Such a move appears to be more efficient and effective as it appears to be delivering the work more cost effectively and to a similar standard which can be measured. It is therefore not surprising to see the growth of a workforce consisting of a variety of support workers and registered nurses to deliver nursing care. It does raise the question as to how this diversity will impact on the social institutions and the communities of practice. However, this move does not take account of the broader system of relations where these activities, tasks and functions are given meaning as these things do not exist in isolation but arise out of, are reproduced by, and developed in communities of practice which define the person as well as their relations (Lave & Wenger 2002). As the context is missed, the meaning and understanding will change which in turn will change the participation and relations within the communities of practice, thus impacting on the practice and the nature of nursing. Some of these changes to

the conceptualisation of nursing are being reflected in the students' accounts particularly in relation to physical care.

6.5 Summary

There is a problem between what students see as being important to learn and what they actually do in placement, which appears to have led the students in this study to compartmentalise their experience in placement between the work and the learning. This finding is not clearly articulated in the literature, however other literature on cultural shock and cognitive dissonance may help us to understand the phenomenon. Cognitive dissonance in nursing is thought to occur from the differences between the ideals being taught by education in relation to the theory of nursing, and the reality of work (Price 2009, Mackintosh 2006). This is discussed further in the following chapter.

Students in placement have to juggle the role of student with that of care giver. The experience puts students in the centre of potentially conflicting values and beliefs between education and healthcare. The extent to which they can assimilate these competing values depends on their experience in placement. Where their expectation of learning coincides with their assigned work within the placement, and where they are working alongside the registered nurse, students normally have few problems being students and care givers, as the roles come together and merge. However, in placements where this is not the case and the students are undertaking different assigned work to the registered nurses, they often do not see this as providing learning opportunities and therefore feel they are being pulled and tugged to do the work, leaving them feeling frustrated and thwarted in their learning, as they feel they are supplementing the workforce by being allocated to the work at the expense of their learning. The students in these circumstances tended to work alone or with healthcare assistants as the registered nurses are less involved with this aspect of care. This experience will shape and mould the students' identity. The next chapter will explore this issue.

Chapter seven

Findings: Identity crisis

7.0 Introduction

Our Identities are shaped not only through participation and non participation in communities of practice that we invest in, but also in our skill to negotiate meanings and shape that characterise these communities (Lave & Wenger 2002). Thus according to Lave & Wenger (2002) identity is made up of identification and negotiability, identification being the investment of self in numerous forms of belonging, and negotiability which is an ability to navigate the meanings that are important to those contexts. Each form of belonging can provide opportunity for both identification and negotiability. However the opportunities will be shaped by the types of social structures and the structural relations affecting the processes within each. The process of identification involves "identifying as" something or someone, as well as participation by "identifying with" something or someone (Lave & Wenger 2008). It is likely that student nurses identify with nursing and registered nurses during their journey to become a registered nurse. During this time, students will be exposed to various social institutions and communities of practice in nursing, each with their own context providing students with opportunities to shape their identities.

The process through which students learn the meanings and shape their identity as a nurse normally happens in the practice setting during the students' placement experience (Chun-Heung & French 1997). In clinical placement, students are required to translate what they have learned in the classroom into practice, whilst learning how to work and behave within the various health care settings each with their own set of organisational and bureaucratic work structures (Hamilton, 2005, Maben et al 2006). Thus, this involves learning the professional culture as well as the functions and activities of the work. A key element for professional culture appears to be a commonality amongst the members (Evans 2008). Day (1999) describes this as "a consensus of norms"

including being and behaving as a professional within personal organisational and broader political conditions.

It has been assumed in the past that nursing was a unitary profession with a set of values and beliefs which are recognised and shared by its members. However, in the 80s, White (1988) argued that it was a plural society with three distinguishable groups which include: the managers who control many staff for the benefit of the service; the generalists who carry out the job; and the specialists with a specialist knowledge base who support a professional basis for nursing. Although this research is now over 20 years old there is some evidence that this may still be the case in nursing. Kitson (2001) highlights that there are differences within the profession between those who cling to the traditional values of nursing and those who aspire to new nursing based on the principles of social democracy. Thus students will be exposed to a melting pot of various configurations of these values through the social institutions and communities of practice they experience during their course. Changes to nursing will also be reflected in the social institutions that students will experience, including changes to organization of work, the role of the registered nurse and the composition of the nursing team. This will also impact on the students' experience and thus on their construction of their identity.

Identity is constructed through the process of participating in the everyday world of practice. Chapter five discussed how students wanted to belong to communities of practice, and in some placements found this difficult. It is assumed that such exposure will be positive and contribute positively to their identity as a student nurse. This chapter will discuss the construction of identity, the identity crisis in nursing, the confusion and cognitive dissonance and the students' dilemma to conform or speak out.

7.1. Shaping identity

One of the most important factors in the construction of students' identity is the behaviour and attitudes of the registered nurses encountered whilst on clinical placement (Levett-Jones et al 2009a, Papp et al 2003), as they will help to determine the practice and relations that students experience in clinical placement. It is during these encounters that the registered nurses can socialise students into the norms of the profession. However this was made more difficult for students in some placement settings as they found it difficult to spend time with the registered nurses, particularly their mentors, discussed in chapter five, section 5.1.1 due to the organisation of the work and which resulted in them undertaking tasks and activities which differed from those of the registered nurse. The students referred to these activities as the work of the placement which is discussed in detail in chapter six, section 6.2. Students cited many reasons why their mentors could not spend time with them including staffing levels, patient turnover, and pace of work as reasons, one of which is illustrated by Christine:

> "In my surgical placement I never went to theatre. I didn't get the chance..... I didn't get the chance to go through the drugs, go to see a procedure. The staff nurse I was with didn't have the time..... I think its actual shortages and the intake of patients they get in. I mean, it was a very quick turnover ward so I think that was more the problem, so I think it was just utilising me where I was needed really, rather than what was best for me".
>
> (Participant 7, page 9)

Julie describes a placement where her mentor was too busy to let her spend time with her:

> "She (the mentor) wouldn't work with you at all. I asked her if she wouldn't mind if I actually worked with her and shadow her for the day and she said, I'll write it down for you, I'm far too busy to work with you, I haven't got the time".
>
> (Participant 10, page 17)

David also describes a placement where his mentor ignored him during his placement experience:

> "For one, two weeks she (the mentor) didn't talk to me. She told me "I don't like students".
>
> (Participant 2, page 1)

From the student accounts, it would appear that some registered nurses within these placements felt under pressure to perform to meet their allocated workload. These expectations of registered nurses, who are mentors, include not only fulfilling the tasks and activities assigned but also facilitating and supporting student learning. This is made easier in placements where these complement each other, enabling the registered nurse to facilitate learning whilst undertaking their assigned tasks. However in other placements described by the students, where the registered nurse undertakes different work activities to the students, this is made more difficult as the organisation of work presents a physical barrier between the students and registered nurses, impeding their working together. Under these circumstances where the student and mentor are apart doing different tasks, mentoring, as the strategy to support the students in placement, is made more difficult, if not impossible, as the registered nurse has to add this onto their working day without the recognition of the resources including the time. Lave & Wenger (2002) state that the community of practice in its entirety is the master, rather than the master being the expert, as the expert is often doing different activities to the novice, and the novice can learn from other members.

The apprenticeship of Vai and Gola tailors organises the process of learning for the novices' so that they build up their skill to be able to create whole garments, but the process does not follow the production sequence (Lave & Wenger 2002). In this instance, the production steps are reversed, which helps the novice focus initially on the broad outlines of the construction of the item of clothing as they handle the garments while learning to sew by attaching buttons, sewing hems and so on (Lave & Wenger 2002) The skill of the master in this case has been in the planning and organisation of the learning of the craft of tailoring, not in being with the novice at all times. However, for this to be effective the novice has to gain access to the community of practice.

It is unclear, from David's and Julie's accounts, whether they were learning from other members of the team. It would appear that in Julie's case, the learning she felt she needed was not supported either by the mentor or others. However, in David's case this is not clear. Having the mentor ignore him may have made his access to the community of practice more difficult. Mentors, as the key to helping students' access communities of practice, will be discussed in the following chapter.

In nursing it is unclear as to the nature of communities of practice, and whether it is easy for students to access these, as they are not members of the workforce and only attend placements for small fixed periods of time. Students will be exposed to a variety of communities of practice which will vary from placement to placement in light of social structures and relations, which will influence membership. Chapter five discusses how the students felt, in some placements, that they were on the margins and did not belong.

The standard laid down by the NMC (2004, 2010) states that mentors are required to work with their mentee for a minimum of 40% of the time on placement. The NMC does not stipulate how this time should be spent. Students have picked up on the pressure, or perceived pressure, that registered nurses were under either through their direct observations or being informed of the pressure from registered nurses themselves. Mentoring in circumstances where the student and mentor have different work activities, making opportunities to work together more difficult is likely to contribute to this pressure being felt by the registered nurses who were mentors. Julie exemplifies this:

> "They (registered nurses) have got so much pressure on them, you can see it, you can ..... you see them stuck in an office for the whole shift, you see them when you're on a break with them, moaning about how much they've got to do".
>
> (Participant 10, page 22)

Clinical placements where students are allocated for experience are often fraught with tensions, as patients and loved ones deal with a range of worries and anxieties associated with their diagnoses, prognoses, treatments and the

impact on their lives (DH 2006). Each work setting will have its own unique work culture, which can be gauged by the ambience of the work setting (Lave & Wenger 2002). The ambience is shaped by a number of different factors, including the way staff interact with each other, the pace of the work, staffing levels, patient turnover and the nature of the work, such as the acuteness of patients' conditions (DH 2006). As these factors are constantly changing from shift to shift, day to day, week to week, they impact on the pressure, or perceived pressure, felt by the staff within the work environment to meet these demands. This can have a dramatic effect on how nurses interact and behave, which affects the ward atmosphere, ultimately impacting on the students' experience on placement (DH 2006). Staff are also under pressure to perform and meet the goals and outcomes of the healthcare organisations which, in today's health service are being run like private businesses to contain the costs of health care (St-Pierre & Holmes 2008), by being efficient and effective and ensuring operating costs remain low whilst achieving good patient outcomes

Although there may be reasons associated with the organisation of the work and the pressures associated with this as to why some registered nurses in some placements appear not to spend time with students whilst in clinical placement, it raises the serious question as to who are socialising the students into the profession of nursing in their absence. It is important for nursing to investigate the social institutions of nursing in order to understand more about nursing's communities of practice, as the students' exposure to practice will have consequences for the future shape of the profession. Lave & Wenger (2002) stress the importance of participation in everyday social practice as key to thinking, learning, knowing. The form that such participation takes will influence these processes. Therefore, if the students are not being exposed to the registered nurses at work, then it will be more difficult for students to experience fully the practice of nursing, particularly such things as the behaviours, the language and the culture. Can these students learn to assimilate the norms of the profession within the functions of the work, when accounts from chapter five show that they are either working alone or alongside health care assistants?

From their experience they will construct an identity which will help to shape the future of the nursing profession as the newcomers, the students, will become the registered nurses, the old timers of the future.

7.2 Identity crisis

Individuals define themselves in practice through the multiple relations within the social practice (Lave & Wenger 2002) which they will experience through legitimate peripheral participation, which is a way of performing in the social world and occurs under a variety of differing conditions. Legitimate peripheral participation is the process involved in transforming the individuals and changing communities of practice. This is integral to the process of learning. Learning seen in this way, involves the whole person and their relation to the community of practice, not only to the specific activities associated with it. For learning it is important to have effective legitimate access to what is to be learned (Hutchins 1993). It is assumed that clinical placements offer students participation in the practice of nursing and what they need to learn to become registered nurses, and that the relations within the communities of practice expose students to the value set of the profession; a profession that is worthy and positive to pass onto aspiring novice practitioners. It was therefore concerning that the majority of students in this study had experienced various forms of work abuse, ranging from minor infringements to major incidents, during their experience in clinical placement.

Work abuse has been defined as:

> "Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well being or health" (International Labour Office 2002 page 3).

This definition includes not only physical violence but psychological abuse as well and shows that work place abuse can be initiated from various sources including the patients

7.2.1 Work abuse – minor infringements

The findings of this study show that fellow healthcare workers were responsible for the verbal abuse suffered by students. They were abused in differing ways; two students, Julie and David were ignored by the mentor or placement staff, leaving them feeling abandoned and having to fend for themselves. These incidents have already been described earlier in this chapter. The mentors in these examples show that they took little interest in the students. This can leave the students feeling devalued. Woelfle (2007) cites disinterest as a form of psychological abuse. These examples also fit the World Health Organisation's definition of workplace abuse, as in both cases they challenged the students safety and well being. David describes the effect this had on his psychological safety:

> "It puts strain on you. If you have a bad day at work you go home and you're quite depressed, but you have to go back and put up a smile the next day and be jolly in order to meet your work outcomes and then come home and be depressed".
>
> (Participant 2, page 11)

This behaviour, including negative interpersonal attitudes and use of language in the placement can lead to abuse in the workplace. Abuse in the workplace has also been described as aggressive or disruptive behaviour of one individual or group towards a member or members of the larger group (Woelfle 2007, Farrell & Cubert 2005, Duffy 1995). As well as disinterest, Woelfle (2007) cites verbal abuse, threats, humiliation, excessive criticism, intimidation and denial of access of opportunity as all forms of psychological harassment. Although the participants in this study cited a number of different examples of workplace abuse they had experienced within their placement they did not fully recognise this as workplace abuse.

In the following examples, it is the behaviour attitudes and language of the healthcare assistants that leave the students feeling devalued and, demeaned or impacts adversely on their capability and confidence which will impact on their learning on placement.

Ann describes how her interactions left her feeling demeaned:

> "Go and do this work and after you've done this do this, do that and it's never like, after you've done this would you like to come with me? You kind of feel demeaned in a way ..... it was like they'd kind of look down on you but I found that quite a lot with health care assistants".
>
> (Participant 4, page 12)

Ann also felt at times that she was put upon by the health care assistants. She explains how a health care assistant was to go back and help a patient dress on completion of her shower, and take her back to bed, but she wanted a cigarette.

> "I'm (health care assistant) just going for a quick fag, get her out of the shower will you she said. I thought, I've been working for the same amount of time. It was just the fact that there were other health care assistants that she could have asked, but it just seemed to me that she said, go on and take her out. I did, and then everyone else went for their break. You kind of feel demeaned. You're not important".
>
> (Participant 4, page 13)

Jane describes how a comment by the health care assistant left her feeling inadequate:

> "A patient who had a cordal epidural, she sat straight up and of course it causes you to faint. She said, I feel sick, I want to sit up, and she tried to sit straight up. I'm left trying to lie her down, get the oxygen from under the bed; nobody put tubing under the bed..... It was only by chance that I looked at the front sheet and saw the previous MI's and angina ..... she had got chest pain. I was trying to lie her down when a nurse came through from the pain clinic and said, Oh, don't let her sit up, and this support worker went, Well, yes, I know, you don't sit them up, as if to say, Oh, the student sat her up. It really upset me..... She made me feel really inadequate".
>
> (Participant 5, pages 12 & 13)

Christine describes how she felt patronised, especially when in her third year she was still being shown at the beginning of every placement how to make a bed and how to wash a patient.

> "They teach you how to change a bed ..... how to give somebody a wash and you feel, Aaahhh, this is the fifth nursing placement and I know how to change a bed! You think, oh just grin and bear it, but it can get quite tedious and thinking, Please don't patronise, I know how to make a bed".
>
> (Participant 7, pages 14 & 15)

Although Christine knew that it was important for the placement staff to ensure that her practices were safe the way in which this was enacted left her feeling demeaned.

Although one student was exposed to workplace abuse she felt she was able to resist the put downs of the staff whilst on placement. She believed she could do this because she was a mature student and therefore able to stand her ground and retaliate. Elizabeth explains:

> "They try I suppose but I wouldn't, I wouldn't put up with that. I am too old see to allow them to do it..... You know they are trying by their attitude and their facial expressions".
>
> (Participant 3, page 7)

For other students they were not as fortunate as Elizabeth in being able to stand against the workplace abuse. Experiencing work abuse can be psychologically distressing for students and often left them feeling demeaned, belittled or made them feel less capable or confident. These problems do not seem to be confined to nursing students in Britain. It would seem that this is a global problem within nursing. Leiper (2005) found in America that 34% of nursing students reported that nurses had been rude, verbally abusive, humiliating or unjustly critical, and 3% of students felt verbally threatened. All examples discussed involve the relations within the clinical placement among the various members. Workplace environments can both create and maintain acts of violence (Stephenson et al 2006).

A study by Daiski (2004) examined the views of hospital staff nurses within an urban hospital in Canada about their relationships with nursing colleagues and other health care professionals. The findings showed that the participants felt that they received little respect and recognition from doctors, nurse managers and their colleagues and described how nurses were abusive to students and newly employed nurses which they labeled as "nurses eat their young" (Daiski 2004 page 46). The study found oppressed group behaviors' with nurses feeling disempowered and powerless within the hierarchical system. Although the

findings in this study cannot be generalised to other placements outside of this setting, it does give some insights as to why individuals may act as abusers, particularly if they are feeling disempowered and have been socialised into these practices as the norm. Such insights help to identify how the organisation and the hierarchical structure can be contributing factors. This has led me to examine where the students within this study fit into the nursing hierarchy within their placement settings. The students' examples of abuse would suggest that they are at the bottom of the hierarchical structure below healthcare assistants and therefore open to abuse from those above them including health care assistants. More insight into the social institutions and communities of practice where the students have clinical placement would help to understand more fully what is occurring in these settings.

7.2.2 Workplace bullying

Workplace bullying has been described as one of the most worrying forms of psychological abuse (Hutchison 2009). Workplace bullying is more than rudeness and bad manners. It can take many forms which are often covert acts rather than direct violence (Maguire & Ryan 2007). Two students within the study describe accounts of their experiences whilst in clinical placement which fall into the category of bullying. Both Sarah and Linda were publically humiliated by healthcare professionals, one being a registered nurse the other a doctor during their placement experience. The first episode, where Sarah was bullied, happened when she took a patient to theatre, and this involved the theatre nurse, leaving Sarah feeling belittled.

> "I had the opportunity to take a patient to theatre during my first placement. The staff nurse had said that she had completed her check list and I took it as a given that it was done and took the patient to theatre. I arrived in theatre to be met by the nurse there who did her check and told me categorically that I was a moron. All this is happening in front of the patient. I should take the patient back down to the area I'd brought him from and never darken her door ever again until I'd learnt how to do it properly. Obviously I'm apologising to both her and the patient whilst feeling completely belittled".
>
> (Participant 9, page 2)

In this case the mentor advocated for the student by making a point of complaining to the registered nurse about her behaviour, however this is unusual as normally nurses do not advocate for or support their nurse colleagues.

In Linda's case the perpetrator was an anesthetist. She describes how she was publicly humiliated by him when she went to observe open heart surgery. She was in a new environment where all the staff were strangers, as she was visiting from the coronary care unit. The surgeon called her over and helped her to get the best view possible. However, during the procedure:

> "This anesthetist looks at me and said; Tell me what you know about the cardiovascular system. Well, I said, I can't. He said, what do you mean you can't? I said, I don't know, I said, I'm lost, I can't think at the moment with all this going on. He said, so you're telling me you don't know what the surgeon is doing? Well, I said, Not exactly..... I'm going redder and redder, I'm getting hotter and hotter but he wouldn't let go. He was like a bull to a red rag to me..... I forgot everything I had learnt. My mind went blank..... I was aware that everybody was looking at me and I thought, God, you must think I'm all so thick and in my head I was screaming, I'm not thick you know ..... That was the only time where I just wished the floor would open up and swallow me up, through no fault of my own. Even if I'd have done something desperately wrong in that room I still wouldn't have expected somebody to have spoken to me like that and he knew what he was doing. It was the way he was looking at me. He wouldn't let me break eye contact. It was in his voice, you know, very sarcastic ..... really quite intimidating".
>
> (Participant 6, pages 13 & 14)

Sarah also brought to light a further episode that involved influencing perceptions about her reputation, undermining her ability to perform her work, which has been identified as forms of bullying (Lewis 2006, Quine 2001).

> "They (health care assistants) would organise to do breaks. They would all go and I wouldn't go with anybody, I would be on my own the whole time and my first break would be about 12 o'clock. If I was on an early where they had all been and were ready for their second break..... They would hide equipment knowing that I needed it. They would send me in directions to go and get stuff that was the wrong place, knowing full well it was the wrong place. They were trying to tell the staff nurses that I was sitting around doing nothing..... When they realised that they wouldn't break me like they apparently had done to the

> previous student, they backed down ..... at the end of my second week or beginning of my third week in placement".
>
> (Participant 9, page 3/4)

Bullies attempt to dominate others (Broome 2008) Sarah did not let these healthcare assistants see her vulnerability as she hid her distress in front of them. In this way she stood up to them. Broome (2008) sees this as one of the cardinal rules for dealing with bullies. Griffin (2004) found that violence stopped when nurses confronted their abusers.

Bullying is complex and not easy to define. Bullying infers unhelpful conduct through actions, gestures and speech which affects individuals' physical or psychological integrity and/or dignity in the workplace (Woelfle 2007). It involves the use of harmful behaviors which are often vindictive, cruel, malicious and humiliating for the purpose of undermining an individual or group within the workplace (Broome 2008). Although the examples cited are very different in nature, they fit into the different forms of bullying described by Hutchison et al 2006), which are professional competence and reputation, personal attack and attack through work roles and tasks. They are designed to adversely influence the reputation of the person being bullied and undermine their ability to perform their work.

In all the examples cited of abuse, the students had not spoken out against or reported the incidents. It was as if this was the norm. Linda thought about complaining but as she did not think it had affected the patient it did not really matter.

> "Maybe you should complain more. I don't know. He wasn't affecting the patient at the end of the day, it was only me, and so it didn't really matter".
>
> (Participant 6, page 15)

Bullying can undermine self confidence and the individuals' perceptions of themselves (Nazarko 2001). The accounts by the students bring to light that their experiences do not always reflect the espoused values and norms of nursing conveyed within the nursing literature where nursing is often seen as

caring, nurturing and compassionate (Price 2009). Nor do students experiences of nursing always live up to the NMC (2004) standards or the professional code of conduct (NMC 2008a). Practice is thought to expose students to the values that are to be adopted. Such exposure will shape the students' understanding of the meaning of nursing and will contribute to the construction of their identity: if there are problems with what students are learning in placement it raises the question as to how this will impact on the future of the profession, and whether the profession wants these behaviours as part of it.

It has been suggested that students are socialised into tolerating group norms which perpetuate and normalise bullying to the extent that it is seen as being part of the job (Randle 2003). This means that such behavior becomes acceptable, and is part of the work experience for many nurses. This may be a reason why, during the personal attack on Linda which was witnessed by the theatre personnel, nobody appeared to come to her aid or her defense. There was silence and inaction, and the incident was allowed to run its course. Stephenson et al (2006) found that nurses witnessing bullying behaviour were reluctant to speak out for fear of reprisals against them. Hutchison et al (2006) believes that nurses normalise bullying behaviours when they tolerate or ignore observed acts of bullying. Powerlessness and feelings of being unsupported by the management may be some reason as to why this is the case (Thomas & Burke 2009), and students often feel fear or retribution.

Abusive behaviour including bullying was seen as a common occurrence in nursing (Hutchison 2006, Woelfle 2007). The NHS has also been seen to have a culture where bullying is a serious problem (RCN 2002). Hickling (2006) believes that bullying has to be understood within the organisational context, and identifies four key interrelated factors which are interpersonal, intrapersonal, organisational and social dimensions. He believes that bullies intentionally manipulate their world to keep things the way they want them (Hickling 2006). This is made easier in health care organisations as the organisational structure supports bullies, as the power is normally exerted downward (Stevenson et al

2006). Thus, student nurses who are at the bottom of the hierarchy are often powerless to respond to such behaviours, and if they do challenge are made to feel that they are failing (Stevenson et al 2006)

Work abuse can have adverse physical and psychological effects on the well being of individuals (Thomas and Burke 2009) which can result in excessive absenteeism (Schewchuk 2005). It also has adverse effects on team working and social support (Hutchison 2009), further contributing to abusive behavior. This will influence the students' participation in placement which will then impact on learning and the construction of identity. Ignoring abusive incidents increases the likelihood of them being repeated which can eventually lead to their acceptance (Hutchison 2009). It becomes a vicious circle. Woelfle (2007) found students had many examples where nurses used their positions to belittle, humiliate and isolate patients. This has implications for students, for how staff behave impacts on the social structure and relations of the placement where the student is learning the practice. A consequence for students of working in placements where abuse is common is that they will learn such behaviours during their exposure and participation in practice, and this will shape their meaning of nursing and their identity. Hinchberger (2009) believes that students will mimic and repeat these abusive behaviours and become socialised into adopting them as the norm. This will impact on the quality of patient care as these are reflected in the care given to patients. Ann describes a situation when a patient was at the receiving end of bullying:

> "I was asked to sort out and clean a patient up. He had an accident in bed. He had Down's syndrome. I asked him if he wanted a shower and he just refused. I didn't know how to deal with it. I can sort of talk to him, that's all I can do and he still said no. So I told one of the health care assistants. She marched into the cubicle, she asked me to help her stand him up and get him into the chair and take him to the shower but I just couldn't because I thought, I can't drag him into the chair because that's not right ..... She called another health care assistant and they sort of grabbed him, put him into a chair and he was screaming. He didn't want to go and that really stood out for me..... I was still new to placement and I had this idea of what it should have been. It was completely

> different; I was kind of taken aback. I thought the man doesn't want to have a shower. He was just made to do what he was told".
>
> (Participant 4, page 2)

Ann, as a new recruit faced with the patient who did not want to shower, had her values and beliefs challenged. She didn't think that nursing was like that.

> "When I went out into placement I kind of heard this, you do your washes and you give them (patients) a choice. I know it's hard. Sometimes it's harder to give a patient choice ..... but I think it is important".
>
> (Participant 4, page 20).

Although she did not join in, she also did not feel able to report or speak out for the patient in this situation. Randle (2003) found that students lack personal and professional resources to confront the abusive practices that they are exposed to in practice, resulting in students joining in and participating in these practices, resulting in patients being placed in helpless positions. This situation happened in her first placement experience which was early in the course. Although students are encouraged to speak out and report poor practice this is a high expectation for someone so new to nursing. As Ann was early on in her first year, this may account for why she did not join in, as she may not have had been exposed long enough in practice to be normalised into adopting such negative behaviours.

Students who are exposed to work abuse or antagonism during their experience of clinical placement have been shown to suffer from lowered self esteem, loss of confidence, and often feel disempowered (Magnusson & Admundson 2003, McKenna et al 2003, Pearson 1998). These negative experiences can have a detrimental effect on students' learning. In placements where staff were unreceptive to students, confidence was adversely affected and their ability to be actively involved in experiential learning opportunities was reduced (Lofmark & Wikbald 2001). Disempowerment reduces the students' beliefs that they are in control of their learning, thus reducing their motivation to learn (Deci & Ryan 1985). Lowered self esteem was found to have a detrimental impact on the development of effective interpersonal relationships (Randle 2003). It is

conflicting for a profession, thought to be caring, that the novice practitioners can be treated in an uncaring fashion which can cause them psychological harm and perpetuate negative culture.

Nursing is portrayed as a caring profession and nurses are thought to be caring, kind, supportive and empathetic (Price 2009). Caring has been one of the most important features that distinguishes nursing from other disciplines. Caring has been seen as what nurses do, including the direct "hands on" care for patents (Bowman 1995). Direct patient care, and those activities which are patient focused including patient advocacy, are seen as some of the important inputs that nursing contributes to healthcare delivery. Nurses' views of caring emphasise human and psychosocial aspects (Price 2009, Patistea & Siamanta 1999) with empathy being a central component of interactions (Burnard 1988, Pike 1990). Caring defined in this way involves talking and listening to patients, which involves nursing time which can be viewed as conflicting with the cost containing agenda of the healthcare organisation. Therefore, these values and beliefs underpinning caring, are not always evident in the practice of caring that students experience during their placement.

Students can have their belief in nursing, and nurses, challenged as they become aware though their experience in practice of negative norms, values and rules that characterise the nursing collective. They often come into nursing wanting to help others, and with an image that nursing will be a caring, nurturing and compassionate profession (Price 2009). If we want students to continue holding such ideals and values, then they need to be exposed to situations where they see nurses and other health care workers uphold these values. Interactions that students encounter with health care workers and teachers should be seen as a caring activity, emulated by nursing (Freshwater 2000). This requires staff to practice collegiality, respect and co-operation for each other as well as the patients (Schmidt 2007). However, the reality is that students are exposed to less satisfactory value systems. This may be why Johnson (2008) states that students' values at the start of their courses are

eroded as they progress. This can give rise to a dichotomy for students between the theory and practice of caring. This is also a problem for newly qualified nurses as they struggle with this dilemma (Mohr 1995), often brought to the fore in the hospital environment, tending to cause newly qualified nurses to move away from their ideals of professional nursing practice towards productivity, efficiency and the achievement of the organisations goals at the expense of the patient experience.

7.3 Confusion and cognitive dissonance

The students' experience of everyday practice will define who they are and become. Thus the values and behaviour being acted out by the members involved in education and health care will impact on how the students come to understand nursing and how they see and act as nurses in the future. The communication student nurses receive during their course in relation to nursing and the role of the registered nurse is often confusing, sending the student mixed messages which they have to try and interpret in order to negotiate and come up with their own meanings. This can cause the student to experience cognitive dissonance which is the existence of inconsistent cognitions that lead to an uncomfortable psychological state motivating the individual to take action in an attempt to achieve the need for consistency (Scott-Kakures 2009).

Student nurses, during their pre-registration nurse education courses are exposed to a variety of messages throughout their preparation which are often contradictory, leaving them confused. Here are some examples. There are differences in relation to the image of nursing held by the student and the reality of the practice they experience. According to Price (2009) students enter nursing with an image of caring, nurturing and compassion and in reality the students have been exposed to incidents of work abuse. There is also disparity between the theory of nursing based on individualised nursing care endorsed by the government and professional body (DH 1999, NMC 2004, UKCC1999) yet in reality, the application of such a theory in the clinical placement is not always evident, as the organisation of the work can make this difficult. There are

discrepancies between what students want to learn and the reality of the work. Students are directed in their learning by the assessment strategies for clinical practice which emphasis skill development but in reality their experience tends to centre on the tasks associated with physical care of the patients. This resulted in disparity between what the students thought they should be learning and the reality of delivering care. Students received mixed messages regarding the value of learning in clinical placement. The message conveyed by supernumerary status emphasises to students the value given to the experience of learning, yet in some placements the reality perceived by the students was of care delivery tasks being the priority. The students also had expectations that they would be working alongside registered nurses but in some placements the students spent time working on their own or with health care assistants, whilst registered nurses carried on their own role often out of sight of the students making it difficult for them to understand fully what nurses did, as students in this study have shown. The data collected from students contains the elements that stood out for them which had meaning and mattered to them. The findings have shown that the expectations of students as to the practice of nursing does not always equate to their realities of the practice. This can lead to confusion and creates cognitive dissonance in the students, which Price (2009) found was due to differences between the assumed ideals and the reality of the work.

Price (2009) states that socialisation involves moving through a process which entails forming an individually constructed reality out of previously held notions about nursing and the reality of nursing in the practice setting. Price (1999) found that newly registered nurses entering the world of work experienced cognitive dissonance between the values and beliefs expressed by the educational institute and that of the clinical areas where they had employment. This related to the values and beliefs of caring. The newly registered nurses felt that they were unable to provide individualised holistic nursing care, as espoused by the educational institute, due to the way the clinical area was organised and managed, fragmenting nursing into tasks which were then divided between the different grades of nurses and support workers. If newly

registered nurses experience cognitive dissonance between the theory of care and the practice of care, then it is likely that the students of nursing are also likely to experience this. Boychuk Duchscher & Cowin (2004), however, believe that students cope with this by compartmentalising the two versions of nursing. However, for some students in this study, highlighted in chapter five section 5.3.2 this does not appear to be the case.

Although Hinds & Harley (2001) state that nurses internalisze the values, beliefs and behaviours of the nursing culture in order to seek acceptance of others and to fit in, Linda showed in the example under section 5.3.2 how she was trying to uphold her values and in the example discussed, showed how she stood up for what she valued. However, whether she could sustain these values as she progressed through the course and in her future role as a registered nurse, remains debatable. Mackintosh (2000) believes students are socialised *not* to care. Drombeck (2003) also found that nurses did not want to be associated with caring, and that this was a source of discontent. This seems to be at odds with the nursing profession, which has had the art of caring at its heart since Florence Nightingale (Rafferty 1996). However it may not be so odd if nursing is now allied with science and technology (Stevens & Crouch 1995). Thus, students can devalue the work associated with caring, as has been evident in the students' accounts explored particularly in chapter six section 6.2.1 where students felt they were being used as pairs of hands to do the work.

7.4 Constructing identity

From the confusion of the dissonance between ideals and realities, students have to negotiate meaning from their experience which will help to construct their identity and how they act when they become registered nurses. The meaning that the students take from their experience including the challenges to their images, values, attitudes and behaviour will be reflected in what they do and how they do it. Students have to decide whether to conform to the dominant workplace culture, presenting a particularly difficult dilemma when it influences the quality of patient care adversely or whether in these circumstances to speak

out which often carries a personal cost. It has been argued that social structures within the organisation mould the person into how they behave (Foucault 1979). However such a theory denies the place of the individual in this process who can resist or conform (Bandura 1977).

7.4.1 Conformity

Daiski (2004) stated that individuals' attitudes and behaviour are mainly shaped by their position in the organisation and the situation in which they find themselves; it was the formal and informal power structures which had the most influence on their work effectiveness their work satisfaction and their health. Organisations have developed systems of discipline, power and punishment in order to shape, and control their employees, which becomes a method of domination as it manipulates individuals in the desired way by exploring, breaking and rearranging their "docile bodies", leaving them powerless in a position of subjugation (Foucault 1979). The outcome is that individuals' behaviour becomes more and more modified which normally results in obedience to the system and dominant culture. St Pierre & Holmes (2008) argue that nurses within healthcare organisations are subject to the same processes described by Foucault (1979).

Nurses in employment are normally organised within a hierarchical system which facilitates surveillance. They are carefully watched by other healthcare workers, peers and patients, as well as being accountable to their manager, the organisation, and the professional regulatory body for nursing. Penalised and punished if they do not behave in the desired way, nurses are subjected to intricate system of punishments and rewards, for example time keeping, appearance, attitudes, attention, promotion and money (St Pierre & Holmes 2008). Bandura (1977) argued that if the actions of individuals were determined only by rewards and punishment then people's behaviour would constantly be changing to conform to these shifting influences.

During their participation in practice, nurses learn how they are expected to behave and are exposed to the norms of the profession derived from the healthcare organisations themselves, as well as nursing's professional body the Nursing and Midwifery Council. Nurses may find these norms not always compatible, giving rise to ethical dilemmas which can lead to punishment from either one or the other or both when the norms have been broken. Boychuk Dutchscher & Cowin (2004) found, in a small study, that registered nurses were being torn between caring effectively by providing comfort to patients and family, and advocating on their behalf and pressure to maintain the structure and rigid routine of care delivery required by the organisation leaving them with the moral dilemma of having to choose which priority to meet.

Nurses often find themselves in the middle, being squeezed between their professional values of being caring and professional, as well as being subordinate to the plans of healthcare organisations aimed at constraining costs. Nazarko (2001) believes that it is impossible to deliver compassionate, high quality care when staff work in an atmosphere of fear and intimidation. In this way, nurses learn that deviating from the norms leads to punishment and exclusion. Such a system promotes conformity. Conformity means to accept and adopt behavior and practices of the social group without question. Baumeister and Tice (1990) found that individuals, in order to be accepted and fit in, are willing to comply, obey, work hard and change their behaviour. This can result in students learning to adopt negative behaviours where these dominate and poor nursing practices are established and perpetuated without question, leading to poor quality of patient care. Studies by Levett-Jones & Lathlean (2008b), Nolan (1998), Randle (2003), have found that student nurses are willing to comply in order to fit in with clinical placement even though they are expected to challenge and speak out against any poor nursing practices they find. However, to do so can result in punishment (McDonald & Ahern 2000), reinforcing conformity and the adoption of poor nursing practices..

7.4.2 Speaking out

Although students were generally unwilling to defend or speak out for themselves when they were being abused, they did advocate for the patient when they thought the care being given was problematic. The following accounts demonstrate this.

Elizabeth describes a situation she witnessed whilst on placement in a nursing home. This patient had a suspected fractured hip which she refused to have x-rayed and as a result was in constant pain

> "I walked into the patient's room....She was just curled up like a ball in the middle of the bed on the plastic mattress where they were washing her, just curled up tight and they were just rolling her from side to side to wash her, just her no sheet underneath, no towel to cover her up and honestly. Oh they must have heard me further down but it was just their way. I don't think they even thought it was wrong. I told them. My god, I got a sheet and towels back under her and a towel over her and I was speaking to the manager and I reported it to the manager"
>
> (Participant 3, page 10)

Elizabeth also spoke out on another occasion for the same patient in relation to analgesia

> "It is one of the patients. She was continually in pain. I was so fed up with the woman being in such pain and he (the charge nurse), they seemed to think that the doctors were gods and the doctor had said no once, he wouldn't up the painkillers, so I told him I would report all this back to the university if something wasn't done and eventually the doctor gave Fentynl patches. Oh, you think she was a different woman, sitting up in bed reading the paper".
>
> (Participant 3, page 9)

Speaking out for the patient resulted in Elizabeth being punished for her actions.

> "When you are in that situation.I was the only student there and in the end I wasn't being spoken too very much but it takes courage to do it really and if a 20 year old had gone in there they wouldn't have lasted because they would have allowed them to get away with it. I just couldn't. When I left she was still on Fentynl patches but goodness knows what's happened now."
>
> (Participant 3, page 9)

Students who are not resilient would not be able to withstand the pressure to conform. Elizabeth in her actions considered whistle blowing behaviour. Such behaviours' have been associated with retaliation, using exclusion and rejection as forms of punishment including, for example, denial of training opportunities, or assignment of less important work duties (Hitlan et al 2006). Not being spoken to is a form of rejection and exclusion and can be interpreted as a punishment for speaking out.

Julie was involved in an incident were the staff nurse would not respond to her pleas for help where she thought that a patient's condition had deteriorated. This situation is not necessarily a clear cut case of abuse, but the staff nurse did challenge the patient's safety by not responding to the student.

> "the patient wasn't rouseable and they just said the patient was sleepy and just having that little bit of knowledge meant you'd think, you'd take your own initiative and do more observations, keep an eye on them and actually keep feeding back to the trained staff, or pop into the office and say look this isn't right I'm really not sure and actually almost pretending your ignorance as a student saying, look can you just come and double check this for me".
>
> (Participant 10 page 13)

The student was unable to engage the staff nurse in responding to what she was saying, so she approached the junior doctor,

> "One of the junior doctors came onto the ward, saying to them, would you mind just having a quick look at this patient? He actually listened to her chest, took arterial bloods and discovered she had pulmonary oedema. That's why she couldn't breathe and that's why she was unconscious, that's why she was losing consciousness".
>
> (Participant 10, page 13/14)
>
> "The patient was taken straight to ITU".
>
> (Participant 10, page 13)

Julie was aware that she had not followed the correct communication process, reporting her findings to the junior doctor in the end, but used her student status to plead ignorance. She did not identify any sanctions taken against her:

> "Because you are a student, you can almost use that as an excuse for not following the correct flow of communications".
>
> (Participant 10, page 13)

Unlike Randle's findings (2003), where the students were unable to confront such practices, the students in this study did speak out and advocate for the patients they were nursing. There is nothing within the accounts to highlight that they were incorporating bullying tactics into their practice with patients which again is different to Randle (2003), who found that students who witnessed, as well as were victims of bullying, incorporated these behaviors into their practice. It is possible, however, that the students didn't reveal this within their conversations to me as they knew I am a teacher within nurse education. However participant conversations were open and spontaneous not guarded which might have been picked up through small nuances during the interview. I made notes after the interview and review of these supports my view that nothing was apparent.

According to Bandura (1977), behaviour from external sources that is compatible with those that are self produced wields the greatest influences. In situations where the behaviour is conflicting, individuals can withstand the pressure to conform. Students in this study showed through their descriptions, and from their accounts that they were able to resist pressure to conform demonstrated through the actions of speaking out and advocating for their patients. This took courage as in some cases they were punished for their actions. Bandura (1977) believes this to be possible as individuals have their own determined built in moral standards which influences how they act by reinforcing the behaviours through rewards which they control when the behaviour aspires to their own standards. When convictions are strong, some individuals are able to stand up against acts that they consider to be unjust or unethical even if the consequences mean they will be punished (Bandura 1977). However, most individuals are influenced by the reactions of others, and would normally strive to be seen in positive light by others, or avoid social sanctions which will have further influence on how they act.

Although students advocated for patients, there was no evidence of the same advocacy for fellow students or colleagues who were being abused (Daiski 2004). Woelfle (2007) felt that nurse education in the USA did not emphasise mutual support. This could be true of nurse education in England. Abuse in the workplace can have other effects on student learning. It is not clear how this impacts on meeting their learning outcomes and their overall academic achievement as there has been little research into the effects of workplace abuse on learning (Thomas & Burke 2009). Also it is not known what long term effect this has on future career development in nursing, except that is it likely that exposure to such incidents must shape their identities and therefore the future shape of the nursing profession.

7.5 Summary

The nursing identities of the students are constructed and shaped through the experience they have during their pre-registration nurse education course, particularly the time spent in clinical placement. It is during this time that the differences between their image and ideals of nursing and nurses, and the reality of practice, can become apparent. It is assumed that exposure to clinical placement is positive as students will be exposed to the socialisation they need to become a nurse. However, the students' accounts of abuse reveal that this is not always the case, and can lead to students adopting such practices into their nursing practice which then become the norm. The behavior of health care staff particularly registered nurses will have a profound effect on the changes that take place and the construction of their identity. Such interaction with registered nurses and health care staff, particularly the mentors, influence the experience and therefore promote change within the students as they proceed through the course. The following chapter will examine the interactions between students, mentors and registered nurses during their clinical placement experience.

Chapter eight

Findings: Human buffers

8.0 Introduction

Students will learn the practice of nursing, and shape their identity as a nurse through their experiences of participating in the everyday practice of the social world. For nursing students, their experience of clinical placement has a major part to play in this process (Chun-Heung & French 1997); the multiple relations they experience during their participation or non participation will define who they are as nurses. It is in these environments that the students will learn the practice of nursing.

The mechanism that has been decided by the Nursing and Midwifery Council (2004) to facilitate the students' learning in placement is the mentoring system, where each student is allocated a mentor whilst in clinical placement. Mentoring in Britain is a learning relationship in the work place, within a framework which is formalised and structured (McCloughen et al 2006). Within this framework the role and responsibilities of the mentor have been identified. A mentor is a registered nurse of at least 12 months nursing experience, who meets the standards set by the Nursing and Midwifery Council (NMC 2008). The NMC (2006, 2008) states that each student on clinical placement will have a named mentor who is responsible for the quality of their learning experience whilst in placement, and is expected to work with the student for a minimum of 40% of their time in placement. The role not only involves facilitation of learning, but also assessment of competence. Therefore mentors require sufficient knowledge and skills to make the judgement that students are fit for practice and competent to register as a nurse (Fowler 2008). The quality of mentors, and their ability to undertake the role, has a major impact on the quality of the placement learning experience for students (Andrews & Wallis 1999, Burns & Paterson 2005, Gray & Smith 2000, Jones et al 2001, May & Veitch 1998, Myall et al 2008, Ralph et al 2009, Wilson-Barnett et al 1995).

The mentoring system has a number of attributes in common with the apprenticeship system that was used historically to prepare nurses; it establishes a master /apprentice relationship. It gives responsibility for planning and organising the student's learning to the master, who in the case of nursing today is the mentor (NMC 2006, 2008). The master legitimises the students entry into the community of practice; the more important the master, the more influence they will have in relation to this (Lave & Wenger 2002), and their access to learning resources. Thus, the mentor is key to facilitating students gaining access to communities of practice, and to legitimate peripheral participation which has the potential to expose students to the history of the practice as well as to its culture (Lave &Wenger 2002), enriching the students' experience. Legitimate participation is dependent upon the social structure and relations within the setting. Social relations involve the attitudes and behaviours of the registered nurses, including the mentors, towards the students, which Papp et al (2003) found to be an important factor in the quality of the learning environment. Mentors therefore have a very important role in shaping the profession of the future through their actions with the students today. Jones et al (2001) discovered that mentors could be the key for students to access the cultural knowledge and practices of the team, particularly if the mentor was a respected member of the nursing team. This helped students to develop their identity within the nursing team. Where this was missing, students had difficulty in doing this as their access to the cultural knowledge and practices were inhibited making learning in these situations more difficult for the student (Spouse 1998).

According to Lave & Wenger (2002), learning, knowing, remembering and understanding take place within social situations. Therefore, to further understand these processes it is important to explore and examine these relationships. This chapter will begin to explore the students' perceptions of the mentor relationships and their role in this relationship.

8.1 The mentoring role

Mentoring was not something that the students were directly asked about at interview but is a theme which has emerged from their accounts. During their accounts students brought to light what mentors meant to them, revealing the multi dimensional and multi factorial aspects of the role. They also illuminated the key role that mentors have, through their actions, in enabling students to access and participate in the practice of nursing. There are five aspects to the role that have emerged from the students accounts. These are:

- Preparing the way
- Planning and organising
- Coaching and Teaching
- Being there
- Pushing and challenging

Each of the above aspects will now be discussed.

8.1.1 Preparing the way

For students, good mentoring did not happen by chance. The students recognised that mentors needed to be prepared for their arrival, and that this preparation was required before the student started the placement. David explained that when this occurred, it could be felt as placements began.

> "You've got to get the feeling they're geared up in the sense of helping students to learn as soon as you walk on the ward".
>
> (Participant 2, page 1)

Although David could feel and sense whether the placement was prepared and ready for him, he was unable to shed light on what it was that made him feel that some places were prepared while others were not. However, Christine was more able to articulate what being prepared meant. She described how the mentor in her nursing home placement had prepared for her placement:

> "She (the mentor) set things even before we arrived ..... It was very planned and structured. We were set tasks and homework; we were set specific things for each day to do."
>
> (Participant 7, page 6)

Similarly, a good mentoring experience for Anne involved a mentor from her nursing home placement, who had planned her learning experience before she arrived on placement. Although the mentor was not present during Ann's first day, she did not see this as an issue, as the mentor had left plans to direct her learning in her absence.

> "My mentor wasn't there on my first day so she left me a care plan for a patient that had been in I think two months. I was actually going to do his care plan. I was really nervous because I thought, I'm going to sit here talking about personal things, but he was brilliant."
>
> (Participant 4, page 16)

These accounts identify that mentoring involved the planning and organisation of the learning situation, and that students could recognise when this had occurred. They identified that the timing was also important, and that the activity of planning and organisation should commence before their arrival at the placement. It would seem that through their actions, these mentors prepared the way for students to gain access to the community of practice and their participation within it. However, for this is to happen in clinical placement, it required that the allocation of students to mentors had to happen in advance of the student's arrival to allow the mentor time to prepare.

Preparing the way and being prepared are things that these students looked for in their mentors and something that they wanted. If someone has gone to the trouble of being prepared, it sends messages to the student that they are valued and are being cared for. It also signals that they are welcome. These are all important elements to help students feel that they belong. Being made to feel welcome, along with induction and orientation, were signaled out by the students as contributing to their connectedness to the clinical placement, which improved their sense of belonging as it made them feel valued and accepted within the team (Myall et al 2008). In chapter five, the need to belong was seen

as one of the most important factors to support student learning in placement (Levett-Jones & Lathlean 2008b, Nolan 1998). Students who did not experience the sense of connectedness and belonging often felt they were on the periphery of the nursing team (Levett-Jones et al 2006)

8.1.2 Planning and organising

For students, planning and organising of their learning was a key factor in their learning experience whilst in placement. They saw this as being part of the mentoring process. From their accounts they begin to reveal, and give meaning, to what this is, and insights as to what this involves. Elizabeth described how her mentor facilitated learning opportunities for her.

> "She would offer to help me do something or offer to let me go a day with the diabetes nurse and she would arrange it - which was amazing."
>
> (Participant 3, page 19)

This happened when Elizabeth was in her second year whilst undertaking her community placement, but this had not always been Elizabeth's experience. During her first placement experience, she was expected to do the planning and organising herself.

> "On my first placement if you wanted anything you arranged it for yourself."
>
> (Participant 3, page 19)

Ann's account gives further insight into what planning and organising means. The mentor had planned learning activities for Ann during her nursing home placement:

> "The first couple of days I was left to read all their notes and I found it quite helpful. The fact that I was given the time to read their notes and got the chance to update some care plans as well so I knew what their problems were when they came in, how they improved and where they had gone down. I got to know the patient through doing their care plan as well."
>
> (Participant 4, pages 15/16)

Ann's example suggests that the mentor had planned and organised her learning, and that there was some sort of structure to the activities she was undertaking.

The structuring of learning may be an important activity to be undertaken by the master, as it can help the student to make sense of the practice by helping them to connect the activities of the practice. In West Africa, the master tailors of Vai and Gola organised how the production processes would be learned, including the order. This order did not reflect the production process. It was structured to help the apprentices to have an understanding of the whole practice of tailoring whilst learning discrete aspects of the practice such as sewing and cutting (Lave & Wenger 2002). This is a less complex undertaking to that of nursing, as it involves making items of clothing rather than dealing with the variances of vulnerable individuals who are often in distressing situations. However, the students have through their accounts, begun to indicate what helps them to make connections in practice. This is illustrated by Ann.

> "She (the mentor) let me look after just one patient. It felt like you were there from the beginning, when the ambulance brings them in, the handover is there, you're there when the doctor sort of looks and ..... them in and you kind of know what needs to be done for this patient. I think just being involved with the whole aspect of that patient rather than sort of saying, Oh - you know, Mrs Smith needs some fluid, can you go and get it? And you're thinking, why are they having this fluid, not knowing anything about that patient. So just being involved in the whole patient care kind of helps I think, and kind of brings it all together. You kind of know what the past history is and when you're talking to them and asking them their past history and the lead up to why they came into hospital, you kind of think, okay, will you know what to do?"
>
> (Participant 4, page 14)

Linda describes what this meant for her.

> "If you're going to provide holistic care you can't just concentrate on a window of a patient's journey. You need to know where they're coming from because when I say that you follow their journey it's not following what they're coming into hospital to have done but the effect on them of what they've come in for".
>
> (Participant 6, page 16)

Linda gives an example of such an experience when she followed a patient from admission to theatre and the immediate post operative experience.

> "My aim was to follow the patient through.They'd come into CCU (coronary care unit where she was a student on placement). It was decided that they needed open heart surgery so I was going to get them ready for theatre ..... we got him ready for theatre, did the check list, the theatre list and when the theatre people came for him I escorted the patient to theatre".
>
> (Participant 6, page 13)

Linda watched the operation. She got to see open heart surgery, the whole cycle. She saw this as being important for the provision of holistic care.

Another student, Jane was helped to see the how the multi disciplinary team worked when she sat in to follow a case, in the following example.

> "I always knew about the (multi disciplinary team) meetings but actually being there and seeing the initial start of the planning for a patient's care with all the different disciplines to me was fantastic, because I realised then what actually goes on instead of just being told. To be sitting there and seeing the patient's results up on the screen and being explained by the radiologist and the consultant of that specialty and discussion between the teams and then you've got specialist nurses in there which I actually sat in on one and then was with the specialist nurse and the consultant when that family heard the diagnosis. I think really that gave me a better understanding ..... you start to relate it and it's amazing how many things are actually linked in the human body".
>
> (Participant 5, page 15)

All these examples involved students being involved in participating in individual cases where they could observe and participate in patient care, which for these students helped them to understand more fully the practice as a whole, rather than just the pieces that make up the practice. These cases included the context and human element. The competency based approach to pre-registration nurse education in Britain has been criticised for its focus on technical competence at the expense of holism resulting in reductionism and fragmentation (Kenny 2004). This can make it difficult for the students to see how the pieces interconnect in practice when dealing with patients.

Planning and organising learning appears to be more complex than it may first appear, particularly in relation to how the activities of the practice are

sequenced to help the students' understand the practice as a whole, rather than as piecemeal activities. This would be worthy of further investigation, however to do this Lave & Wenger (2002) believe that it would require a change to the notion of master and the science of teaching. Thus, this would alter the relations of the master as the centre of authority to the community of practice as a whole, and would change the focus of teaching from the master / student to the structure of a community's learning resources.

When analysing the student accounts, planning and organising began to uncover other aspects apart from the planning and organising of learning activities. It also showed the signals and the messages sent through these actions. In Ann's earlier account within this chapter, it shows that she had been given permission to pursue this learning opportunity and the time to do so. This is also demonstrated by Jane.

> "My mentor said, No, I want Jane to go to theatres because I've booked this, but if she had not I don't think I would've said, But I want to go to theatres. I know I wouldn't have done..... 'cause you don't want to rock the boat."
>
> (Participant 5, page 8)

Through these actions, mentors are helping to structure the participation that students will experience, which helps to shape their growth and development as registered nurses. These examples begin to uncover more about planning and organisation, particularly the hidden messages that can be translated to members of the community of practice. It sent the message to the placement staff that students needed to be released from the work and be given the time to pursue the learning opportunity, and it sent a message to the students that they have been given the permission to do this. This study did not examine, and therefore will not discuss, the relevancy of these learning opportunities. Further aspects of planning and organising learning opportunities were revealed in other students' accounts. Some of the students also saw this as involving the arranging of cover when the mentor was not around. These accounts begin to suggest that mentors may hold a key that opens the door to the learning opportunities the students feel they need in their pursuit of registration, however

those pursuits do not necessarily need to involve the mentor. Lave &Wenger (2002) show, in their compilation of apprenticeship systems, that the emphasis on learning is more apparent than teaching.

Absence of a mentor can result in these messages not getting through to other members of the community, and can adversely affect the learning experience particularly in relation to restricting the students' opportunities for learning. Another student Ken, felt that learning opportunities external to the clinical placement were particularly affected when not allocated a mentor, as shown in the following account, when his mentor went off sick on the first day and a replacement took some time.

> "I didn't have problems getting things done but I had problems arranging days off the ward to go and watch procedures."
>
> (Participant 8, pages 5 & 6)

Sarah felt she had less learning opportunities when she was not allocated to a mentor in her placement.

> "There were opportunities to learn but I think I would have had more if I'd have had my mentor who'd have pushed me, not so much pushed me, but pushed others to allow me to go and do stuff. I spent a lot of time on the ward just being another pair of hands really ... It would have been nice to have the opportunities to get off the wards and observe other things."
>
> (Participant 9, pages 6/7)

For Sarah, a mentor would have signaled to others in the placement that she as a student, should be given opportunities to pursue her learning as well as being given the time to do this, and therefore this had an impact on the learning experience. Without a mentor, Sarah felt consigned to do the ward work as a pair of hands on placement. Gray & Smith (2000) also found that students who did not have a mentor felt their learning lacked direction and purpose, as they ended up just "tagging along".

Ann describes her experience when she was not allocated a mentor in her first placement.

> "On my first placement ..... I wasn't appointed a mentor. On all my other placements I've always known who my mentor is. I think knowing clearly who your mentor is helps because you have someone to home down on. You know, Can I do this? Will you sign this off for me? Will you watch me do this?"
>
> (Participant 4, page 21)

Ann's account uncovers the need of students for someone, particularly mentors, to guide them through their placement experiences. Ann describes what it was like when there was no allocated mentor to do this for her. She felt lost and alone during this experience.

> "Going back to my first ward ..... you're just standing there and they're whizzing by you and you're thinking, what do I do? It does feel like you're invisible."
>
> (Participant 4, page 3)

For Ann, being without the guidance of a mentor had a profound influence on how she perceived her experience in placement as it made her feel invisible, suggesting that she did not feel as if she belonged. A key role of the mentor appears to be related to access for the student into the community of practice and to subsequent participation or non participation, and that participation appears to be linked to the activity of facilitating the learning resources. Jones et al (2001) state that students whose mentors were absent spent significantly less time working with other registered nurses, thus impacting on the quality of their learning experience. In the absence of mentors students were often reduced to "hanging about" or "tagging on" (Phillips et al 1996). Gray & Smith (1999) found that those students who worked unsupervised were likely to be allocated to tasks similar to those appropriate to nursing auxiliaries rather than registered nurses, or they were left to their own devices. Therefore the amount of time that students spent with their mentor was seen as influencing the quality of their placement experience (Myall et al 2008). Lloyd-Jones et al (2001), stressed how insufficient time with the mentor, or having no identified mentor (Jones et al 2001) whilst in clinical placement can have an adverse impact for the student in achieving their identified learning outcomes. Further research into the planning and organising of the learning resource may help to provide mentors with valuable direction and instruction.

8.1.3 Coaching and teaching

The students' accounts brought to light coaching and teaching as a key activity that they wanted from placements. Although the students mainly related this activity to their mentors other members of the placement team participated in this as well. However, accounts describing coaching and teaching by other registered nurses were less evident. Sarah, Ann and Linda describe their experiences with their mentors. Sarah describes:

> "My mentor, in my first placement, took me through a new skill, she'd take me in Sister's office and we'd shut the door and we'd talk it through and she'd say to me, Now, this is what I want you to do step by step and when we go there I will support you and if you forget anything I can prompt you, but I won't tell you what I want you to do, I want you to try and remember what it was."
>
> (Participant 9, page 13)

Ann describes:

> "She (the mentor) had me on the same shifts as her, we'd have the handover and then she'd tell me, these are the patients, and these are the presenting problems. What do you think you're going to do first? I'd tell her what I'd think would need to be done and she'd say, Well no, let's do this first and let's do that ..... I learned a lot from her."
>
> (Participant 4, pages 6/7)

Ann was being coached by the mentor to help her to undertake and make decisions about the everyday nursing experiences she faced within Accident and Emergency and when she did not know what to do she was shown by the mentor.

> "She (the mentor) said I'll show you. She showed me and after that if she said, Can you do a neighbor strap on this patient, it was like - okay. I did it and I felt quite confident. So just being shown and then having the opportunity to do it yourself, I found it was quite a good way of learning for me."
>
> (Participant 4, pages 5 & 6)

Linda describes:

> "My mentor was actually teaching me how to manipulate the muscle to make sure I was putting it in the right place ..... it was a good experience."
>
> (Participant 6, page 3)

The mentors spent time with these students coaching them in aspects associated with the practice of nursing, and the students were able to experiment safely as they were being observed and guided by the mentor, the registered nurse, which these students found to be positive. It also showed that at least during these times, the students were enabled to utilise the learning opportunities and were engaged and participating in practice under supervision which provided the mentor with opportunities to feedback to students on their performance. Students attached importance to feedback as typified by Julie, during an episode when her mentor was helping her learn drug administration:

> "I had a mentor who turned round to me and said, I would like you to have a go. Here's what I want you to do. Here's the drugs chart. I would like you to get this patient's medication out of the trolley. I want you to set it all up. Leave all the packets out and then in 5 minutes time when I've finished what I am doing I'll come back and I'll check it and then we'll go and give it to the patient and I want you to do it and I'll observe you, and I want you to talk me through what you are doing. And that's fantastic because I did it all wrong."
>
> (Participant 10, page 19)

It is surprising that Julie found this a fantastic experience, but this was because she was so grateful to receive the feedback she did. The feedback she received helped her to learn from her mistakes and improve her practice.

> "She (the mentor) corrected me. She showed me what I had got wrong and I didn't do it wrong again."
>
> (Participant 10, page 19)

This experience gave Julie the opportunity to learn and further develop her practice of drug administration. Julie realised the value in this. She worried that if she did not know the area of her practice she needed to improve and develop, she could not address these.

> "I think the frightening thing is that you don't know if you've messed up if you're not being supervised."
>
> (Participant 10, page 11)

Without supervision and constructive feedback students were left fearful, exposed and vulnerable. They feared that they may harm the patient. Ann shows this with her account.

> "I mean I'm going back to my first placement. We were shown how to do certain dressings before we went out (before leaving university for placement) but I didn't know what to look out for on a hip wound, what signs of infection. I had an idea oh; this is what you look out for but to look at it, was completely different. I mean I could look at a wound and think that's okay and the nurse would say, no that looks infected and a lot of the time I would be doing the dressings by myself and a lot of it was just guesswork. I didn't feel comfortable at first....you feel as if you are going to be in trouble if you put the wrong dressing on."
>
> (Participant 4, page 9)

When Ann did ask for help in this placement, the help available was from the health care assistants which, in this situation, added to her confusion.

> "In my first placement, you were asked to do a dressing. You didn't know how to do it but you thought you had to do it. You'd ask a health care assistant and they'd show you but a lot of them didn't do it like you're meant to and I thought, I'm doing something wrong or something."
>
> (Participant 4, page 6)

The development of propositional knowledge with its control and predictability was meant to standardise practice and minimise the risks to patients. Inherent within the development of propositional knowledge is the notion that practitioners can apply rules, procedures and formulae, in a straight forward way to solve the problems in practice (Dunne 2007). However, the students suggest that this is not as easy or straight forward as it seems, even when they have been educated in the procedures or supplied with the rules, as they do not always recognise and understand what they see. Hence the importance of being able to experiment in practice safely, and being cued in to the practice situation. Scholes et al (2004) found, in their study, that students were not being cued into the higher order skills within basic care.

Another aspect to coaching and teaching brought to light by Jane, Christine and Julie, was advice and guidance on learning and understanding. This included being taught the underpinning rationale for care as well as being directed to sources of learning to develop further knowledge and understanding. Julie's example shows how pleased she was to receive this guidance and how she valued this mentor.

> "She was brilliant. She had only recently qualified; I think that made a difference, a big difference. She was really keen too. If she was doing something she would actually involve you in it, give you the opportunity to do things for yourself whilst it's supervised. Point you in any directions for further learning experiences that you could do, refer you to different departments and say, This is relevant, I suggest you go and do this, or sign your book (practice assessment documentation) eventually after she 's spent time with you." It made me understand what you needed to know so I understood what I needed to go away and research, and what I didn't actually understand myself so I needed to learn, and it gave me a lot more opportunities, which was great."
>
> (Participant 10, page 7/8)

For Jane and Christine being taught the underpinning rationale to their practice helped them to link theory to practice. This is exemplified in the accounts by Jane and Christine

> "She (the mentor) would not say to me, you need to do this, this and this. She would tell me why we did this, the reasoning behind it and what they had found ..... things to look for.
>
> (Participant 5, page 3)

Jane gave an example of how her mentor did this. This example relates to a patient who had just returned from theatre.

> "The patient was shaking ..... She (mentor) asked me what I thought and I said, temperature. She said, Okay, do the obs., apyrexial. She said, Why's that ..... what are the causes? She went through everything but she did that with every single thing that we did together."
>
> (Participant 5, page 3)

Christine's mentor also spent time explaining why a patient who was in the terminal stages of her illness needed her analgesia reviewed and changed.

> "It was really well explained, why they were changing the medication. She was getting nausea and dizziness and this was making her feel very agitated so they were changing it to different things."
>
> (Participant 7, page 6)

This helped Christine to relate the theory to the practice and make the connections, as she was helped to see how the analgesia contributed to the patient's symptoms, and how a change in the regime could help to reduce these.

In each of the above examples, the mentors were using the practice situations to base their teaching around. This appeared to help the students with their learning, particularly in helping them connect the pieces together. Christine states that:

> "It made a lot of things stick in your mind very easily. She'd literally sit down and go through a specific person, what they've got, go through the drugs they were on, why they were here. It was brilliant, really learnt loads."
>
> (Participant 7, page 6)

In each of these cases the students describe time that the mentor spent with them whilst participating in practice. Spending time with the mentor seems to be an important aspect of the process of mentoring, and one which influences the quality of the placement experience (Myall et al 2008). In their study, contact time was described as being able to work with the mentor during the first week in a new placement, being able to spend three or more shifts working with them in addition to other protected time (Myall et al 2008). This is more than the standard set by the NMC which is currently 40% of the placement time working with the mentor (NMC 2004, 2010). However the time available that mentors have to work with their students will depend on the work practices of the placement and also the number of students they have to each mentor at any one time. The amount of time a mentor has to spend with a student has been shown to be influenced by a number of organisational and contextual issues including workload (Mitchell 2003), staff shortages (Edmond 2001), and staff: ratio in the clinical placement (Hutchings 2005). Jones et al (2001) found that

the amount of time mentors had to fulfill the role remained constant regardless of the number of students they had to mentor, and that the quality of mentorship decreased when staffing levels were low as it reduced opportunity for supervision. Even though mentors experienced constraints around increased workloads and lack of time to carry out this role, Myall et al (2008) found evidence of commitment to providing students with quality mentoring and many of the students in the study reported having productive and positive experiences with an allocated mentor with whom they worked regularly, and who had provided opportunities to discuss their learning outcomes (Myall et al 2008). These results have to be viewed with caution as the student and mentor return rate to the survey was only 10% and 25% respectively.

Students have shown that they valued coaching, teaching and the time that the mentors spent with them. They have identified various activities associated with this function including being taught, being supervised, experimenting in safety, feedback and guidance for future learning. It is also revealing that in the examples where the student felt they were not being supervised or receiving feedback, they felt vulnerable and were concerned as to the quality of their practice. Patients are exposed to risk in these circumstances.

8.1.4 Being there

"Being there" is a term I am using to articulate what supportive mentors meant to the students in this study. It not only appeared to involve the relationship between the student and the mentor, but the feeling that the mentor was taking an interest which was demonstrated through their behavior and attitudes and which provided the student with a form of comfort. This is shown in Sarah's account, when she was talking about a mentor whom she held in high regard.

> "There were times when I wasn't feeling very well. I didn't take time off but if I had finished on an early she would give me a ring later that day to see how I was feeling, to make sure I was okay."
>
> "She was fantastic. She went above and beyond her call of duty "
>
> (Participant 9, page 5)

In this example Sarah felt cared for, which was an experience, transmitted to the student through the action of their mentor however some other students may have interpreted the phone calls as surveillance or intrusive behavior on the part of the mentor, and may have been seen in a very different light. Ann also had a positive experience of mentoring in Accident and Emergency which left her feeling as if the mentored cared about her.

> "it makes you feel like they care and they're willing to show you."
>
> (Participant 4, page 6)

Being there did not only involve the undertaking of activities by the mentor but also included the way in which they went about their execution, which brought to light some of the qualities that the students valued and which made them feel cared for. This is exemplified in Elizabeth's and Linda's accounts.

> "She couldn't have done more to help ..... she just explained everything in really simple terms, didn't make me feel stupid, didn't talk down to you, praised you when you got something. She was a really friendly, nice girl. Just made a huge difference."
>
> (Participant 3, page 5)
>
> "She was younger, she wanted to show me what she could do and she did in a really good way. She was patient and willing to go over things ..... and didn't make me feel like, small or thick. She was very technical minded, very what I would call a real clinical nurse and although I'd say that I could give her a run for her money in basic care, her technical expertise was absolutely fantastic which is what I wanted to learn."
>
> (Participant 6, page 11)

Being cared for was a feeling that students felt when their mentors were there for them, and one which they found was important to their learning. This feeling is transmitted by the actions and qualities of the mentors and includes the messages sent to students when mentors have made the effort to be prepared for them, when they plan and organise their learning experience, and coach and teach. It would appear to be a culmination of not only what they do, but how they do it, which is important to making students feel cared for and one which may be important as part of the arsenal that helps students feel they belong.

Julie and David identify accounts when they found that there was a problem with mentoring which illustrate the mentors were not around for them, did not appear to work with them, and in both examples left the students feeling unsupported.

> "I didn't work with my mentor at all during the placement ....A lot of the time they were doing paperwork, in the office or just disappear. They were always too busy for you to work with them. They didn't like having students with them."
>
> (Participant 10, page 17)

> "She (the mentor) told me, I don't like students. Fine I said, I'll stay away..... For one or two weeks she didn't talk to me ..... when I was with her she ignored me..... It puts a strain on you. If you have a bad day at work you go home and you're quite depressed but you have to go back and put up a smile the next day and be jolly in order to meet your work outcomes and then come home and be depressed. It wasn't necessary. I wouldn't say it was good but it was an experience."
>
> (Participant 2, page 11)

Being alone was discussed also in chapter five, section 5.2 where loneliness was an issue. Kileen (1998) identified that caring can help patients who are experiencing loneliness. It is feasible that if students felt cared for it would also help to minimise or even alleviate the feelings of loneliness and isolation. Being cared for also involved the students and mentors connecting, and it also involved how the mentors related to the students. The mentors in these last examples show that they were not there for the students physically or psychologically, and there was minimal, if any, interaction and connection between the mentors and the students. Some experiences do not relay to the students the feeling that they are being cared for. Lack of partnership working in the student-mentor relationships can have an adverse effect on student learning (Spouse 1996). According to Webb and Shakespeare (2007), poor mentor attitudes can ruin the placement for the student as well as making it ineffective as a learning experience. It is often when things do not go according to plan that further insights are revealed. From all the examples including the last two, it would appear that taking an interest in the student is an important aspect of the mentor / student relationship and lack of this impinges on the quality of the mentoring. When someone spends time with another and helps and supports

them, they then form the impression that the person is taking an interest, and the opposite if the converse happens, as in David's and Julie's examples.

The students' accounts highlight that mentoring involves the mentor having to spend time and energy in order to execute the role effectively. If recognition is not given to this work and the time required, then it is unlikely to be factored into the work schedule of the mentor. However, recently the NMC signaled a need for such a commitment when they stipulated that sign off mentors required one hour per week protected time over and above the normal 40% of the time expected for mentors to spend with students (NMC 2008). This raises the question as to how this workload is accommodated into the day to day activities of a registered nurse. This may not be such an issue for those mentors where the workload of mentoring compliments their day to day activities but it does raise ethical dilemmas for those mentors where their day to day activities do not easily allow them to undertake the activities associated with mentoring. In these circumstances mentors can view students as being a hindrance and a burden. Mentoring is a partnership between the student and mentor and involves both parties taking an active involvement.

8.1.5 Pushing and challenging

Pushing and challenging were mentor activities that students raised. Jane was challenged by her mentor to learn information in relation to the drugs used in the placement.

> "My mentor, she used to give me one drug to memorise and then the next day she would say, what do you give it for?"
>
> (Participant 5, page 9)

For Christine the mentor used to set tasks and homework to do everyday.

> "It was very different; we were set tasks, homework and specific things for each day to do."
>
> (Participant 7, sentence 6)

Although the mentors may have adopted different ways to challenge the students, common to them all was the setting of small attainable goals for the students to achieve in relation to their learning. This implies that the mentors had some knowledge and understanding of what the students needed to learn and were able to translate this into small bite size pieces. It was not just the setting of the goals, as Christine goes on to show, but also the follow up action by the mentor that was also crucial to this activity. Christine gave an example of how the mentor did this. The mentor would ask:

> "What have you done today? Do a little bit of a write up for me on what you've felt you've learned and how you're going to use that in the rest of your placement and we'll go over it tomorrow, and she'll say, If you want any more I can get it, and she would, she'd get everything."
>
> (Participant 7, page 7)

For Christine this had a positive impact on her learning in this placement.

> "It made a lot of things stick in your mind very easily".
>
> (Participant 7, page 6)

For one student challenging and pushing also involved more than just challenging the student. This student felt that it also involved the placement staff being challenged and pushed to allow her to go and access learning opportunities. Sarah describes how on this experience she did not have an identified mentor which impacted on her learning opportunities. From this account she explains what effect a mentor might have had.

> "I was able to learn stuff and I was able to do certain tasks because the staff nurses were very good ..... some of the staff nurses I've known for years, hence the reason I was able to latch on to them and learn stuff. I did learn a few things but I think I would have learned more if I had had a mentor from the word go. I would've been encouraged to do more. There were times when there were things to be learnt and I was pushed aside so that the third years could do it. But I think if I had a mentor she'd have said, No, I'm sorry but it's all students ..... There were opportunities to learn but I think I would have had more if I'd have had my mentor who'd have pushed me, not so much pushed me, but pushed others to allow me to go and do stuff.
>
> (Participant 9, pages 6/7)

This experience also shows the importance of partnership working between the student and the mentor. It is also dependent on the student being engaged in the activity. For the majority of students, they recognised that they had an active role to play in their learning. This will be discussed in the following section.

8.2 Active players

The planning, organisation and implementation of learning appears to be a complex phenomenon. On the one hand, the students have described their perceptions of the role of mentor. On the other hand students were able to demonstrate their active involvement in the learning process. Active involvement of students in their learning whilst on placement is a complex process which appears to be multifaceted. It involves the students making decisions of when to take control of their learning, and when to hang back. Students appear to be learning when to utilise each activity depending on the practice situation they find themselves in. This was a revelation to me and something I was not anticipating.

8.2.1 Taking control

Being actively involved in their learning involved students taking the initiative to either develop their knowledge base or to find, plan and use learning opportunities. This meant they had some understanding of what they needed to learn; their own learning needs. Often their direction for learning came from the learning outcomes contained within their practice placement learning assessment documentation. The processes involved varied, but the goal remained the same, to access the learning they thought they needed from the placement. The students were actively involved in developing knowledge, and also involved in finding, planning and utilising learning opportunities within the placement. Some students were involved in both areas, whilst others tended to concentrate on one or the other.

Developing knowledge

The development of knowledge reflected the personal needs of the students. It was common that students recognised that they needed to develop, and took the initiative to develop their knowledge, and did it usually to inform their practice in placement. For some students, their active involvement with their learning in placement began before they arrived on placement, with the activity of reading up on the experience relevant to the placement. This is illustrated by Linda.

> "Depending on the area I'm going to, I would have read up on it because I think that's important ..... there would be different knowledge that you would need ..... so I would always read up around the subject to the wards I was going to, so everything that I'd practiced I'd always had the theory of anyway .....".
>
> (Participant 6, page 7)

Linda thought this was important as a means of trying to ensure that her practice was safe, as she did not trust that all the nurses on the placement would be good which has been described in chapter five, section 5.3.2. One student thought that it was important to read up in order to improve her understanding, so that she was in a better position to question and challenge when she was in the placement.

> "Reading up for yourself, the only way of learning, to learn the reasons behind things like peg feeding. It gives you a better understanding of things. It also enables you to question why they are doing things in a certain, said with a bit more authority behind you".
>
> (Participant 10, page 12)

The accounts by Linda and Julie suggest that both students needed to have an underpinning knowledge base as part of the arsenal they required to question and challenge the placement staff. This suggests that these students were not always going to accept what the placement staff said.

At other times, students engaged in this activity during their time off duty, in response to aspects of practice they had encountered during their shifts. This is demonstrated by Ann and Christine.

> "There are going to be things that came up where you're going to go away and read about at the end of your day".
>
> (Participant 4, page 22)
>
> "They're like; do you want to do suppositories? I was like, can I watch one first..... Yep, that's fine ..... you can do it tomorrow ..... and then to go away and look at why the suppository was being given rather than oral senna or lactulose or something like that and then the reason for the position of the patient, little things like that ..... I don't like just doing things without knowing the background behind it. I think that can lead to mistakes quite easily".
>
> (Participant 7, page 12)

These examples show that the students were showing a commitment to their learning and using their time off duty for this purpose. There was no evidence that the students were given the time to do this whilst on duty in the placement. As was discussed in chapter six, section 6.2.2 the students felt they were being continually compelled to do the work of the placement and were not always afforded the opportunity to follow up on developing their knowledge that was related to the learning opportunity that they had just been involved with. Although the knowledge that most students looked for, and developed related to aspects of the nursing practices, this was not the same for Ken. He developed knowledge about the placement environment so that he could be seen to be fitting in and doing the work.

> "I try and get as much information from everyone that could help me learn quickly the ay the ward works, then I can fit in easy 'cause I know how it works. I can go and do without having to ask anything..... If the nurse says, I need this, then I know which door to go into to get it from, pick it up ..... so I'm not wasting 20 minutes looking for it and they don't say, where have you been today?"
>
> (Participant 8, page 17)

Ken's account suggests that he has learned that it is important to appear efficient and that this helps to fit into the placement avoiding the negative consequences associated with not fitting in. Fitting in and belonging are important to students and is discussed in chapter five, section 5.1.3.

Finding, planning and utilising learning opportunities

Students were on the lookout, or searched, for learning opportunities that would meet their learning needs during their placements. This meant they had to have some notion of what they wanted, and then be able to recognise suitable opportunities that arose. For many students, they took their direction from the content of the assessment documentation including the learning outcomes. Often, opportunities related to the learning outcomes arose within the placement from the practice situations that the student was exposed to. Once an opportunity was found and recognised, students took the initiative and employed various strategies so that they could access and utilise it. In one particular instance, this involved David begging the staff to let him practice taking an electrocardiogram.

> "It was my initiative at all times, my initiative to learn ..... I said, can I please try (to do ECG). I was begging them. She said Yes, basically they just showed me how to do it ..... she showed me twice and then I was doing it".
>
> (Participant 2, page 15)

In the case of Sarah it was not a particular aspect of practice she was looking for. She was looking for any opportunities to work with registered nurses as she had not been assigned a mentor. She also used her initiative and latched onto the available registered nursing staff that were on duty.

> "Some of the staff nurses I had known for years, hence the reason I was able to latch on to them and learn stuff".
>
> (Participant 9, page 7)

These examples did not bring to light the planning and organisation that was involved in order to utilise the learning opportunity effectively. For some students, finding, planning and utilising learning opportunities became a skill in itself which involved intricate planning and organisation that usually remained hidden from view. Elizabeth, in her first placement, learned to plan and organise her own learning opportunities, however the process that went into the planning and organisation was not made explicit.

"If you wanted to do anything (on my first placement) you arranged it for yourself.

(Participant 3, page 19)

The process involved in the planning and organisation is revealed in the following accounts. Linda described that the process started with an understanding of what you needed to learn.

"Firstly I think to make sure you're aware of what you need to learn, it's easier then to go out and find ....."

(Participant 6, page 3)

"Sitting in report in the morning listening and sometimes I was given my own patients so I get my report, I'd know exactly what was needed and or what my patients needed that particular shift, if it was a learning outcome that I needed because I'd already be prepared for that. I'd know, I'd have in the back of my head what I needed to do, so I'd pick specific things that the patient might need that morning, that I needed to learn and to get signed off as being competent, and then I would find my mentor and I'd say, I know this patient needs an injection, or, they need to be catheterized, can we meet at such and such a time and I'll do it?"

(Participant 6, page 5)

For Linda, the process involved not only being able to recognise learning opportunities, but also involved planning and negotiating with the mentor so that she could experiment in safety under the supervision of the mentor. The intricacy of the planning is made even more explicit in the account by Julie.

"You can listen to handover in the morning and sometimes opportunities come up from that, somebody's going to a different department to have a procedure or need something, or if they're being discharged, or if you've got new admissions you might say to them, if you get the opportunity, you can say to the member of staff, who's looking after ..... Would you mind if I be involved in that? Would you mind if I did this? Or, I've done it before, can I do this?"If they remember ,if you're around at the right time when it happens you can get involved in it but it really is timing.....You have to try and work out how the staff on the ward work what their routine is, when they go for their breaks and when their more likely to be doing certain things.....and then try and make sure that you're free at the time they're more likely to be doing it and make sure you're in the room at the time so that you can just say, would you mind if I do that.

(Participant 10, page 21)

Julie called this "putting yourself in the right place" and explained that it was important to learn about timing. This demonstrates the complex process that

some students are learning in order to plan and utilise learning opportunities on placement. It was highly enlightening to understand the detail of the planning students invest for one chance at gaining access to a learning opportunity, all of which remained out of sight and hidden from view.

Some students learned to take advantage of situations. Rather than plan specific learning opportunities, they learned to utilise the situations and the health care professionals involved to their advantage in order to promote their learning. Julie describes how she has learned to use people to her advantage.

> "You take advantage when people are actually there. If you're with a patient and a physio comes to you ..... you'd actually take the opportunity and say to them, Look would you mind if I came with you, or, I've spent the day with you, and then you'd try and negotiate the time away from the ward to actually spend time with the physiotherapist".
>
> (Participant 10, page 6)

This student also describes how asking the consultant, rather than nursing staff, if she could take part in the ward round tended to have better results for her learning.

> "Because you tend to get involved more if you go straight to the medical staff. If they're doing something they're more helpful. They'll actually explain things to you, take the time to do things with you than the trained staff (registered nurses)".
>
> (Participant 10, page 22)

Linda also learned to plan and organise her time using health care professionals who could assist her with her learning.

> "If my mentor happened not to be there on my day for whatever reason I would either go with another nurse that hadn't got a student with her or I would phone, and I've done this on occasion and I was encouraged to do this, I would ring another area and just say, Can I come with you for the day? Whether it would be physiotherapists, OT's (occupational therapists), intermediate care, theatre..... I just tried to pack in as much as I could".
>
> (Participant 6, page 5)

These accounts demonstrate the active involvement of students in their learning. However, more importantly, it reveals how the students are involved,

and the lengths they are prepared to go to, in order to get the experience they need to help them learn. This reveals the hidden skills that students develop along the way. It shows their initiative and creativity. This activity is not confined to pursuing learning opportunities; students are actively involved in deciding when to make use of the learning opportunity and when to hold back, as revealed in the next section.

8.2.2 Holding back

Holding back is another aspect of students taking control of their learning. This usually involved students making decisions about when to hold back from accessing learning opportunities. From the students' accounts, three reasons were brought to light as to why students would refrain from accessing learning opportunities. These were:

- Permission
- Experimenting Safely
- Fear

Permission

Although learning opportunities were available within placements, some students waited until they were given explicit permission to access these. In some cases the permission was given, allowing the student to access the learning, whilst at other times this was not forthcoming thus restricting the student's learning.

This is shown in the following accounts by Jane and Ann.

> "My mentor did say, No I want ..... to go to theatres because I've booked this, but if she had not I don't think I would've said - oh - but I want to go to theatres, I know I wouldn't have done".
>
> (Participant 5, page 8)
>
> "The first placement it was pretty much working alone, learning what you could learn. I know a lot of it is down to the student putting themselves about and

> saying can I do this? But I think sometimes if the opportunity is not put forward to you, you can't really take it".
>
> (Participant 4, page 8)

Permission is a complex concept. Permission means being given the go ahead, agreement or consent (Collins 2006). In the previous examples, students sought permission by asking if they could do this or that. However in those circumstances they made the initial move by seeking out the learning opportunity and then planning and organising for its use. Although permission had to come from the relevant staff in the placement it was the student who appeared to be driving this forward. They appeared to be the ones in control. In Jane's and Ann's accounts the student is in a passive role, waiting for the placement staff to give explicit permission before they can initiate the process. This is an important disclosure as it can impact on the students learning experience.

Experimenting safely

Students declined learning opportunities where they felt it would not enable them to practice safely. From the students' accounts, this included not being shown how to do something, and therefore not having a visual picture of what to do. This is exemplified by Christine's account when she was asked to give suppositories for the first time.

> "Do you want to give suppositories?I was like can I watch one first. I know it sounds silly but I've never really seen one, you know. I've seen it on the model at university but I've never actually seen a suppository. Yep that's fine.....you can do it tomorrow".
>
> (Participant 7 page 12)

Students also declined opportunities where they had never been shown how to do an aspect of practice, and supervision was not on offer. Sarah describes:

> "I was asked to commence a peg feed and I'd never actually done one ..... the ward was busy. I said I'm sorry, I've never done this before but if you could show me..... I'll be able to do it for the next time. She didn't have time so she

went off and did it herself and she did it so quickly I didn't have time to pick up everything she had done".

(Participant 9, pages 15 & 16)

In these circumstances the students recognised the need for experimenting in safety. Where this was not available within the learning opportunity, some students were declining the opportunity. This also shows that students were learning about being accountable for their actions and were demonstrating accountability within their practice by recognising their areas of deficits within their learning, and acting responsibly. Sarah identified this in her account.

"I don't do something to either make myself look stupid or harm anyone else. I would hate to do that..... I'm able to say that I'm sorry, I've never done that before so unless you're able to show me before I go off and do it then I'm afraid I don't feel comfortable to do it and therefore can you find somebody else?"

(Participant 9, page 15)

Linda also identified that there was also a need to have the underpinning knowledge before you did something.

"I would never do anything without having a bit of underpinning knowledge".

(Participant 6, page 8)

The reason why students did not want to be eager to access learning opportunities or avail themselves of these could also be misinterpreted by the placement staff with consequences for the student. Elizabeth highlights this with an example of her experience when she was a student in the intensive care unit.

"I was made out that I was unwilling to do things but I'm sorry in that situation (intensive care unit) ..... I needed to be told, Can you do that, and can you do this. It was too dangerous for me just to have a guess at what I, can do, but that was held against me".

(Participant 3, page 5)

Elizabeth felt she had been punished for holding back in situations where she did not feel confident in doing an aspect in practice, and felt that she could have caused harm if she had proceeded. However, she felt some staff interpreted this as laziness. This is another important disclosure for placement staff to understand, as it would indicate that mentors and placement staff need to

explore holding back in more depth with the student if the student is to receive the appropriate help they need.

Fear

Some students held back due to fear. This fear took on different forms. For Ken,use of the learning experiences at Accident and Emergency were impeded as he felt fearful of some of the situations he found himself in, as they were often new to him and he felt over whelmed at times. He was scared that he could cause harm. This is exemplified in his account.

> "A two year old came in (to A & E) with a big gash on her forehead. She was screaming the place down and the nurse ..... wanted me to hold it still. I thought I can't do it."
>
> (Participant 8, page 22)

He was fearful that he may bruise the baby when he was holding her as he did not know his own strength.

> "I'm not going to bruise the baby ..... so I shied away".
>
> (Participant 8, page 11)

Another student David, he was afraid that he may be judged as arrogant if he jumped in to do something professing to know it. He therefore hung back and made a judgment about the situations he found himself in.

> "You want to jump to it and show that, that's chance for me to do it and at the same time, sometimes in people they will think you are arrogant ..... I think it is a bit more of a cautiousness because you have to observe, you have to judge on the situation".
>
> (Participant 2, page 5)

The students, through their accounts, have revealed the extent of their involvement in their learning which has allowed me to see and understand what this means. Such insights can help to inform facilitation of learning in placement so that staff and students can work together effectively.

Becker (1972) believed that exposure to, and participation in, a chosen practice places students in appropriate settings for their learning. He also believed that

teaching was a central element of apprenticeship systems and that the student must plan and organise their own learning and the teaching they require, which gives the student an active involvement in their learning and puts them in control. In my role as placement development manager, I was under the misapprehension that students were very much more passive participants in their learning whilst on clinical placement. What I had not been aware of was the hidden activity that goes on in placement by the student to ensure they get exposed to the learning they perceive they need.

8.3 Summary

Mentoring, as described by the students, revealed that it was a complex phenomenon. Through their accounts, activities of the mentor and the student were revealed along with some insights into the partnership and relations between the student and the mentor. Of particular note was the activity of planning and organising, which both the student and mentor engaged in; the mentor in preparing for the students arrival and their access to learning resources, and; the student in preparing themselves for practice (by developing their knowledge base) and then in setting up their own learning and recruiting staff to teach them. These activities open the door to us seeing mentoring in a different light. Planning and organising, as the key to mentoring, challenges the traditional notions of mentor / student relations and teaching, and moves the focus to the learning resources of the practice community and how these are harnessed and utilised by mentors and or students.

The activities show that both the student and the mentor need to be active members in this process of mentoring, and as such require time and commitment to fulfill this activity. This can give rise to a moral dilemma for many registered nurse mentors particularly for those where the role of mentoring does not fit easily into their day to day work activities, thus leaving them to juggle the two.

The themes from the findings have each been examined in a separate chapter. The following chapter will examine and synthesise the findings in order to bring together the findings as a whole.

Chapter nine

Discussion of findings

9.0 Introduction

My study set out to examine how the lived experience of clinical placements impacts on the learning and identity of student nurses from one university in England. My interest in the topic was raised a number of years ago, when I was challenged about my notion of the nature of nursing by a student who wanted to change her nursing placement to avoid doing the "vile work" of the placement, which the student articulated as meeting the physical needs of the patient. At the time, I was working at a university as a principal lecturer with responsibility for the planning and organisation of placements for all nursing and midwifery courses. I was troubled by this student's remark, as my conceptualisation of nursing centred on the notion of individualised holistic nursing care, which I had constructed to mean incorporating the physical care needs of the patient as a central tenet of good nursing practice.

The literature review raised a number of important points that provided insights into the purpose of nurse education, and the role of clinical placement in that process, as well as a number of issues associated with the experience of clinical placement, impacting on learning and identity, including the clinical learning environment, belonging and fitting in, relations in clinical placement and how these impinged on learning and identity. Although the literature provided a rich and valuable source of knowledge, the subject areas were normally treated separately and often not from the perspective of the student. I felt that learning, socialisation and identity were interlinked and therefore the whole had the potential to be greater than the sum of the parts. This, for me, was where there appeared to be a gap in the literature. I wanted to explore the phenomenon from the students' perspectives to begin to gain insight into how the experience of clinical placement impacted on their learning and identity, and their understanding of nursing and the role and function of the nurse.

I undertook a qualitative hermeneutical phenomenological study which examined the lived experiences of student nurses on placement who were undertaking a pre-registration nursing course, adult branch, in order to study the phenomenon. The data was analysed and themes identified. Each theme formed the subject of a chapter, together revealing how students experience clinical placement. It shows how in some placements students felt they were on the outside, confined to the edges and the impact this had on them, their learning, their identity and their coping. This chapter will now examine how these themes interconnect and relate to one another. To make sense of the data in this way Lave and Wenger's (2002) theory of situated learning has been used as a tool to help synthesise the data.

9.1 Situated learning theory

A theory contains the underlying assumptions about the world. In the case of a learning theory the assumptions normally relate to the person, the nature of knowledge, and knowing (Wenger 2008). This theory will act as a guide regarding what to pay attention to in the world, what difficulties to expect, and directs our approach to these challenges. Lave &Wenger (2002) have built their theory on the premise that the person is a social being and this has directed their view of learning. Learning is seen as a social phenomenon which means that learning cannot be separated or isolated from its context. This is a different stance to a number of the traditional theories of learning where learning is an individual activity as it is the individual mind that processes and assimilates. Such views do not consider the social world and its impact on learning in particular how social structures and relations shape meaning and understanding. In contrast situated learning theory (Lave & Wenger 2002) sees learning as an integral activity of everyday living, and therefore does not only involve the person, but others as it is a social phenomenon.

The theory of learning influences how education is structured and developed. If knowledge is viewed as bits of information which are stored and retrieved by the brain, as in some traditional views, it is logical to design systems where the

information is bundled into bite size pieces which are then delivered as clearly and efficiently as possible. This does not reflect the complex interplay of experiences student learners encounter in placement. According to Lave & Wenger's (2002) theory, the information stored and retrieved in the brain is only part of the process of knowing. As knowledge and knowing is part of everyday living, then the only way to learn is to be part of this experience. From this perspective the learner requires opportunity to learn in situations that are not devolved from the context or human element. Therefore traditional designs and frameworks of delivery would not be so productive when learning is viewed from this perspective. Thus any design or framework would have to include opportunity for the student to access and participate in settings where this is happening. Lave & Wenger (2002) call these communities of practice.

A community of practice is a group of individuals who have a shared interest in a topic and who interacting regularly with each other around this shared enterprise, gain a greater degree of knowledge and expertise (Wenger et al 2002). Communities of practice are the social groupings that the person belongs to within their everyday lives. Most individuals will belong to a number of communities of practice in relation to home, work and leisure, however membership depends on how the individual engages in the world. Often communities of practice are informal. They do not normally have a title or formalised lists of membership, and as such often go unnoticed (Lave & Wenger 2008, Probst & Borzillo 2008). Learning, from this perspective, changes the focus from the individual to the community, as the individual is learning through interacting with the other members within the community. It is this process which enables the person to learn the practice of the community. Thus students need opportunities to become involved in their communities of practice in order to learn. Lave & Wenger (2002) call this legitimate peripheral participation.

Legitimate peripheral participation is:

> "a descriptor of engagement in social practice that entails learning as an integral constituent" (page 35).

This describes the process by which newcomers to a community become included, and is therefore the process of belonging to the community. It has been argued by Lave & Wenger (2008) that legitimacy and peripherality are necessary for participation, as peripherality gives an approximation of full participation that exposes the person to the actual practice, and legitimacy grants the newcomer access to the community of practice where participation is possible. Thus, the form that these take defines how the individual is accepted into the practice and the format of participation. This will shape their experience as well as shaping the communities of practice, as the individual has the ability to potentially transform the community while the community has the potential to change the individual (Lave & Wenger 2002). In this way communities of practice can be shaped and changed.

Participation, in situated learning theory (Lave and Wenger 2002) goes deeper than just taking on the activities of the community with its members. It involves the negotiation of meaning. Knowledge is constructed and given meaning through participating in the practices. It is only in this way that the person comes to "know". Knowing cannot be separated, therefore, from the context in which it is occurring. It is this which gives rise to meaning and understanding. It changes the focus of this activity from the traditional approach which emphasised the teacher /student or mentor/mentee relationship, to a focus on the learning resources of the community and their planning and organisation. Such a stance requires new designs for learning if this theory is to be implemented. One such approach is facilitation of learning. However this relies on the assumption that knowledge has no absolute foundation either internal or external (Basford & Slevin 2003). Knowledge is not the actual existence of things, it is our awareness and understanding of these things and an acceptance as a group that this understanding is true (Basford & Slevin 2003). People construct

knowledge out of their perspective, discourse and language available to them. Through the experience of practice, the student is guided to deconstruct, construct and reconstruct knowledge. In this sense, knowledge is understood in the dynamic of each generation.

A key factor in the quality of learning within this theory, for the person is the form that access and participation in communities of practice take, as it is this participation which will provide them with opportunity to shape and construct meaning and understanding; the authors believe that meanings are always social (Lave & Wenger 2008). From their experience, the person will negotiate what the practices mean to them and what they understand. This process in turn will help to shape and construct identity.

Identity is:

> "The way we define who we are by the ways we experience ourselves through participation as well as by the ways we and others reify our selves". (Lave and Wenger 2002, 2008).

In this way learning and identity are interconnected and related. Thus identity is an integral part of learning and not something which is separate (Lave & Wenger 2002, 2008).

There are numerous theories of learning that each involves a perspective containing underlying assumptions. The choice of perspective is important as it guides what we think, what we can see, and how we act. This will direct how we approach and design the structures to support learning.

9.2 Justification for choosing Lave and Wenger's theory

Choosing Lave & Wenger's (2002) theory of situated learning has influenced my thinking and my interpretation of the findings in this study. Some of the key reasons for this choice will now be discussed, but further justification will be revealed through the chapter. One of my key reasons was that this theory challenged the traditional approach to learning and provided opportunity for me

to see learning in a different light particularly in relation to the person, knowledge and knowing. This gave me new insights on which to further review and synthesise my findings. This enabled me to interrogate and synthesise my findings for the purpose of having a deeper understanding and making sense of the whole. It was a theory that was inclusive of the individual, including the cognitive processes, but also recognised the significance of the context on meaning and understanding, and also viewed identity as an integral part of learning, whereas in the past these two processes had often been viewed as separate entities. The analysis of the findings showed that context was very important and also revealed the dual processes of learning and identity. I also felt that, to deepen my understanding of my findings, I needed to interpret how the pieces connected as it is the relationship and interconnectedness of the parts within the context which enable the component feature(s) to emerge (Woods 1998). This knowledge consists not only of the constituent parts, but also properties and values which have been attached to it, and which cannot be explained in terms of its parts (Woods 1998). Holism for Jean Paul Satre (1946) involved the interconnectedness between the person and the lived experience. Situated learning theory by Lave & Wenger embraced holism and this resonates with me.

The perspective from which nursing is viewed will direct what we give our attention to, what we focus on, and how we deal with the challenges. It is assumed that the practice of nursing can be viewed separately from the context in which it is happening. This has influenced how nursing knowledge is developed and how practices are understood. However, I view nursing from the stance of a social phenomenon which is contextually dependent. Nursing viewed from this premise means that practices of nursing can only be understood by having some practical knowledge of nursing which relates to the meaning of acts and actions. The act is given meaning only through the context in which it takes place. Thus, nursing cannot be removed from the context, as it is this which gives it meaning. So, for nurses to come by their practical knowledge, it would require them to have opportunity to participate in the

practice. This is how they would learn, which is consistent with Lave and Wenger's theory of learning, but would not relate to a number of traditional views who see learning separately from the context. For these reasons, I have chosen Lave and Wenger.

9.3 Communities of practice

Communities of practice within nursing operate within organisations of health care which have their own visions, structures, strategies and rules (Lave & Wenger 2008). Communities of practice also have their own visions and structures. Each will influence the other. Learning as participation, according to Lave & Wenger (2008), is caught in the middle of the social structure, which emphasises cultural systems, discourses, the history, and the everyday practice involving the social interactions and relationships of the individuals within that environment. Students need to have access and participation to communities of practice if they are to learn the practice of nursing. However, the access and participation has to be with communities of practice which are successful and which undertakes the practice the students need to learn.

9.3.1 Successful communities of practice

Students in this study described positive experiences of learning in clinical placement when they were working alongside their mentor or other registered nurses undertaking similar work related activities. These descriptions can be found in chapter five section 5.3.1. In these circumstances the students gained access to the community of practice of registered nurses and were given legitimacy to participate in the practice of the community. In this way students learnt their practice from the old timers; the registered nurses. They had opportunity to observe these nurses at work and for them to be observed which Bandura (1977) and Marshall (1972) see as being important functions in learning. Students found the experience relevant, they were keen to learn from the registered nurses and could relate to and understand the experience from their perspective. In these situations the communities of practice appeared to

work well. They displayed key characteristics of a successful community, which includes: a core membership, regular one to one interaction, meaningful experiences relevant to the daily work, newcomers identifying with and wanting to learn from the members, and newcomers being able to understand the practice from their experience (Probst & Borzillo 2008). These communities were also operating in a social structure which complemented the elements described. The organisation of work and the division of labour facilitated students working with the registered nurses as they were assigned similar duties.

9.3.2 Unsuccessful communities of practice

Communities of practice are not always successful (Probst & Borzillo 2008). They have identified five key areas that contribute to why communities of practice are not successful. These include: lack of a core group of members, low level of interaction between members, rigidity of competencies, lack of identification with the community of practice and intangibility (Probst & Borzillo 2008).

Students identified placements where they were assigned to activities generally undertaken by health care assistants as problematic as there was little opportunity to observe or work alongside registered nurses or to be observed. A finding which is supported by Scholes et al (2004) who found that student nurses were involved in basic care such as meeting the physical care needs of patients, whilst registered nurses were involved mainly in the organisation and management of care.

Fragmentation of care in this way is not something new to nursing. Davies (1995) reported that much of health care and nursing was still organised along hierarchical and bureaucratic lines that reflected the reduction of the work into tasks which were then divided amongst the team. However, there are differences within the structure of health care and the composition of the team that have moved on since the late 80s, reflected in the rise of the health care

assistant role (Scott 2003). These staff undertake a variety of duties including, in some placements, direct patient care particularly in relation to meeting the physical care needs of the patients as well as some other skills which may include wound care, catheter care and measurement of vital signs.

In these contexts, students described how they did not feel they belonged. They either worked alone or with health care assistants. This left them feeling alone and confused. From the students' accounts, there was lack of one to one interaction with registered nurses. Students saw this as meaningful, but did not get access or legitimate peripheral participation in the community of nursing practice and therefore lacked concrete experience to understand what registered nurses were doing.

The students' accounts began to reveal the formulation of more than one social grouping, each with their own clearly identified enterprise within the placement, and saw the nursing team as split into two teams; the health care assistants and the registered nurses. Communities of practice are social groupings that are involved in an enterprise. Through this involvement the members define this enterprise as they pursue it together. In the process, the members will interact with each other and formulate relations (Lave & Wenger 2008). It is plausible that communities of practice will be formulated around the enterprise of delivering physical care to patients and the membership would include those individuals involved in the practice, which in the case of these placements are the health care assistants and the student nurses. Thus, the members in each of these communities will define the practice and give meaning and understanding to the actual practice.

In these situations, the students were allocated to the work activities associated with the health care assistants, whilst registered nurses were involved in doing other things. It meant that the students were more aligned to members of the community made up of health care assistants rather than registered nurses. Students found this unsatisfactory as they did not identify with health care assistants and therefore did not perceive the members as providing them with

useful knowledge and practices to assist them in learning the practice. Students therefore did not recognise these opportunities as providing them with the learning they needed and wanted. They saw it as the work of the placement. Some students were uncertain as to whether to trust the practices of health care assistants and were therefore less willing to integrate these practices into their daily work. The opportunities to engage in regular one to one interaction with registered nurses were restricted. This often led to tensions and conflicts for students as they struggled between the two. Students perceived they were being pulled between these two teams, registered nurses did not appear to want or have time for them, whilst health care assistants wanted them to do the work but not necessarily as members of their community. In these circumstances students were learning knowledge of the practice mainly from health care assistants or from working on their own. Often in these situations, students did not feel that they belonged to either community.

Professionalism conveys the culture and the key functions of the work of the profession (Evans 2008). Learning professionalism is a key element of professions and is normally undertaken by the members of that profession. Professionalism is a key element of discipline-specific behaviour students learn from the members of that profession. This is demonstrated within medicine and allied health professions where the organisation of work and the division of labour allows for students to learn the accepted professional practice and behaviours from members of their own community of practice. In this way student doctors learn from doctors and student physiotherapists from physiotherapists. In nursing, it appears that student nurses learn their practice and behaviours from non nurses.

It could be argued that learning the practice from the professionals is less important to-day, as the essential knowledge and skills of the practice of nursing has been built from propositional knowledge which yields generalisable procedures, rules, formulae to use in various situations to solve the problems that arise in practice (Dunne 2007). If this works then it is minimally dependent

on the discretion and judgement of the individual professionals who practice (Dunne 2007). It assumes that the knowledge is easily applied to the practice situations encountered, however this has been identified as problematic. Scholes (2004) found that students needed help from professional practitioners to apply their knowledge to practice situations. Such an approach also denies the human and contextual nature of the practice. If we recognise that nursing is a social phenomenon which is dependent on its meaning from its context, then it will require students to have the knowhow knowledge as well, and this needs to be learned from registered nurses in their communities of practice.

9.4 Access and participation

To learn the practical know how knowledge of nursing students require access to communities of practice where members provide opportunities for students to engage in that practice in a way that enables them to learn through the experience. Students will learn to talk the talk and walk the walk of nursing. From these experiences students will negotiate their own meanings and understandings of nursing and construct their professional identity as a nurse. The quality of the students' experiences will impact on how they practice, and ultimately will impact on the future practice of nursing and the profession, and the experiences of those who receive nursing care.

Access involves creating enough relationships with the established members, the "old timers" of the group, so that they can help the newcomers by spending time and energy introducing them into the actual practice of the community (Lave & Wenger 2008). In some placements this happened and the students accessed and participated in the community of practice of registered nurses (chapter five, section 5.3.1).

A number of factors are required for this to occur, as previously identified by Probst & Borzillo (2008). Not all communities of practice succeed. Students described placements where communities of practice were not successful. In these situations students had difficulty in accessing and participating in the

communities of practice whose members were registered nurses. Communities of practice operate within a social structure which in these situations mitigated against students' access and participation, as their work activities separated them from the registered nurses creating a physical barrier. In these circumstances the students described the difficulties they had, not only in working with registered nurses, but also observing what they did (chapter five sections 5.1.1 and 5.3). Thus, students' opportunities to learn the knowhow knowledge of nursing were restricted. In these situations students had more opportunity to be with health care assistants, as their assigned activities coincided with health care assistants, making it easier for them to observe and work with them. However the students in this study could not identify with this community and rejected any ideas that health care assistants could assist them usefully in nursing knowledge practices.

Learning nursing practice from non members will impact on students' learning, as participation in health care assistant community of practice will reflect a different social context to that of registered nurses due to the differences in knowledge base, history, culture and discourse. It is these which shape the practice. The knowledge base of registered nurses is different to health care assistants. The curriculum for pre-registration nurse education in this study was based on the standard of proficiency for pre-registration nursing (NMC 2004), and expects students at the point of registration to assess, plan implement and evaluate care that is professional and ethical as well as being safe whilst operating with the multidisciplinary team. It is difficult to see how the students can learn this from health care assistants, who have not had the same level of preparation and do not perform these aspects of practice.

9.4.1 Practical knowledge of a profession

The practical knowledge of a profession needs to be passed on by those in receipt of this knowledge. It is assumed that it is those members who practice their profession who have this. Students will learn this by observing professionals at work, as well as participating in that work. Practical knowledge

relates to the meaning of acts and actions. The act is given meaning only through the context in which it takes place. This means that practical knowledge is contextually dependent. Insight into this practical knowledge of nursing has been sought through the study of "tradition" (Cash 1998). Tradition, it is thought, is central to the understanding of the conceptual nature of practical reasoning (Cash 1998). There are different accounts of tradition and the ways in which it relates to practice (Cash 1998). For example MacIntyre's (1985) contains the notions of virtues or moral orders that guide the intent and act, and which sustain practice, whilst Benner (1984) believes that practices are given meaning by the tacit background in which they are embedded. The use of tradition has its implicit difficulties, which Cash (1998) identified as deciding whose tradition to follow, how boundaries between traditions are determined and crucially the relationship to power (Cash 1998).

There are a number of problems that the students' accounts have illuminated. They have identified that in some placements their access to participate in the community of practice of registered nurses is restricted. This will limit the opportunities that students have to learn from the old timers who are thought to be in possession of this knowledge. Secondly, where the students are aligned to work alongside the health care assistants is this practical knowledge containing the traditions the same as the registered nurses who are the professionals? I would argue not. Thirdly, there is an assumption that, by participating, students will learn this practical knowledge containing the traditions; however these may be less obvious and more difficult for the students to discern. Drummond (2007) states that when education becomes systems driven and outcome focused, the aesthetic and moral value of the educational encounters can be overshadowed. It is in these elements that the virtues are to be found. MacIntyre (1985) argues that technical competence without virtues is not a practice. Therefore, such an emphasis will lead to changes to the practice of nursing, and even the demise of the profession as we know it.

Such a focus can lead to emphasis being given to technical competence (Standish 2007), minimising the traditions of the practice which can constrict and narrow the practice (Dunne 2007). It is the combination of the two which gives a practice its unique form (MacIntyre 1985). Such an approach splits theory from the practical situation, and although such an approach provides the pieces for the student, it is difficult for the student to integrate and make sense of the whole unless they are helped to do so (Scholes et al 2004).

9.4.2 Competency based nurse education

Pre-registration nurse education is competency based (DH 1999). The knowledge deemed necessary for nursing is broken down into its constituent parts, which has led to the development of specific outcomes, standards and competencies (Drummond 2007). Such an approach to pre-registration nursing education has proved difficult to translate into practice, particularly around the definition and meaning of competence. (Bradshaw 2000, Watson 2002). This can be seen in the assessment tools used to measure competence as most were locally constructed without being tested for validity and reliability. As a result the tools were difficult to understand and apply in practice (Norman 2002). Consequently this has focused the learning of students on the outcomes to be achieved as identified within their assessment documentation. These help to signal to students what is important to learn, as reflected in their accounts which are discussed in chapter six, section 6.1.1.

Students also interpret what is important to learn through observing what the registered nurses do; students perceive their actions represent what is valuable and important in the professional practice of nursing. It is these aspects of professional practice that students want to learn. Students in this study could not see the relevance of learning the basic care (meeting the physical needs of the patients), when the registered nurses were involved in co-ordination, organisation and management. This was also found by Scholes et al (2004) in their study. Students are expected to practice individualised holistic nursing care (DH 1999, UKCC 1999). From the majority of the students' accounts, basic care

was described as a series of tasks such as performing bed baths rather than the emphasis being on the individual who required the basic care, which would emphasise a more holistic approach, changing the focus of the actual practice where the higher order skills of clinical judgement, decision making and problem solving would feature in the care. This fragmentation can lead to the students being engaged in the activities of the community without actually participating in the practice itself. As Lave & Wenger (2002) discuss this does not constitute as legitimate peripheral participation in nursing. Scholes et al (2004) found that registered nurses and students found the integration of higher order skills with basic care to be unrealistic. It is probable that the "old timers" registered nurses of today have also been exposed to similar processes of learning the practice of nursing, where the opportunity of exposure to old timers was limited during their own student learning contributing to this integration being less probable. Successive generations of students becoming nurses through these problematic learning experiences will continue to shape the meaning and understanding of the nature of nursing, progressively influencing the actual practice. This, together with the development of the underpinning knowledge base for nursing and the changes to the health service impinging on the role of the nurse, will impact on the conceptualisation of the profession of nursing and its practice.

9.4.3 Belonging

Accessing and participating in communities of practice have been described as ways of belonging (Lave & Wenger 2002). Human beings need to feel a sense of belonging through the formation and maintenance of social relationships (Baumeister & Leary 1995). This is a two way process where persons need to feel that they are valued, needed and accepted, and can reciprocate by showing they value, care and mutually accept the individual or group. Opportunity to develop such relationships is more likely for students when they have access to, and participate in, the communities of practice, as it is in these situations where interaction and social relations occur. Being excluded can prevent the formation and maintenance of social relationships and bonds which can lead to feeling

socially excluded. Social exclusion can take many different forms including marginalisation and ostracism, making it a complex phenomenon to understand. Within their stories students have described differing forms of exclusion including examples of marginalisation and ostracism (Chapter five, sections 5.1, 5.1.1, and 5.1.2). Marginalization is defined by Hall et al (1994), as the confinement of individuals or group to the fringes by the dominant central majority, whereas ostracism in the workplace is the act of being excluded, ignored or rejected by an individual or group that hinders or prevents the establishment or maintenance of social relationships, favourable reputations in the workplace, or work related successes. This not only leaves the injured party excluded, but also isolated.

Frequent social contacts with individuals who are indifferent or who are not supportive, or where contact is limited, will not foster feelings of belonging (Baumeister & Leary 1995). Students have described placements where they have encountered one or more of these challenges. In these situations they felt they were on the margins (Chapter five, sections 5.1 and 5.1.1). As well as potentially having detrimental effects on their well being, including suppression of the immune system, (Kiecolt-Glaser et al 1984), students may also suffer increased anxiety, depression and a lowering of self esteem (Baumeister and Tice 1990, Leary et al 1995). Unsurprisingly these problems can also impact on the students' ability to learn. Intellectual thought is reduced, leaving individuals less capable of reacting and performing in intelligent ways (Baumeister et al 2002).

9.4.4 Mentoring

The mentor system is the model adopted by the NMC to support students in clinical placement. This system should help students to access and participate in learning the practice of nursing, the culture, history and discourse and knowledge from the old-timers; learning in time the community of nursing practice. Students describe how this access was made easier when the mentor invested in the planning and organisation of their learning experience, which the

students indicated needed to start before the placement commenced (chapter eight section 8.1.2). As well as having identified opportunities for learning, it had the potential to send messages to members of the community regarding their legitimate membership as a student in the community, and of their need to participate in the actual practice. Students brought to light that sequencing was an important element in the planning and organising of their learning. Sequencing of the learning seems to be an important element in helping students to have an understanding of the whole practice. Vai and Gola tailors had developed a sequence for students to learn the practice of tailoring which did not follow the production processes but gave the student opportunity to see completed garments whilst learning to sew thus when they were exposed to other activities in the production for example pattern laying and cutting out, they had a concept of the whole and had more opportunity to see where each element fitted in (Lave & Wenger 2002). Having a concept of the whole seemed to provide the student with a framework to help them connect the pieces and make sense of the whole. Sequencing of the actual practice to facilitate students understanding of the whole is not something that tends to be emphasised in the literature for nursing. It would appear that this is worthy of further examination.

9.5 Failing communities of practice

According to Lave & Wenger (2008) "a community of practice" allow its members to interact and respond to each other through their engagement in the practice. Through this process, the individual learns their own way of being in that context. In this way, the person constructs their identity. Seen from this perspective, the development of an identity is an integral part of the learning process, and its shape will be dependent on the access, level of participation and the social interactions and relations within the community of practice. Accessing and participating in a community of practice is a way of belonging. Belongingness has been defined as:

> "a deeply personal and contextually mediated experience that evolves in response to the degree to which the individual feels secure, accepted

included ,valued and respected by a defined group; connected with or integral to the group and; that their professional or personal values are in harmony with those of the group". (Levett-Jones et al 2008a, page 9)

Such a definition is problematic where the professional and / or personal values of the nurses working in the clinical area are educationally or professionally unsound. In these situations it would be inappropriate for students to replicate the values of the group. However individuals are willing to comply, obey, work hard, and change in order to fit in (Baumeister & Tice 1990). Students have been found to adopt negative behaviours and poor nursing practices without question, leading to poor quality of patient care in order to fit in and belong. Levett-Jones & Lathlean (2009b) and Randle (2003) have found evidence of compliance in student nurses even though they are expected to challenge and speak out. However the findings from this study did not support this as the majority of the students spoke up for their patients even at personal cost to themselves.

Current modes of pre-registration learning is based on the assumption that the process of providing students with clinical placements where they can access and participate in the practice of nursing will give them a sense of belonging which will provide them with the experience they need to learn, and that it reflects the culture, discourse of the profession which is often portrayed in the literature as a caring profession with nurses being seen as being caring, kind, supportive and empathetic (Randle 2003). This is not always the reality for students in clinical placement.

Social relations in nursing have not always been positive. The literature has identified that there is a problem of poor interpersonal relationships amongst colleagues within nursing but is unclear as to the cause (Duffy 1995, Farrell 1999, Quine 1999). Social structure theories and theories of power have been used to try and explain the reason for this, enabling the problem to be seen from differing perspectives revealing its complexity. Farrell (2001) believed that one theory alone could not explain what was happening and proposed that it was

due to a combination of factors including oppression, organisational structures and the dynamics of interpersonal relationships including the individuals themselves. It should, therefore, not be surprising to find that the students in this study encountered problems in clinical placement associated with social relations.

Work abuse was identified from the students' accounts. Some episodes were minor, however some students suffered bullying, and there was one example of ostracism. In a number of examples described by the students, the values, attitudes and behaviour of health care staff did not reflect the underpinning values of the profession of nursing. The student descriptions reveal episodes of work abuse and bullying which have been described in chapter seven. This is not an exceptional finding, as the high incidence of work abuse has been identified from the literature (Duffy 1995, Rippon 2000, Rowe & Sherlock 2005, Stanley & Martin 2007, Whitehorn & Nowland 1997) even though it is difficult to define adding to the problem of identification (St.Pierre & Holmes 2008). It has been described as aggressive or disruptive behaviour of one individual or group towards a member or members of the larger group (Farrell & Cubit 2005, Woelfle 2007). Woelfle (2007) cites disinterest, verbal abuse, threats, humiliation, excessive criticism, intimidation and denial of access of opportunity as all forms of psychological harassment. Randle (2003) believes that student nurses are quickly socialised into tolerating group norms that perpetuate and normalise bullying to the extent that it is seen as part of the job making it more difficult for students to recognise such behaviour as a problem (Jackson et al 2002). Ignoring abusive incidents increases the likelihood of them being repeated, which may eventually lead to their acceptance and adoption (Hutchison 2009). However, the students in this study did not appear to conform to accepting and adopting the abusive behaviours and practices of the social group. Students may not have wanted to share these experiences with me, but their actions as described in their accounts, suggest something different. The majority of the students spoke out against abusive behaviours that they witnessed against patients even if they incurred sanctions. This form of action

would be less likely if they were conforming to abusive behaviours. Bandura (1977) believes that individuals have internal moral standards which they use to judge their own and others' actions. It is this which helps to direct behaviour, however individuals require to be resilient if they are to withstand the pressure from the group.

This study has highlighted that in some clinical placements the behaviour of the registered nurses and health care assistants exposes the student to unprofessional behaviours, which if adopted and applied to nursing care by the students in their future practice would impact negatively on the quality of care patients receive. It is necessary for students to learn from registered nurses who will demonstrate professionally and educationally sound practice, which the students can observe and participate in. This will provide them with experience from which to shape their future understanding of nursing and identity as a nurse.

Communities of practice help to promote an environment in which knowledge can be developed and shared to improve existing practices in organisations (Lesser & Everest 2001), providing the members are professionally and educationally sound. This is not always the case and remains a problem for such groups. Few studies have been undertaken to identify specific governance measures to guide communities of practice which could help to resolve this problem. Probst & Borzillo (2008) have identified 10 areas of governance relating to communities of practice which have merit. However the research leading to their development was done in industry. Their replication in healthcare would have to be studied. This is an area that would benefit from further research.

9.6 The future of nursing

The new standards for pre-registration nursing education will help to shape the future of nursing practice (NMC 2010). These set out the minimum standard of competence (knowledge, skills and attitudes) that the student must achieve by

the end of the course to be eligible for registration, along with the standards for education which educational institutions must attain for approval and delivery of pre-registration nursing education. These new standards are radical in that they change the academic criteria for registration to become a nurse to the level of bachelor's degree. The profession has been working towards this since, Peach argued for an expansion of graduate preparation for nursing over a decade ago (UKCC 1999). The Royal College of Nursing (2002a) believed that the complexity of nursing needed to deliver services in a rapidly changing health service require the nurse to have, a level of knowledge and skill commensurate with the level of degree, and that this should be reflected in the academic award from pre-registration nursing programmes. It also believed that the knowledge and skill required in nursing is not less than other professions nor, are the contributions of nurses any less in multi-professional activity in health care, and that the preparation and award should reflect equity. The new standards reflect the shift to degree level with more emphasis on higher order skills such as decision making /judgement, problem solving and critical thinking as well as nurses being expected to manage and lead. It is thought that such a change will prepare nurses to deliver high quality health care in a continually transforming health service.

This change has implications for nursing, its culture and education as the emphasis needs to change from nurses as doers to nurses as thinkers. This requires nurses to change from valuing student behaviours which are "doing activities" (Gearlish &Smale 2011) to valuing "thinking activities". This means that students need to be given opportunities and the space to do this without being seen as lazy or slacking. This means:

- Changing the culture of nursing (from servitude and discipline to autonomy and accountability)
- Getting nurses to embrace the changes

- Rethinking the learning opportunities for students in clinical placement which will have implications for the planning and organisation of placements
- Changing the perception of students and staff as to the importance of higher order skills. Currently neither students nor mentors see the relevance of these (Scholes et al 2004).
- Developing assessment strategies that emphasis these skills as the participants in this study identified their learning from the assessments
- Educating mentors as to how to facilitate and assess such learning

This can be achieved but it is a massive undertaking without additional resources and will require HEI's and their partners to work together. However whether it will produce new registrants who deliver what is wanted is open to question.

These standards are built on the premise that the nature of nursing and its practice in today's and future health care is known, although this assumption is not clearly addressed in these new standards. Peach identified the impact that changing societal views in relation to caring, aging and death would have on professions, fuelling the stimulus to reassess and re-evaluate professional roles and core values (UKCC 1999). This has been occurring over the last ten years and has influenced the nature and practice of nursing. The roles performed by nurses in today's health service are many and diverse, although it has been argued that they all contain elements of technical skill, supervision and management (Carr 2008). As predicted, caring activities such as washing, dressing, observations and wound care are now undertaken by increasing numbers of informal, unqualified or qualified carers who are non-nurses (UKCC1999). These activities have traditionally been the foundational practice of nursing and we need to consider their place in nursing's future, and how new registrants should be prepared if these activities are not regularly being practised by registered nurses. These new standards have neither clearly identified the philosophical underpinnings upon which nursing is based nor the

pedagogy from which nursing should be practiced. This has not helped to address the loss of identity in nursing. Instead, the standards are based on a set of old assumptions about nursing that may not be appropriate in today's world of healthcare. Nursing needs to address these basic problems and reclaim its identity. This may help to inform the core business of nursing within the health care system and clarify nurses' contribution to the patients' health care needs as well as helping to address my participants' confusion as to the role of registered nurses even after exposure to nursing practice.

These new standards do not address the conflict between preparing new registrants to be fit for practice whilst concurrently ensuring that they are fit for purpose. This can give rise to tensions and confusion which impacts on the nature and practice of nursing. These standards set out the requirements of the NMC to be fit for practice. Fitness for purpose on the other hand is difficult to define due to the speed and context of an ever changing health service. According to Peach it is therefore an unreasonable expectation for pre-registration nursing except in its broadest sense (UKCC 1999). Having some understanding of the aims of health care and what makes a good nurse and health care professional would help to ensure that changes to nursing education would be based on well considered and constructed arguments which would deliver the outcome expected. These are questions that need to be debated if we are to prepare nurses for the future. The Nursing and Midwifery Council has failed to tackle these difficult questions which lead one to question whether the ultimate aim of safeguarding the public by ensuring the delivery of high quality care is achievable with this new preparation.

Ten years on from the publication of "Fitness to Practice ", nursing education is expected to produce nurses who are fit for practice by achieving the standards laid down, whilst at the same time ensuring that nurses are fit for purpose without clarity as to what this means. These standards build on previous educational standards and strategy to address the concerns, issues and deficits from previous editions (NMC 2004, UKCC1986, UKCC 1999). However, they

have been developed from previous assumptions that need to be uncovered, challenged and debated to ascertain if they are still relevant for the future. These include:

- competency based education
- supernumerary status
- mentor model
- individualised patient care

The following paragraphs will also show why I believe these new standards will not address fully the issues raised in this study.

Competency based education

Competency to practice at the point of registration was identified by Peach to be a problem which would be addressed by an outcome-based competency approach to education (UKCC 1999). According to Bradshaw (2000) competence in nursing has historically been associated with the role of the nurse in the delivery of basic care. However, this role has now been mainly taken over by non-nurses such as health care assistants, whilst nurses are involved in more advanced and specialist activities in line with the reconfiguration of the workforce. Professional boundaries have become less clear and the competence needed to undertake the new roles that have grown from this has resulted in confusion and loss of identity for nursing in the 21st century (Bradshaw 2000). This makes it difficult for nursing to identify the purpose, function and core competencies of the nurse's role and, secondly, the nature of nursing resulting from the loss of its foundational place at the bedside in the delivery of basic nursing care (Bradshaw 2000).

Kitson (2001) identified that the challenge for educationalists in nursing is to develop a competency based framework which will move nurses to become the autonomous, responsible and safe practitioners whilst keeping the traditionalists in nursing and their supporters on board and accepting of the change. The standards reflect the need to develop nurses in the way described by Kitson

(2001). This requires nurses to develop and practice higher order skills, but will the culture within nursing and health care allow such a radical change or will the translation reflect more of the same problems in relation to competency that have dogged nursing over the years, particularly in relation to understanding competence, developing the tools and preparing practitioners to measure it? Competency in nursing has often reflected a behaviourist approach (Kitson 2001) which is considered to be reductionist and restrictive, and to mitigate against the development of higher order intellectual skills (Girot 1993, Le Var 1996). This study highlighted how the design of the competency tools directs what the student expects to learn in practice and the need to get this development right if we are to prepare nurses to these standards. The question is whether educationalists and their partners are up to the challenge.

Supernumerary Status

The standards for education have not changed the status of student nurses in the workplace. They are to continue to be supernumerary, which Peach (UKCC 1999) identified as contributing adversely to the quality of student learning in clinical placement. Supernumerary status is defined as meaning:

> "the student will not, as part of their programme of preparation, be contracted by any person or body to provide nursing care".
>
> (NMC 2010 page 65).

Even though it has been defined here and in the past, the meaning of supernumerary status lacks clarity and is open to differing interpretations giving rise to confusion.

It was thought that supernumerary status would unshackle students from the workplace as they were not to be counted as part of the manpower of the placement, thus freeing them to avail themselves of the learning opportunities required to be a registered nurse. This had a profound effect on how students were seen and who had responsibility for their education. The result was that

students were no longer part of the staffing establishment and had to compete with employees such as health care assistants for the limited resource of registered nurses' time, which was made even more acute by staff shortages and the changes to skill mix. The introduction of this resulted in a trend where health care organisations abdicated their responsibility for pre-registration nursing education, particularly in relation to clinical practice to HEI's. Even though relationships between higher education institutes and health care providers have developed and partnership working is common-place the problems relating to supernumerary status remain. A major challenge arising from this is access to the practice which students require if they are to learn to become nurses.

Supernumerary status of students increases the reliance on the nurses in placement who control access to practice for the students (Grealish and Smale 2011) and this can create a barrier if registered nurses are unaware of their role as the gatekeeper. This in turn will impact on the quality of the clinical education and thus the future practice of the profession. Nurses have to be open and accepting of students in their everyday practice if access is to be achieved (Grealish and Smale 2011). Students who are prevented from accessing the practice feel that they do not belong. For example participants in this study identified difficulties in some placements in accessing legitimate peripheral experience and thus felt they did not belong. This left them feeling alone and on the outside. Students need to feel they belong in placement (Levett-Jones & Lathlean 2008b) if learning is to be effective. Belonging recognises the need for access to meaningful practices and participants in this study, as well as those in a study conducted by Elcock et al (2007), would go to various lengths to be let in and be accepted such as participating in low level tasks. This ultimately had consequences on what they were learning.

Supernumerary status sends out messages to the student in relation to the conceptualisation of work and learning and the values attached to each. It conveys to students that learning and work are separate entities. Such a split is

thought to curtail the development of critical thinking skills (Gearlish & Smale 2011) which these new standards want future registrants to demonstrate. Such subliminal messages can influence how students see and understand their experience. Students in this study had conceptualised learning as something different to work. Their conceptualisation of learning was influenced by the assessment of their practice and the work of the registered nurse. Learning in the eyes of the student, was seen as something of value, whereas work was not. Thus, the activity of learning was seen as more important than work, and this guided students' perceptions and expectations of learning in practice. They perceived that they would be given the time to learn and this influenced what they saw as learning opportunities in placement. The majority of the participants did not see learning opportunities within the work they were assigned. As they spent the majority of their time doing the work, this led them to feel frustrated and let down.

The issues raised above have not been addressed in the new standards and therefore have the potential to continue to cause problems.

Mentoring

The model of support for students' learning and assessing in clinical practice remains unchanged in these new standards, as the Nursing and Midwifery Council has continued to use the tried and tested model of mentoring. There have been significant developments to address the quality of mentors and mentoring. Registered nurses have to be prepared for the role to a standard stipulated by the NMC, require an annual update, and to have a triennial review every three years (NMC 2006, 2008). Criteria have also been identified which clarifies the role, as well as standards which identify what is expected of the mentor. However, these measures do not address the fundamental problem highlighted by Peach (UKCC 1999). He identified that less time was available for registered nurses to supervise and mentor students due to the pressures being felt in care settings from increased throughput of patients, more acutely ill patients and staff shortages, as well as changes in service delivery such as

alterations in shift patterns leading to the removal of shift overlap. These problems remain today. It does not resolve the pressures produced from either the changing health care environments or the complexity of the organisation of work, where in some settings, registered nurses are separated from the student due to the nature of the work activities allocated to each.

In this study, participants identified the same issues as outlined by Peach (UKCC 1999), notably that registered nurses were under pressure and too busy to spend time with students to support their learning in clinical placement, even though these standards to support learning and assessment in practice had been implemented before the data for this study were collected. Participants described how they found it difficult in some placements to work with, observe or even be around their mentor due to the work organisation where students were assigned different activities to the mentor. This produced physical barriers for support and supervision, despite the requirement that:

> "40% of the student's time in the direct delivery of care must be spent being supervised (directly or indirectly) by the mentor".
>
> (NMC 2008 page 31).

This requirement was already in place at the time of data collection in this study, and was monitored by the NMC through ongoing quality monitoring by checking that off-duties matched for at least 40% of the time in placement. Thus access to practice was restricted at best, and denied at worse. This influenced not only what students could learn but how they shaped their identities and conceptualisations of the nature of nursing. There is nothing new to suggest that these problems will be different in the future. Students accessing clinical education in the future are likely to experience similar problems, as the underlying issues of "pressures" and "time" have not been addressed within the new standards for education nor in the ongoing quality monitoring process.

This study identified that participants had experienced work abuse at the hands of their mentors and other health workers. This finding corresponded to the

findings in the literature (Hutchison 2006, Randle 2003, RCN 2002, Stephenson et al 2006, Thomas &Burke 2009, Woelfle 2007). Although there are measures in place to monitor the quality of mentors and mentoring as outlined in the standards documentation (NMC 2006, 2008), there appear to be problems in identifying mentors who are either professionally or educationally unsound. This can have profound effects not only on the quality of the students' learning experiences in placement but it may also impact on their physical and psychological well-being. It is assumed that nurses normally want to do the best for patients, so it raises the question as to why individuals may behave in such ways towards students.

Savage (2011) suggests that the work-setting can influence how nurses behave. The culture can mitigate against professional practice, particularly when supportive and positive work settings are not available .This can lead staff to become anxious and cause them to act in defensive, negative and inhumane ways (Savage 2011). The ongoing quality monitoring process in relation to mentors does not appear to be able to identify those who have unprofessional values, attitudes and behaviours, even though there is a system in place (triennial review) to monitor this. However, such behaviour may be difficult to identify if this is the norm within the work setting or in the health care organisation.

Clinical placements have to be audited before students are allocated to them, and subsequently every two years (NMC 2010). It is assumed that this will identify any issues of unprofessional values and behaviours. However the data it provides depends on the composition of the monitoring tools used. The Nursing and Midwifery Council is beginning to recognise the value of working in partnership with other regulatory agencies (Jeager 2011) which helps them to identify areas of concern and to check how the risks are being managed. HEI's are now expected to know and respond in an appropriate manner to adverse reports regarding the quality of care in provider units from the Care Quality Commission. This can help to contribute to ensuring that students are allocated

to environments where care reaches at least the minimum quality standard. This may help to signal areas where there may be unprofessional or educationally unsound practices. However, the incidence of work abuse identified in this study and supported by the literature (Hutchison 2006, Randle 2003, RCN 2002, Stephenson et al 2006, Thomas &Burke 2009, Woelfle 2007) would suggest that this is a problem requiring further action. It is one that is worrying and concerning for service users and staff and should be examined further within the NHS to ascertain the extent of the problem and to develop actions to address this.

Individualised patient care

The new NMC education standards (NMC 2010) do not refer to holistic individualised care. However the domain of professional values does expect nurses to deliver person-centred nursing, which includes care tailored to the individual needs and choices of the service user, taking into account diversity, culture, religion, spirituality, gender, age and disability as well as practice in a holistic, non-judgemental, caring and sensitive manner. Thus the underpinning values of holistic individualised patient care are still evident within these standards. However, the demands for nursing in health care settings are technical competence and scientific rationality, trends that were identified by Peach (UKCC1999). This sets up contradictions and conflicts for nursing which are being played out in healthcare settings in the debate between positivism and humanism.

Playle (1995) believes that the development of nursing knowledge has favoured positivism with its underlying objectivity and reductionism, which excludes subjectivity and the personal at the expense of other epistemological forms. This, he believes, has given rise to barriers in delivering individualised patient care as it requires the integration of the art and science of nursing (Playle 1995). Further barriers are apparent from health care work organisational structures, such as task allocation which also mitigate against it (Melia 1987). If the NMC believe that the underpinning values in nursing continue to reflect the practice of

individualised nursing care, then more needs to be done to remove the barriers to its implementation.

The Future

The new NMC standards for pre-registration nursing education (NMC 2010) do not address some of the fundamental problems facing nursing in the 21st century which have been brought to light by this study. It is therefore unlikely that their implementation will fully address them.

9.7 Pedagogy

Nursing has always had, as a core value, an orientation to the holistically understood individual in context (Thorne & Sawatzky 2007). It is this unique relationship with the human being in context, which is fundamental to the discipline's vision and to how it views health phenomena. Such a stance requires nurses to develop knowledge that has been obtained through science integrated with that gleamed from other ways of knowing, including experiential learning and pattern recognition (Thorne & Sawatzky 2007).

In today's world, the demand for accountability has created a need for health care which can be defended by evidence (Thorne & Sawatzky 2007). This has led to tensions and conflicts between holistic individualised patient care as a core value for nursing, and society's trends for accountability and metrics resulting in confusion in the pedagogical stance for nursing. Student nurses are being prepared to understand and use evidence that directs them towards the population, the system and the underpinning knowledge base rather than towards the patient as a unique individual (Thorne & Sawatzky 2007). In practice they are exposed to clinical placements where the work is fragmented into its component parts and divided between members of the workforce, making it difficult for students to practice holistic individualised nursing care. To practice from this perspective involves using other ways of knowing gleamed from experience, as well as using pattern recognition. For students to learn this requires practitioners to cue the students into what they are seeing in the

practice situation to help them construct their actions whilst still using the evidence to underpin practice. Thus, key to the understanding of practice from this perspective is the context and the human beings involved. Where the focus is on the application of the evidence the human being and context are lost.

Ideally nursing needs to review its philosophical underpinnings and make a case for adopting a pedagogy that reflects that. However in today's reality, that decision is not under the control of the profession and will instead be directed by the NHS through its workforce agenda and fit for purpose requirements which are subject to an array of competing agendas and priorities.

9.8 Summary

Students need to learn the practice of nursing from practitioners who are themselves professionally and educationally competent. This will involve practitioners facilitating the students' learning experience and providing them with appropriate opportunities they can learn from. In nursing, this role has been given to mentors who are registered nurses. To undertake this function, the mentor has to plan, organise, and logically structure the learning resources available within the clinical placement. For this to happen, the mentor has to prepare the way for the students to access their community of practice, and registered nurses need to allow students to access and facilitate legitimate peripheral participation within their community. By doing this, students have opportunity to learn the practice of nursing from the professionals; the knowledge, the culture, the appropriate discourse of the profession. If the students are cued in to the practice situations they encounter, it gives them opportunities to recognise and apply their knowledge to individual unique cases they encounter in context.

In some clinical placements, with the fragmentation of nursing reducing the work into its components and the division of labour, students have problems in gaining access and legitimate peripheral participation with registered nurses. In these circumstances students are aligned to work alongside health care

assistants, and their access and participation with registered nurses is restricted. Students have more opportunity to learn the practice of nursing from the perspective of health care assistants, with their knowledge, culture, and discourse thus changing the focus.

This assumes that registered nurses are the appropriate group to direct and focus student learning, but only if they behave professionally as this learning will provide the students with understanding of the nature of nursing and shape their identity as registered nurses. Students in this study experienced work abuse, including bullying at the hands of health care workers. This is consistent with the literature that identifies this as a problem in nursing. The literature also suggests that such exposure can lead to the students adopting such behaviours as the norm in their desire to fit in and belong, which is then reflected in their care of patients. Although the students in this study did not reveal that they had adopted abusive practices, further exposure may result in a different outcome. This study has revealed a number of findings that impact on the practice of nurse education. The following chapter will discuss these.

Chapter ten

Conclusion

10.0 Introduction

This chapter will close the work of this study by drawing conclusions as to what this means for me as Placement Development Manager, pre-registration nurse education and the profession of nursing. I will also finish with a brief discussion as to my personal learning from undertaking this journey. I will identify what the study found and what can be done to resolve the issues. Each issue will be dealt with under a separate heading.

10.1 Belonging and modelling

This study found that in some placements students did not feel they belonged to placement and they encountered problems with modelling from the appropriate nursing professionals both of which impacted on their learning experience. They had difficulty observing and working alongside registered nurses which left them confused as to what registered nurses did. Although it is important for students to belong and to model themselves on registered nurses the following have to be read in conjunction with the measures taken to address failing communities as it is imperative that students do not fit into a placement by adopting unprofessional practices.

The following measures have been chosen to assist students to access and participate in the practice of nursing undertaken by the registered nurse as a means of helping them to belong:

- Develop strategies to assist mentors to facilitate students' access and participation within the community of registered nurses in the clinical placement and include these within the preparation and updating sessions for mentors and evaluate the outcomes

- Using the students' accounts of their tactics as a basis, develop strategies that students can use to increase their access and participation to registered nurses in clinical placement, and evaluate their outcomes
- Develop strategies that mentors can use to facilitate students' learning, including managing the learning resources and planning and organising learning opportunities for students
- Develop tools to monitor that students are working with registered nurses for the minimum period (40% of their allocated time in placement)

10.2 Developing an overview of practice

The findings from this study showed that students had difficulty in connecting the pieces in order to have an overview of the practice of nursing.

The following have been chosen to assist students to develop an overview of practice:

- Adopt and utilise a hub and spoke model of clinical placement experience clustering the practice experiences around clinical pathways and the patient's journey
- Develop outcomes for the assessment of practice documentation where the student has to follow patients' journeys under the direction of their mentor and present their studies
- Develop strategies to help mentors deconstruct and reconstruct their practice and include these in the preparation and updating of mentors and evaluate the outcome
- Undertake research into how to sequence the practice of nursing to enable students to get an overview by participating in the activities of the practice
- Use the findings from the research to develop strategies to help mentors do this

10.3 Conflicts and tensions

In bringing to light the students' stories it became clear that there were tensions and conflicts between students' expectations and understanding of the nature of nursing and the role of the registered nurse and the university and placement providers understanding of fitness for practice and purpose. Students normally did not see the basic nursing care of patients as providing them opportunity to learn the practice of nursing but in reality were often assigned these activities making them feel they were being used to supplement the work of the placement and they were confused over the role of the registered nurse.

The following measures have been identified to manage expectation and conflict:

- Build into the programme plans to manage the student expectation in clinical placement
- Develop conflict resolution strategies for use by students
- Build into the programme opportunities for students to practice using conflict resolution strategies
- Develop a learning outcome in the assessment of practice documentation that demonstrates the use of conflict resolution strategies in the placement setting
- Share the conflict resolutions strategies with mentors by including them in the mentor preparation and updating and develop with them how they can facilitate students to use them in their practice

10.4 Failing communities

Various forms of work abuse were identified from the students' accounts of their experience in clinical placement. The abusers were not confined to nurses but included other health care workers suggesting that the issue is not only within nursing. Exposure to work abuse can lead to students being acculturated into these ways of behaving. Although this was not the findings from this study the literature identifies that students and staff after exposure to work abuse adopt

such behaviours into their practice. This will ultimately affect the care given to the patients and the respect and dignity shown to them.

The following measures have been developed with a view of managing this issue:

10.4.1 Auditing of clinical placements

- Undertake research into measuring governance in communities of practice within health care institutions
- Develop governance measures that can be used by health care organisations to ensure that communities of practice are professionally and educationally sound
- Incorporate the essential factors for successful communities of practice into the auditing tools measuring the quality of placements

10.4.2 Curricular content for pre-registration nurse education

- Teach students what work abuse is and how to recognise it
- Develop strategies to help students be resilient, assertive and challenging as a means of helping them to stand up to work abuse
- Develop mechanisms that encourage students to report work abuse

10.4.3 Policy development

- Review and develop a policy for students to raise concerns that is clear and simple for use
- Develop support structures to support students through the process of raising concerns or reporting work abuse

10.4.4 Curriculum development

- Design and develop a values-based curriculum for pre-registration nurse education that reflects the values of the university and its partner provider organisations

- Design a framework from the values that students can use to reflect on their practice and build in regular sessions throughout the course where students have opportunity to do this
- As part of the reflective sessions help students to construct strategies that will help them to develop their practice underpinned by the values
- Develop an assessment strategy for practice that incorporates the value base

These solutions regarding curriculum development have been informed by the 2011 pre-registration nursing curriculum design developed by Southampton University.

10.4.5 Mentor preparation and updating

- Review and redesign the mentor preparation course that incorporates the same value base
- Develop strategies to help mentors facilitate students in using the value base framework
- Incorporate the measures already discussed under section 10.1 and 10.2 into the preparation course for mentors.
- Develop audit tool to evaluate mentoring practices, enabling good practice to be recognised and poor or abusive practice to be challenged

10.5 The university studied and its partner placement providers

Further work needs to be undertaken by the university and its partner placement providers to examine the concepts of fitness for practice and purpose in order to unpick what these terms mean, review the findings for compatibility and areas of tension and conflict and to develop clearer understandings of the terms that minimise areas of tensions and conflicts but still reflect the statutory and professional requirements. This should then be used to develop a clear vision and outcome for pre-registration nurse education which should then direct all decisions for pre-registration nurse education for

that university including curriculum development; mentor preparation; ongoing education; and placement planning and organisation. The vision needs to be communicated to all relevant staff and students and education planned to help them understand it. The implementation needs to be carefully planned and monitored to ensure that all those involved e.g. practitioners, students, and academics are working together for the same goal.

Curriculum for pre-registration nursing is changing to reflect the new standards for pre-registration nursing (NMC 2010). The findings from this study and the above work should help to direct the design and development of this new curriculum. As well as the curriculum being designed and developed the mentor preparation and updating should be reviewed and rewritten to reflect the developments of the new curriculum.

Further research should be undertaken to ascertain the prevalence of work abuse and the findings acted upon.

10.5.1 Other universities and their partner placement providers

It is probable that a number of issues raised are not unique to this university but are common problems in other universities. It would therefore be useful for other universities to examine the issues outlined in this study to identify if these are prevalent in their institutions. Although the underlying principles in relation to the measures taken to resolve the issues may form a basis of actions to be taken other universities will need to develop their own which take account of their unique situation.

10.6 National level

The key stakeholders responsible for directing pre-registration nurse education need to ensure that their statutory and professional requirements are clear and compatible and give the profession of nursing a clear vision for the future.

10.7 Dissemination of findings

The findings from this study need to be disseminated within the profession of nursing. The following are the methods I hope to employ to achieve this:

- Present study and findings to nurse education colleagues at the university and to our partner provider colleagues
- Present study and findings at national conferences
- Prepare and submit academic papers of the study and findings for nursing journals
- Use the knowledge gained from this study to lead and direct the writing of our clinical component for the new pre-registration nursing course

10.8 My journey

My journey was sparked by a request made by a student who wanted to change her placement as she did not want to do the "vile work" of nursing (meeting the physical care needs of patients). I initially thought that the student had chosen the wrong profession or that our selection of students was wrong. This study has given me greater insight and knowledge relating to learning in clinical placement and the construction of identity. I now have a more in depth understanding behind this request. The process has enabled me to grow and develop personally and professionally. I have developed determination and resilience and developed further skill in searching out answers to meet the challenges that were posed by the study.

It has opened my eyes to aspects of clinical education I did not see in the past including the confusion students experienced in relation to the conceptualisation of nursing and the role of the nurse, the difficulties students face to belong and fit in, and the loneliness they experience. I was heartened to discover that the students often displayed care and compassion within their accounts and how they tried to hold on to these values even when they were exposed to abusive behaviours. I was troubled by their accounts of their experiences of work abuse. I was surprised by students' active involvement in

their learning which showed great determination, resourcefulness, creativity and innovation which mostly goes unnoticed. I am determined to use the knowledge and skill obtained to lead and direct developments within the clinical education component of pre-registration nurse education.

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Appendix one

My story (the prejudices and the biases)

Introduction

This is an insight as to how my experience has shaped my understanding of nursing. It attempts to reveal my prejudices and biases that have developed from my experience of living in the world.

The beginning of my story

My story begins when I was challenged about my beliefs about my concept of nursing from students on a pre-registration nurse education course (adult branch) during my employment at a university in England. Their views of nursing were reflected in conversations where they requested to change placement to avoid participating in meeting the physical care needs of patients such as washing, dressing and mobilising. I believed in individualised holistic nursing care. I had never conceptualised basic nursing care as not being part of nursing nor as "vile work" which some students referred to it as. The essence of nursing for me was caring for patients in a variety of circumstances which included helping them to meet their basic needs when they were unable to do this for themselves. Caring is at the heart of my understanding of nursing. Asrif (2009) describes caring as involving compassion and thoughtfulness, consideration and mindfulness and vigilance and safe keeping. This was what nursing was all about in my mind. I wanted to understand what the experience of placement was like for the student in a bid to begin to understand their requests. I was curious as well as being unsettled as I was shaken out of my reverie as to my understanding of nursing. I placed students into placements every day. I wanted to find out more about the student experience and why students had this idea about nursing.

My experience of nursing

I really started my nursing career when I was 11 by becoming a voluntary worker in the local ear, nose and throat hospital. Even after all these years I can still remember that Monday night when my dad took me along to the hospital to meet the matron. I was so excited. The matron told my dad that I was too young but after some discussion it was agreed I could start. Off I went every Monday evening 6-9pm for approximately the next 5 years. There was no CRB (police check) no paper work I just turned up and started. Even after all this time my memories still produce excitement. I loved that experience. Just being there, the smell yes I can still smell the place it was of hospital. I spent most of my time in the kitchen helping the staff wash and dry the dishes and then having tea with them afterwards but just being in this environment was enough for me. As a treat I was sometimes allowed to have tea with the nurses and I remember listening to their stories and conversations with awe. I was also allowed onto the wards. There were three wards male, female and children's wards. I can still picture these with the long corridor connecting them although they are long gone and in its place is a series of flats. I would fetch and carry things but at times I actually got to help patients. I remember holding a child's head while they vomited and being asked for a slipper by a male patient and having to ask why he only wanted one and not two not realising that it was a urinal he wanted. This experience only reinforced my desire to be a nurse. I consider this to be my first experience of nursing and the start of my career in nursing.

Becoming a registered nurse

I was educated at Edinburgh University where I undertook the Bachelor of Science degree in Nursing Studies. I found out about this course from the family doctor who knew about my desire to be a nurse. He listened to what you had to say and was interested in you as a person. To this day I can't believe how insightful this GP was and how lucky I was to have met him and been given this sound advice. Getting on the course was a challenge. Making a difference, helping others and caring for others are common reasons given as to why

individuals choose nursing as a career (Andersson 1999 Mackintosh 2006). I was asked why I wanted to be a nurse and I replied I just did but why I don't know. I said I just know this is what I want to do. I did not analyse my reason for nursing it just seemed a natural choice. The course as I remember was hard work but exciting and enjoyable. A number of leaders in nursing were in the Department of Nursing Studies when I was reading for my first degree including Alison Tierney my clinical teacher, Winifred Logan, Anne Monday, Annie Altshul, Ruth Schrok, Rosemary Crow and Nancy Roper to name just a few. The place buzzed with excitement and I was encouraged to explore and develop including going abroad during the course to experience nursing.

The course as I remember was based on the underlying principles of holistic individualised nursing care which was a new way of looking at practice particularly in the early 70's. The course was reflective of new nursing. I spent most of my placement experience at Edinburgh Royal infirmary mainly organised during the last 18 months of the course after completing the theoretical elements of the course. I did have some experiences in other institutions including an experience in a hospital in Toronto Canada. This experience was memorable as the ward delivered individualised holistic care and for the first time I saw how this conceptualisation of nursing could be applied in practice.

I remember that I enjoyed my placement experience during my course although we did stick out like sore thumbs in our white dresses. This did make us different from the rest however I managed to fit in. I remember that I made a point of washing lockers cleaning the sluice to show that I was willing to muck in and I have no memories of being treated badly on placement. This could have been because being treated badly was the normal and therefore did not stick out or more likely I didn't have bad experiences on placements. This course as well as providing the knowledge and skills required to practice nursing was part of my socialisation into the profession of nursing. The process of socialisation involves the marrying of previously held beliefs assumptions and expectations

with the reality of practice to shape and develop an individually held construct of reality (Price 2009).

Working life as a registered nurse in nursing practice

My socialisation into the profession of nursing has been further shaped by my occupational experiences. After satisfactorily completing my course and becoming a registered nurse I was employed at Edinburgh Royal Infirmary in a male surgical ward. This experience was a happy and enjoyable one. After leaving Edinburgh I went to nurse in America. I began this experience in a small 35 bedded hospital in a small town 100 miles west of Houston Texas before migrating to work in a large hospital in the centre of the medical centre in Houston. It was during this experience in America that I was surprised to find that normally registered nurses did not undertake bedside nursing. This had not been my experience in the past and I had always been used to being involved in the direct care of the patients including meeting their basic needs. However on this occasion this was undertaken by either the licensed nurses or ward aides and I did stand out as being different when I tried to help. When I moved into Houston to work in a larger hospital the experience was more marked.

During my time working in Houston as a nurse my work consisted of either being an administrator /advisor of nursing care or an administrator of patient medication. As an administrator/advisor of care I was responsible for managing and supervising the nursing care of the patients on the floor (in the ward) during the shift. This role partly involved assessing patients at the beginning of the shift and using this information to direct the care of the patients during the shift and transcribing "doctors' orders" which I would then ensure were implemented. As an administrator of patient medication I had responsibility for administering the patients' drugs as prescribed. This involved dispensing and administrating the patients' medications for the shift at the exact times prescribed on the medication chart. This was a significant change to my previous experience where drugs were administered at pre set times throughout the shift. Although nursing in Houston was an interesting experience I missed the patient contact

particularly the rapport with the patients. I found that I sorely missed being involved in direct nursing care.

I continued to nurse on my return from America. I undertook a course in oncology nursing at the Royal Marsden where I remained as a staff nurse on successful completion. It is interesting to note that during this time there was a movement within the Marsden to change nursing care to incorporate individualised holistic nursing care which I felt at home with. This view of nursing was evident in the hostel ward where I staffed after completion of the course.

After staffing at the Marsden I was employed as a ward sister on a burns and plastics ward in London where the care was individualised and holistic.

Work experiences in nurse education

I moved into nurse education in the 80's and completed a diploma in nurse education that enabled me to register as a nurse tutor. I was employed as a nurse tutor in a school of nursing in London which used a medical model approach to nurse education which was reflected in the design of the course and the teaching strategies used. Teaching sessions included such topics as the nursing care of a patient with a myocardial infarction. The medical model views the patient in an objective way from the perspective of their disease. This approach is seen to be narrow and reductionist which can lead to care becoming fragmented. Such an approach has the Cartesian effect of separating the mind from the body. I found this to be alien to my previous learning and experience of nursing and struggled with the conflict that such an approach had to my conception and understanding of the person and nursing. This approach to nurse education did not reflect the caring, holistic healing view of nursing that I believed in.

I have had experience of two other schools of nursing during my career in nurse education and I have lived through many revisions and changes including Project 2000 and "Making a Difference" reforms. I found part of this time extremely challenging because of the fear of being made redundant. This was

particularly worrying as I had just come through a divorce and was the sole provider for my young son. It was also a distressing time as you were competing with colleagues some of whom were your friends therefore success was often tinged with guilt and loss.

I had the privilege of working with some colleagues who were gifted and creative and who shared my vision of nursing. These were some of the most exciting and rewarding times in my nursing career. It was around this time when discussions were afoot regarding the move of nurse education from schools of nursing into higher education institutes. I was very excited as I believed this is where nurse education should be as I firmly believed that nursing would benefit from the expertise of a university. I think I based this decision on my prior experiences of being a student at university a period of my life which was stimulating and exciting and I wanted nursing students to have the opportunity to be exposed to this. I firmly believed that such a move would provide the foundation that nursing required in order to further develop although I am not sure now that I fully understood why or could articulate this. I believed in the vision of a registered nurse being educated at a university to become a "knowledgeable doer". I was excited about this new development for nursing but totally naive as to the potential consequences for my profession. Carr (2008) summarises these changes as impacting on the nature of nursing, selection of future nurses and models of nurse education.

Care according to Woodrow(1997) consists of two elements the expressive component relating to meeting the patient's psycho social and emotional needs which some have described as relating to patients on a human level and treating them as individuals (Savage 1990) and the instrumental component consisting of the technical aspects of care. The change appears to be in the focus given to these elements. Today the emphasis is more towards the technical aspects of care where the students focus more in developing the technical skills (Kenny 2004). This split between instrumental and expressive care mirrors the separateness of the science and humanities found in our

universities. Such an emphasis can hide the individual characteristics of the patient's health care needs (Chan 2002). Nursing requires both the sciences and humanities in order to practice. Such a split not only makes the integration of these components more difficult but can also detract from the caring and humanistic philosophies (Benner, Tanner & Chesla 1996) associated with nursing.

The profile of those being recruited into the profession of nursing has also changed reflecting the widening of the entry where recruits are more mature on entry as well as some students who have more difficulty making the transition into higher education due to their lack of confidence with literacy and numeracy skills (Carr 2008).Cohort sizes have fluctuated but have tended to grow in size influencing the teaching strategies used. The courses are now planned and delivered in partnership between the university and health care organisations which impacts on the students as they have to juggle between the different cultures and value systems of education and practice during their clinical placements (Carr 2008).

During my time in education I have had various roles including teaching, course planning and organisation. My gravitation towards nurse placements within pre-registration nursing happened slowly. I suppose it began when I was working to bring in the first Diploma course with a colleague; one of my responsibilities was to ensure that the placements for students were available and planned. This role began to feature more and more in my every day working life and it was something I not only enjoyed but one where I also found challenge and stimulation but for many of my colleagues they found it less appealing , less worthy and the poisoned chalice. I have now been responsible for ensuring the availability of nursing and midwifery placement requirements within a higher education institute for a considerable period of time.

Summary

The information contained within this appendix has been written in an attempt to show my prejudices and biases which will influence the interpretation of what I have found during this research. I have worked in nursing except for a few weeks surrounding the birth of my son. My initial education and subsequent experiences have had a significant influence on how I understand the nature of nursing which is a bias that has influenced what I chose to study as well as the interpretation of the findings. I will also come to this study as a white middle class female who has had the personal trauma of divorce and bringing up a young son on my own. These experiences have also shaped me and will influence my interpretations.

Appendix two

Research letter

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Dr Linda Merriman
Dean of Faculty

Nursing, Midwifery and Health Care
Richard Crossman Building, Room 403

Direct Dial 024 7679 5899
Email: J.AstleyCooper@coventry.ac.uk

January 2007

To whom it may concern

I am writing to invite you to participate in a study entitled: The Experiences of Adult Student Nurses in Clinical Placement. The purpose of the study is to describe and analyse the experiences of student nurses learning and being taught in clinical placement.

I am currently recruiting student nurses from years 1, 2 and 3 of the pre-registration adult nursing course who have completed at least one clinical placement experience, to participate in this interpretive study.

Participation involves being interviewed by me (the researcher), normally twice. The interviews will be non-structured and conducted at a date, time and place of your convenience. The interviews will last approximately 45-60 minutes. The initial questions asked by the interviewer will take the form such as:

"As you think about your experiences as a student nurse in clinical placement, please describe a time that stands out for you because it reflects what it means to you to be a student nurse."

The interviews will be audio-taped and transcribed verbatim into a written text by a transcriptionist. All tapes will be stored securely until the completion of the study. An electronic file of each interview will be saved in a password protected database and hard copies of transcribed interviews will be stored in a locked filing cabinet until the completion of the study.

Following the initial interview I may contact you for a follow-up interview for the purpose of exploring further events and issues from the first interview, clarifying meanings and for your reflections on the interpretation of the text developed from your first interview.

It would be a privilege to have you participate in this important project. With your help this study will contribute to developing a better understanding of how student nurses experience clinical placement, which will help to inform nurse education. If you would like to discuss this further, please do not hesitate to contact me by telephone (024 76 795899) or email at J.AstleyCooper@coventry.ac.uk

This study has been approved by Coventry University's Ethics Committee. An information sheet is attached. If you are willing to participate in the study please contact me by telephone (024 7679 5899) or email at J.AstleyCooper@coventry.ac.uk or at the following address: Room 403 Richard Crossman Building, Coventry University, Priory Street, Coventry CV1 5FB when I will answer any questions you may have and will schedule an interview at a mutually convenient time.

Thank you for your consideration.

Jean Astley Cooper

Faculty of Health & Life Sciences
Direct Line
Fax

www.coventry.ac.uk

Appendix three

Information shee

THE LIVED EXPERIENCES OF STUDENT NURSES IN CLINICAL PLACEMENT
INFORMATION SHEET

VERSION NUMBER: 2 **DATE: JANUARY 2007**

Introduction
I would like to invite you to participate in this research study. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part it is important for you to understand why this research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or you would like more information.

Why am I doing this study?
The purpose of this study is to describe and analyse pre-registration adult nursing students' experiences of learning and being taught in clinical placement in order to identify common patterns and shared meanings which will inform the practices within nurse education.

How do I plan to find out this information?
I am asking first, second and third year student nurses enrolled on the pre-registration adult nursing course at Coventry University to participate in a series of two interviews to explore in depth their experiences of learning and being taught in practice placement.

Can you participate?
If you are an adult student nurse enrolled on the pre-registration nursing course and have had experience of practice placement, and are willing to share these experiences in depth, I am keen to hear from you.

What does taking part involve?
If you would like to take part in the study after reading the information sheet can you please contact me using the contact details provided, or in person, to arrange an interview at a date, time and venue convenient to you. This, normally, will involve a series of two interviews. The initial interview will last approximately 45-60 minutes, the second interview may be shorter, and will be arranged at your convenience. It is important that you are willing to describe in depth your experiences in clinical placement.

Is the information you provide confidential?
Yes. The researcher only will know the identity of who is participating in the study. Please also note the following points with regard to confidentiality:

- Interviews will be anonymised and anonymity will be further sought by carefully editing the content, including removing any references to names, places and institutions that could lead to identification.
- Consent forms will be filed separately from the interview data.
- Interviews will be given a reference number which will be used to identify the data collected.
- Computer discs and all paper, including notes, will be stored under lock and key when not in use.
- Computer screens will not be left unattended when displaying confidential information pertaining to the study.

- Security measures will be put in place to prevent unauthorised access to data stored on the computer.

How will the information provided in the interview be used?
This information will be used to produce texts from which interpretations will be developed. You will have the opportunity to comment at the second interview on the text produced from your initial interview to ensure that this reflects your experiences accurately or to clarify meaning. The interpretations will be used to identify common patterns and shared meanings, which can be used to inform the practice experience in pre-registration adult nursing programmes. I will write a thesis which will be part of a taught doctorate programme being undertaken at the University of Wales in Swansea. Articles will be written for professional journals and I will talk about what I have found at professional conferences. I (the researcher) will own the data and I will be responsible for ensuring, within reason, that the interests of the research subjects are safeguarded.

What are the risks of taking part?
The risks to you from taking part in this study are minimal. Although unlikely, it is possible that you may be upset as a result of sharing your experiences of learning on placement. Support would be available to you.

How long will the study last?
The data collection will take approximately one year. However the study is expected to take a minimum of two years up to a maximum of four years.

Who to contact for more information
Jean Astley Cooper
Telephone Number: [redacted]
Email address: J.AstleyCooper@coventry.ac.uk
I can be contacted at: Room RC403
Richard Crossman Building
Coventry University
Priory Street
Coventry
CV1 5FB

I am happy to answer any questions you may have so please do not hesitate to get in touch.

Taking Part
Thank you very much for taking the time to read this information. I would be very pleased to hear from you if you want to participate. Please contact me in person, by phone, e-mail or in writing using the contact details provided above to arrange an appointment.

Appendix Four

CONSENT FORM

TITLE OF THE PROJECT: **THE LIVED EXPERIENCES OF STUDENT NURSES IN CLINICAL PLACEMENT**

STUDENT IDENTIFICATION NUMBER FOR THIS RESEARCH PROJECT:

NAME OF RESEARCHER: **JEAN ASTLEY COOPER**

You are invited to participate in this research project designed to explore adult student nurses' experiences in clinical placement. Participation is completely voluntary. If you wish to participate please initial and sign this consent form.

I ..... (Please print name)

	Please initial in box
• confirm that I have read and understood the information sheet dated ..... (Version 2) for the above study and have had the opportunity to ask questions	☐
• understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my course of study or my legal rights being affected	☐
• consent to the interview data collected on me being analysed to construct (anonymous) interpretations which will formulate the submission of a taught doctorate programme	☐
• consent to findings of this research being presented publicly	☐
• agree to take part in the study	☐

Signature .....

Date .....

Appendix five

Summary of Decisions

Lincoln & Guba (1985) believe that the inclusion of the decisions made and the decision making process throughout the study undertaken contribute to the assessment of rigour. For this reason I have included a table containing a summary of my decisions regarding this study.

Summary of decisions	Cross reference in thesis
My interest in the topic is related to my work as placement development manager at a higher education institute and began when I became aware of students wanting to change their placement to avoid doing the vile work of nursing. I remember at the time being shocked and taken a back and found it at odds with my conceptualisation of nursing. My conceptualisation of nursing was of individualised nursing and I began to question the students choice of career pathway or the selection strategy in relation to choosing prospective students. I remember not being satisfied with these reasons and wanted to explore the topic in more depth to try and understand. I had a feeling that I I needed more in-depth knowledge to help my decision making regarding placement organisation.	Chapter 1 Appendix 1 Chapter 1
My interested in the students experiences of clinical placement led to the development of the research Question.	Chapter 1
The literature review was for me a challenge as the topic was complex and far reaching. I found it difficult to know where to start but decided to look initially at the purpose of clinical placement. The literature review was developed through the course of the study and the process was like peeling an onion. As I read the literature it gave further insight into those factors which promote clinical learning. This provided the basis for the next stage of literature review. Again this literature provided the basis for further searching to understand those aspects that hindered learning. I felt it was important to attempt to discover how learning was being affected by these factors. As I read the literature I was aware that each issue was dealt with separately and I was interested to find out how these interrelated and impacted on the students experience in placement. This was not evident from the literature and required me to put the pieces	Chapter 2

together.	
Philosophy, Methodology A number of reasons led me to undertake a Heideggerian Hermeneutical phenomenology. These included • I had been introduced to the philosophy of Heidegger in year 1 of the course • Having been introduced to Heidegger's view of the person and the world during the philosophy module in in year 1 it resonated with my beliefs about the person and the world. • I was very interested in the experiences of student nurses in clinical placement and this methodology lent provided me with the vehicle to examine and analyse experience. • I felt it could provide me with further understanding that would inform my work	Chapter 3 Chapter 1
Interviewing I decided to use in-depth interviews as the method to collect the data for this study as this would enable me to capture students experience of clinical placement. However although I was an experienced lecturer with communication skills I was not confident about undertaking these research interviews so made the decision to attend courses in America which included interviewing. This helped me to develop opening questions to commence the interview and also how to use prompts to explore the students understanding of the things they talked about. I was initially nervous at the start of the interviewing process but relaxed as the interviews progressed. I employed strategies to try and facilitate the co-construction of the data	Chapter 3 Chapter 3 Chapter 3
Sampling My decisions regarding sampling were made to ensure I had students who had experience of clinical placement. I also had to fit my doctoral studies around my full time work commitments and responsibilities. Taking these things into consideration and reviewing the literature I decided to go for a non-probability sample.	Chapter 3
Data collection As I did not want to be distracted from being able to respond spontaneously in the interview I made the decision to tape the interviews unless the student(s) objected.	Chapter 3

Data Analysis I wanted to get to know the data including not only the words but how these were being spoken therefore I transcribed all the interviews myself. Even though this took hours of work I felt it was well worth it as it helped me to become familiar with the data. I also did not want to miss anything vital from the data which influenced my decision to transcribe them in full. I needed to employ a strategy for data analysis that reflected the overall framework of the study. As there were different strategies to choose from I found it difficult at first but decided to choose thematic analysis using line by line approach for a number of reasons including • .I could understand this approach. • It was thought that there was opportunity to err or to see meaning that is idiosyncratic. • It fitted into the overall framework of the study • It had the potential to produce the desired • outcome i.e. to identify common patterns. This approach was very time consuming as it involved many stages but enabled me to become submerged in the data. When reviewing each sentence or sentence or sentence cluster I felt I had to go beyond the words to interpret the meaning. I had to keep going backwards and forwards between individual transcripts and the whole. It involved me being sensitive to the data and open mind I felt this helped me to be within the hermeneutic cycle	Chapter 3 Chapter 3
Findings I should not have been surprised by some of the findings of this study as the clues were available within the literature however I still felt some degree of shock as well as being humbled that the students had shared these experiences. I had had difficulty putting the pieces together to see the phenomenon as it was complex and multi faceted. I eventually after much thinking could begin to see the connections with the theory of situated learning by Lave and Wenger and I made the decision to use this theory as a tool to synthesise the data to help bring it altogether.	Chapters 5-8