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AN EXPLORATION OF THE SHIFTING IDENTITIES OF PRE-REGISTRATION NURSING STUDENTS ACROSS A BSc ADULT NURSING PROGRAMME

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Abstract

The adult student nurses of today are continually challenged to negotiate the meanings of their experiences as members of different communities of practice, both as students of a university and also in the myriad of clinical placements that are so integral to their achievement of fitness for registration by their professional body. This study aims to explore the shifting identities of pre-registration students across a BSc adult nursing programme and gain deeper understanding of their participation in both university and clinical practice. Adult nursing students are currently attempting to develop, achieve and learn how to be a nurse in a challenging, ever changing context still reflecting on several high profile scandals and reports of poor care and less than ideal nursing practice. These events have led the profession, public, politicians and media to question the values, skills and principles of those who are choosing to take up nursing and question if nurse education is producing the necessary empowered, confident caring staff and strong leadership essential to ensure the delivery of optimum clinical care.

This thesis details a qualitative study exploring the experiences of student nurses and how the communities they find themselves in construct their identities and is an investigation of their perceptions and understanding of nurse identity and what they believe it means to 'be a nurse'. Focus groups and interviews were completed with students in each of the three years of a BSc adult nursing course at a university in the north of England and a systematic thematic analysis of the data undertaken. The three main themes that were generated were:

Becoming a nurse

Engagement with old timers

The University - Practice dissonance

The findings indicate that participation in clinical practice and university produces a perception of intellectual power in the students that sustains them and helps to offset any negative experience in clinical practice and helps maintain a belief in their unique roles as positive change agents and 'nurses of the future'.

The recounting of their experience highlights significant problems with the apprenticeship model and challenges the belief that apprenticeship type approaches are necessarily a guaranteed way to promote positive outcomes, quality and any reduction in the likelihood of further failures of care in the healthcare environment.

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Acknowledgements:

Firstly, I would like to express my sincere gratitude to all the participants in this study who kindly agreed to take part and give up their valuable time; without them this thesis would literally not have been possible. It was a privilege to spend time with them and share their fascinating experiences. I wish them all well and have great confidence that they will make a significant difference as their nursing careers progress.

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Chapter One: Preface

This thesis explores the shifting identities of adult nursing students across an undergraduate BSc nursing programme. In this chapter I will briefly recount my own personal and professional background and the context that prompted my initial deliberations and explorations into the experiences of student nurses. On reflection there were probably two main, long standing - and long exasperating - preoccupations that came together to drive my determination to undertake the research project; contribute to the literature and the body of knowledge that supports the nursing profession and, critically for my own motivation, help clarify my thinking on a significant professional issue.

Undoubtedly, my research interests were influenced and framed by my enduring reflection on the major professional and national policy discourse regarding the current context of nurse education, the fitness for purpose and fitness for practice of the contemporary adult nursing student and the purported association of current educational priority and philosophy with several high profile national scandals related to poor clinical practice. Plans to undertake the study were unquestionably prompted by my disquiet concerning the political and social narrative appearing to assume that something was fundamentally 'wrong' with the current philosophies of care of the newer, university educated students in the adult field and registered adult nurses. My experience of teaching many students and undertaking the role of personal tutor and clinical link tutor – a supportive and facilitative liaison role whereby nurse academics are available to support clinical staff *and* nursing students during their placement experience in a specific, designated clinical area - had reassured me that the values and philosophies of care evidenced and articulated by the students were very much in line with the values espoused by the professional guidance and literature and, indeed, consistent with the needs and beliefs of patients and service users.

The second, equally important subject that had periodically occupied my thinking for many years was my attempt to comprehend, with any level of confidence, the concept of identity. On leaving secondary education I had studied a BSc in philosophy at university until my early twenties and can still vividly recall how, in an examination, I had been challenged by a question entitled: '*What makes me the same person I was yesterday*?'. This had fascinated me ever since, and had particularly resonated when on several occasions after I had become a registered adult nurse, I had heard relatives of patients that I was caring for, use phrases such as: '*He is not the same person since he had his stroke*' or '*she is not the same person since she's been on this medication*'. I have, therefore wrestled with the concept of identity for some years and it had

also become clear to me that the concept of identity was also key to understanding nursing and the shifting identities, characteristics and selves of those student nurses who were now under the spotlight in relation to their practice, behaviours, values, suitability and fitness. Following several discussions with a colleague in the Department of Psychology I was encouraged to explore further the concept of identity through the lens of Lave and Wenger's (1991) work on communities of practice as a means of further contextualising the student nurses' experience.

1.1 Background

As a registered adult nurse and subsequently a teacher in a Professional Development Department in an NHS Trust for some years, and as a lecturer in a university for several more, I had reflected on the circumstances of nurses' learning and development on many occasions. I have experience of the differing views, perspectives and espoused values of many registered nurses and student nurses as they progressed through their various careers. In the early 2000's, in a previous role as a nurse teacher in a local Trust I had responsibility for the provision and evaluation of mentorship and preceptorship courses for registered nurses which made me well placed to gain insights into the experiences, thoughts, beliefs and identities of those who, both individually and in groups, took significant responsibility for the support, development and assessment of learning of the future nursing workforce. The articulated learning outcomes of such education provision were invariably related to how best to support and engender learning within students or more junior nurses. This aspiration to meet necessary and essential outcomes promoted significant and frequent reflection on my part and also promoted substantial discussion within the groups, whether spontaneously or as a result of encouraged facilitation within the study sessions themselves.

Discussions invariably included consideration of the shifting identities of the current student population or the changing requirements, support and guidance of their newly qualified colleagues. Inherent in such discussions for some of the nurses was a fundamental belief that the current system was flawed and resulted in student nurses who were not 'fit for purpose' although it was often accepted that this was not necessarily through any fault of their own (Gilbert & Brown, 2015). Discussions would include how to get the 'right' student nurses on the adult nursing course in the first place, and how to subsequently ensure an experience that helped shape their identities appropriately to guarantee they became 'good nurses'. Other passionate arguments included how some commentators felt confident in the qualities and competence of the future adult nurses or, conversely, others who believed that things may have

'gone wrong' and what might be responsible for this (Willis, 2012). These deliberations had been further crystallised by the decision, after several years of professional and political debate, to concede that nurses would be best educated in universities and with a related move from training within hospitals. In 2004 the Royal College of Nursing (RCN) voted for degree only preparation for nursing registration, and by 2009, with the support of the Nursing and Midwifery Council (NMC), all nursing courses in the United Kingdom (UK) were to be at degree level by 2013 (Department of Health, 2018).

My personal move to a career in Higher Education therefore allowed me a differing perspective and insight into the potentially conflicting priority assigned within such complex debates. These insights were gained from a variety of sources, whether as a module leader and lecturer on a variety of undergraduate modules on the BSc and Diploma undergraduate nursing courses, as a personal tutor to adult nursing students experiencing the challenges and changing expectations that were intrinsic to their successful progression; as a facilitator of Mentor Update sessions within a variety of local hospital Trusts and also subsequently as Director of Health Partnerships for the School of Human and Health Sciences. These various roles and the responsibilities, accountabilities, experiences and insights that they brought made me frequently consider the experiences afforded to student nurses and the communities they were part of and how this related to the construction of their identities, their burgeoning and changing understanding of nurse identity and what they believed it meant to 'be a nurse'.

Discussions with the various stakeholders in this complex set of circumstances indicated that student nurses were being shaped by the variety of experiences within a variety of different environments or communities. The two most obvious being the communities they experience whilst in university and those that take up the other 50% of their degree – the various communities of clinical practice. It also became recurrently clear that many students were gaining experience in communities that were challenging their fundamental beliefs about what nursing was and what nurses needed to know. Their experience was confronting them with profoundly differing epistemological and ontological perspectives.

The nursing curriculum allows a variety of pedagogical approaches and it would be wrong to assume that 'lecture' is the unique and only teaching and learning approach. Students also experienced smaller group seminars, spent time in simulation suites, and so on, and could recognise the value of such variety but were also able to articulate a recognition of the potential dissonance that these experiences in different communities can generate. I had many

discussions with students who would frequently question the value and relevance of some sessions in relation to their fundamental aspiration of 'being a nurse'. Although several students were clearly challenged by the environment of clinical practice and the support they received there; others sought further time in the 'real life' of practice where they felt more like a 'real nurse' and could be involved in practices that they believed more genuinely advanced their progress to achievement of successful professional registration.

Several students appeared to quickly recognise that, what they viewed as, equally effective learning took place outside of their relationship with the official curriculum as represented by the traditional dyad of teacher/lecturer and student. For example, the mutual support engendered amongst their peer groups was often articulated as more beneficial to their progress than the groups and experiences more officially facilitated by the school and the academic body (Green, 2018; Rohatinsky & Harding, 2017).

Reflexivity on my part was also prompted by regular and frequent meetings with clinical colleagues to discuss individual student's progress, mentor update events, clinical link meetings and meetings with senior management colleagues to discuss shared strategic priorities. The discussions, not surprisingly and appropriately, often involved exploration of the care experience of patients and the student's actual or potential contribution to the established teams within the particular organisation. Debates often related to the students' readiness and preparedness for the challenges of modern healthcare practice, their ongoing development or hindrances to their progression and their overall needs and requirements. These discussions were attempts to explore the students' potential contribution to the specific and local setting but were also within the ever-changing context of national and international, social and political priorities of health care. It was always necessary to remain cognisant of such influence and changing priorities; together with the necessity to retain currency and focus for student development and related patient safety.

1.2 The current nursing curriculum – fit for purpose?

My considerations led me to believe that there might be an inherently problematic assumption underpinning the delivery of much of the nursing curriculum within the university sector. It became clear to me that the central paradigm conceived of learning as principally involving the student, in some way, acquiring a formal body of knowledge essentially *from* an expert. For example, for many nurse education roles, being a registered nurse is mandated by the NMC (Nursing & Midwifery Council, 2018) with a certain amount of experience, evidence of which

was time spent 'in the field'. These are experts who had in some way 'paid their dues' and were now, for a variety of reasons, often very laudably and altruistically hoping to 'pass on' their knowledge, experience and expertise to the next generation of the profession. On several occasions colleagues expressed the view of themselves, not as academics, but as essentially 'nurses who like to teach'. This is not highlighted in anyway critical of colleagues or their perceptions of their position in academia - however it is evidence of their view of their role in the learning of students.

My impression was that the traditional pedagogical philosophy could be represented by students, essentially, being recipients of learning via the contribution of an expert. The 'worst case scenario' example of this *might* be the experience of a student on a nursing degree at university studying a module with very clearly articulated, assessed and broadly non-negotiable outcomes; often as a member of a group of hundreds of other students, most of whom they don't know, in an enormous lecture theatre with a traditional lecture delivered by an academic colleague, who they had no previous relationship with, delivering content against set outcomes and in a circumstance that discourages individual discussion and engagement. One can only assume this will remain an ongoing issue should the initiative to attract more adult nursing course applications be a success; although evidence indicates that applications for nursing courses in the UK have fallen by approximately a third in the last two years, which amongst other things, may further compromise the likelihood of recruiting the 'right students' on to the adult nursing BSc programmes (Stephenson, 2018; UCAS, 2018).

Attempts to address this apparent disconnect inherent in the central educational paradigm; such as the 'facilitation' of smaller groups - notwithstanding the resource intensive nature of such strategies - still position the individual student as amassing knowledge and skills in some way due to the contribution of an expert and the implication of an unproblematic passage of knowledge and skills from one individual to another.

Moreover, there was also an oft expressed view that the nursing students, who colleagues had responsibility to teach were 'adults' the implication being that, as such they should be able to successfully manoeuvre themselves around the complexity of the undergraduate experience without too much help, beyond being the beneficiaries of the expertise of academic staff. These discussions often involved consideration of students who were not progressing as might be hoped - or shared reflections on a teaching experience that had not 'gone quite as well as

expected'. The inference of such discussions appeared to be that the student, or group of students, had not been an appropriate 'recipient' of the teaching for whatever reason.

Fundamentally this philosophical approach, to a large extent, removes the student from their social context and ignores, or at least reduces the significance of, the cultural process of socialisation and the social construction of a professional identity.

These contemplations therefore encouraged me to explore the conceptual approach of situated learning as articulated particularly by Lave and Wenger (1991). Situated learning as proposed by Lave (1988) - and others such as Dewey (Pring, 2014) and Vygotsky (Gredler & Shields, 2008) - suggests that learning is inextricably linked to authentic activity, context and culture. Whilst behaviourist theories and cognitive theories explain knowledge as in some way external to the world (Olson & Hergenhahn, 2016) - whether that be behaviours or internal processes and structures - situated learning essentially claims that learning is doing. Learning is a process that takes place in a participation framework, not in an individual mind (Lave & Wenger 1991). There is recognition of the essential interaction between individuals and the environment and that learning is situated within the activity in which it takes place. Knowing is inseparable from doing, as all knowledge is situated in activity bound to social, cultural and physical contexts. Cognition can never be separated from context (Lave & Wenger, 1991) - as opposed to an assumption that understanding is more concerned with the storage and retrieval of conceptual knowledge. Therefore, rather than the transferring of facts and rules from one person to another, learning is a process of social activity with emphasis on issues of identity, participation and membership in a community. Clancey's (1995) proposal of a concept of 'social choreography' further assisted my understanding. This concept highlights that activities being social does not necessarily mean that they must be with other people or situated in a specific location, but rather, that action is situated because it is constrained by a person's understanding of his or her 'place' in a social process, and an awareness of this choreography orientates how participation, information, rules, values, principles, and so on, are communicated.

Lave and Wenger (1991) also believed there was a need to 'rescue' the idea of *apprenticeship,* as they argued that the prevalence of the term has led to lack of precision and clarity. The nursing degree apprenticeship now refers to a very specific initiative (Department of Health & Social Care, 2016). However the underpinning philosophy that learning through an apprenticeship model was related to the traditional notions of 'learning by doing' or 'learning in situ' was, in fact, better encapsulated by the more encompassing concept of *legitimate*

peripheral participation, as conceptualised by Lave and Wenger (1991), resonated again with my understanding of the student experience. This and other related concepts will be critically analysed throughout the thesis.

1.3 'Nursing eats its young'?

The recruitment and retention of nurses remains an international concern and constant challenge for many complex reasons. However my longstanding interest in the experience of the students who are to be the future nursing workforce also made me reflect on discussions I had had with many students concerning their challenging experience in clinical practice and their attempts to become part of the clinical teams and contribute to the team ethic. The difficulties experienced by students has a long history of evidence and research in nursing – not least captured by the phrase 'nursing eats its young' (Gillespie, Grubb, Brown, Boesch & Ulrich, 2017). I was keen to explore further the current context for degree educated students as they actively attempted to find their way to influence positively the status quo and the prevailing power dynamic in the well-established teams that they joined as part of their educational journey.

1.4 Overview of the Thesis

Chapter One: Preface

This chapter briefly recounts my own personal and professional background and the context that prompted my explorations into the experiences of student nurses, my perception of the underpinning philosophy of the current nursing curriculum, the concept of identity and the work of Lave and Wenger.

Chapter Two: Conceptual Analysis

This chapter explores some of the major concepts that underpin the research and how they might inform further understanding of the experience and perceptions of a group of student nurses undertaking the adult nursing programme. The concept of communities of practice is critically analysed; along with concepts such as practice, participation, identify and boundary and how student nurses negotiate meaning in their experience and how this results in a shift in their identity.

Chapter Three: Literature Review

This chapter provides a critical review of the literature pertinent to the study, allowing an in-depth appraisal of the construct of meaning and identity of student nurses and a greater insight into what was present *and* absent in the literature concerning the current context of nursing. This includes the regulatory, higher education and clinical settings, and the key relationships that influence the students' subjective experience; their perceptions of the socio-cultural interactions in their development of learning and their ability to negotiate entry into groups, teams and communities and their subsequent shift in identity.

Chapter Four: Methodology and Methods

This chapter explores the rationale that supported the key decisions made during the research - decisions such as choice of research design and a focus group and interview approach. The chapter describes, explains and justifies the methods utilised to support the study and achieve the proposed aims and outcomes of the research; recognising and accessing appropriate participants; the difficulties encountered and the strategies devised to ensure solutions to these difficulties and the addressing of any ethical considerations generated by the study.

Chapter Five: A Narrative Presentation of the Data

This chapter presents an analytic narrative which illustrates the key stories and explores the richness of the data as a means of properly representing and doing justice to the perceptions, experiences and realism of meanings of the participants. This narrative approach helps address the research aims as it promotes capture of the perceptions and subjective experience of the students in their participation in the various communities of practice whilst gaining greater insight into their understandings of what it means to be a nurse and their shifting identities. The chapter highlights how identification of concepts in the raw data as codes, categories and patterns was a way of "thematising meanings". The themes represent a level of meaning discovered within the data that capture something of key importance in relation to the research question.

Chapter Six: Themes

This chapter provides a further overview, discussion and analysis of the major themes generated from the data produced during the focus groups and interviews. These three major

themes were generated following an examination and analysis of the broader narratives of the participants.

The main themes engendered by such an immersion in the data were:

1) Becoming a nurse
2) Engagement with old timers
3) The University - Practice Dissonance

The analysis and discussion of these key themes offers insight into how the students fundamentally change as a person and how they literally become a different individual. It will also show how theoretically the data shows that this shift happens as a result of *participation* in the communities of which they are a part.

Chapter Five and Chapter Six include the key discussion aspect of the thesis and where I have located my research findings within the prior research literature, theory, policy and context.

Chapter Seven: Conclusion

In conclusion I provide an overview of the research process; what was done; how it was done and why - and what was discovered and why it matters. The unique contributions to knowledge are highlighted as are recommendations for potential future research, education policy, curriculum development and clinical practice support.

Chapter Two: Conceptual Analysis

This chapter discusses some of the key concepts that underpin the study and explores how these concepts might support further understanding of the experiences of student nurses undertaking an adult nursing programme as they progress their journey towards registration. The lived experience and related identity formation of the students are critically reviewed and conceptualised via the framework of *communities of practice* as introduced by Lave and Wenger (1991). This framework promotes greater insight into areas such as students' perceptions of nursing, relationships with established nurses; issues related to increasing participation, developing confidence, improved understanding and response as their identity shifts in relation to the overall context of professional practice. This context highlights the considerable complexity of the clinical and university environments and includes the cultures and the espoused values of the various communities of practice they experience and engage with. The significance and relevance of situated learning theory will be explored in contrast to more traditional learning theory. Exploration of concepts such as *practice, participation, identity* and *boundary* is important to understanding nursing and the way student nurses negotiate meaning in their experiences, occasioning learning and a resultant shift in identity. This chapter therefore includes an analysis of how the meanings that emerge through that experience relate to the wider context of situated cognition, facilitated learning and a burgeoning professional identity.

2.1 Background

Learning takes place in a variety of different contexts and environments and, as Lave (1997) highlights, individuals can engage in a 'learning curriculum' that is different from the teaching curriculum - whether in opposition to it or encompassed by it or *indeed both those positions*.

Students recognise that equally effective learning takes place via the mutual support engendered amongst student peer groups for example (Rohatinsky, Harding & Carriere, 2017). These less formal contexts can be viewed as equally beneficial to their progress as the more formal groups and experiences facilitated by the academic body or their mentors in practice. Indeed in relation to their fundamental aspiration of 'being a nurse' some students question the value and relevance of much of their time at university. They seek further time in the 'real life' of clinical practice where - despite its considerable pressures - they can feel more like a 'real nurse'. Their belief being that it is in the clinical environment that they may be more supported, guided and challenged and yet involved in practices that they believe are more representative

of what it is to be a nurse and therefore might more genuinely advance their progress to achievement of successful professional registration (Ford, et al., 2016; McIntosh & Gidman, 2014).

Student nurses therefore form relationships, both positive and less so, with others within their various communities. These include: registered nurses - in particular mentors, service users and carers, other health professionals, fellow students and university staff. The NMC have recently launched a new set of standards for education and training 'to shape the future of nursing for the next generation' (Nursing & Midwifery Council, 2018) and these include new Standards for education and training. The Standards are set out in three parts:

Part 1: Standards framework for nursing and midwifery education

Part 2: Standards for student supervision and assessment

Part 3: Programme standards

There have been significant amendments to the previous Standards - one of the noteworthy modifications is the word *mentor* does not appear at all. Mentor has been replaced by the dual roles of as practice *supervisor* and practice *assessor;* roles which remain crucial to the creation and maintenance of a positive learning environment and ensuring the support and assessment of all adult student nurses. Although the Standards indicate a shift in emphasis and role titles, the supervisor and assessor roles retain the previous *mentors'* role in having a particular and unique responsibility to facilitate the development of a professional identity and assess evidence of progress against explicit NMC Standards.

It is important to recognise that the student nurse participants in this research have all experienced practice, clinical and academic assessment and educational learning outcomes matched against the previous NMC Standards to support learning and assessment in practice issued in 2008 and the Standards for competence for registered nurses published in 2010. Therefore, for the purpose of this thesis much of the discussion and reference will be related to the 2008 and/or 2010 Standards as that is the context of their experience, the Standards that they recognise and are assessed against and need to attain. Similarly the term 'mentor' will therefore continue to be used throughout the thesis, as the term to represent the key supportive and assessing nursing role in clinical practice - this is the term the participants know, recognise and use.

Irrespective of any change in emphasis and terminology from the NMC; an exploration of the experiences of student nurses and how those experiences shape their practice, beliefs and values remains valuable. A deeper understanding of students' perceptions of their participation and experience in the complex milieu of undergraduate nursing, whether that be in clinical practice, university or wherever learning takes place, can have considerable influence on contemporary professional debates and contribute significantly to nursing knowledge. It would also help inform local and national discussions about students' 'fitness to practice' and explore how the development and shifting identity of nurses might ensure appropriate and continued advocacy for patients and service users and encourage a challenge to poor practice in such circumstances as highlighted in the Francis Report and beyond (Francis, 2013; DH 2013b).

2.2 The current educational paradigm

My experiences, observations and reflections on the students' experiences, frequent conversations with students themselves and discussions with academic colleagues led me to fundamentally reconsider my appreciation and understanding of the apparent underpinning paradigm of learning inherent within, what might be called the 'theoretical' component of the current nursing curriculum. Nurse education has engaged with such principles as evidence based practice and the utilisation of research to support practice (Brown 2014; Cullum, Ciliska, Haynes & Marks, 2013) and has also embraced educational models such as problem based learning (Applin, Williams, Day & Buro, 2011), outcome based learning (Tan, Subramaniam & Ping, 2018) and skills based or simulation teaching approaches (Lavoie, et al., 2018) to support the development of the future nursing work force. However in many ways, the philosophical ethos that supports much of the curriculum is still often represented by the traditional dyad of lecturer and student; where learning is essentially viewed as involving the acquisition of a formal body of knowledge from an expert. In this approach the lecturer takes the role of an expert, invariably a nurse with previous experience of clinical, patient-care related practice and an 'appropriate' level of experience; who are now hoping to 'pass on' their knowledge, experience and expertise to the next generation of the profession. A similar philosophy also underpins the recommended relationship between student and mentor. Many approaches still position the individual student as amassing knowledge and skills in some way due to the contribution of an expert; with the implication of an unproblematic passage of knowledge and skills from one individual to another. Primarily this philosophical approach removes the student from their social context and ignores, or at least reduces, the significance of the cultural process of socialisation and the social construction of a professional identity.

As we shall see, this also works against what Lave and Wenger would call *full participation* in the *community of practice* as not only does membership and participation change an individual but also participation presumes power of the individual to also change the community of practice itself (Hughes, Jewson & Unwin, 2007).

This philosophy is also inherent in the NMC's insistence that those who teach nursing students must have clinical credibility and competence and also complete a postgraduate certificate in learning and teaching, along with the mandate insisting that at key points in their practice student nurses can *only* be legitimately assessed by a registered nurse (Nursing & Midwifery Council, 2008). A student's experience in clinical practice, as articulated by the NMC, views the role of mentor as essential and instrumental in the organisation and co-ordination and assessment of the learning and development of students (Nursing & Midwifery Council, 2008). Similarly the RCN (Royal College of Nursing, 2017a) define mentoring as: the teaching and assessment of students in the practice setting by knowledgeable and skilled role models who are responsible for helping prepare future practitioners to demonstrate competency to practise. The fundamental underpinning professional ethos of the student/mentor relationship by the NMC and the RCN, therefore, indicates a similar educational philosophy.

This dominant discourse positing learning as a circumstance whereby knowledge is in some way transmitted from one individual to another felt generally problematic. Methodologies or philosophies that emphasised such individualistic approaches to learning, whereby the student is perceived to acquire knowledge, learning and competence through such a transmission would not appear to best explain the lived experience of students or indeed represent a coherent understanding of how learning occurs.

2.3 Situated Learning

The underpinning pedagogical paradigm therefore prompted me to explore the conceptual approach of situated learning as articulated particularly by Lave and Wenger (1991). Situated learning as theorised by Lave (1988) and others suggests learning is inextricably linked to authentic activity, context and culture and is a process that takes place in a framework of participation (Lave & Wenger, 1991). It thereby recognises the interaction between individuals and the environment, as learning is situated within the activity in which it takes place. Learning *is* doing. Knowing is therefore inseparable from doing as all knowledge is situated in activity bound to social, cultural and physical contexts. Cognition cannot therefore be assumed to be

concerned with the storage and retrieval of conceptual knowledge as it cannot, in fact, be separated from context.

Learning is not, thereby viewed as the transmission of decontextualized and abstract knowledge from one individual to another, rather it needs to be viewed as a social process where knowledge is dynamically co-constructed as individuals conceive of what is happening to them, communicate, relate and exchange with others (Fuller, 2007). Knowledge is viewed as a capacity to coordinate and sequence behaviour and thereby adapt to changing circumstances with action, whilst being situated in a role as a member of a community (Clancey, 1995). Although knowledge may be modelled by a set of descriptions or collection of facts or rules, for example, and knowledge may be represented by textbooks, expert systems and so on, these are tools rather than the knowledge itself as 'the map is not the territory' (Clancey, 1995 p.1).

Therefore, rather than the transferring of facts and rules from one to another, learning is understood as a process of social activity with emphasis on issues of membership, identity and participation in a community – such as a ward, unit or community nursing and clinical team. Clancey speaks of a 'social choreography' (Clancey 1995 p.2) and reinforces that action is situated because it is constrained by a person's understanding of his or her 'place' in a social process rather than activities necessarily needing to be situated in a specific location. An awareness of this *choreography* orientates how information, rules, values, meaning, and so on, are communicated. Some students, for example, - as will subsequently be discussed - recognise quickly the assumed but unspoken power dynamic in certain ward or unit teams and they may quickly gravitate to well established healthcare support workers as they quickly perceive '*who is running this place'* and who may help them further their participation and membership.

The emphasis on social activity resonated particularly in my previous conversations and discussions with many nursing students. They seemed to recognise that the expertise they were striving for, and was required of them to progress, was not simply about someone, usually their mentor in practice or lecturer at university, telling them the 'rules' of how to succeed in the community they were in. It was more to do with ways of interacting with other key players in that community, an awareness of roles and making certain conceptual interpretations that cemented their positions or conversely excluded them from the community. Learning cannot simply be accomplished by describing or telling alone, and nor is it simply 'trying something out'; it is more about a person's conceptualisation of their role. The problem-solving skills that are necessary, and also assessed as evidence of a student nurse's learning, for example, are

essentially an assessment of the student's ongoing reconceptualization of their role and their insight into what they should be doing as a developing member of that particular community of practice.

Reconceptualization and insight highlights negotiation and a growing shared experience and shared meanings. Wenger argues that such meanings become 'reified' as objects with a force and power of their own. Influence within a community can be result from both *reification* and *participation*. Participation is the direct interaction between members of the community, whereas reification is the use of objects to impose or affect others' behaviour. Reification may be of certain influential and powerful *imagined* social constructions; however, they can also be encapsulated in artefacts such as the Practice Assessment Document (PAD) as an example of the reification of the mandatory assessment of the competence, ability and attitude of the student. The PAD is a document utilised by many universities in the UK to record a student's ongoing development. The PAD can include feedback from mentors, other clinical colleagues, service users and university staff and also record judgement and grading against the NMC mandatory progression points at initial, mid-point and final assessment. All students, involved in this research, are assessed against the four NMC Domains of Nursing - not least domain three: 'Nursing Practice and Decision Making, where students are required to literally demonstrate their fitness to practice in a variety of contexts and situations.

2.4 Apprenticeship-type models of learning in adult nursing

Lave and Wenger (1991) utilise terminology such as *apprentice* and *apprenticeship* throughout their discourse although they admit that such terminology can be imprecise and lacking in common definition (Lave & Wenger, 1991 p.30). Whilst acknowledging that a *nursing degree apprenticeship* can now imply a very specific initiative and approach planned to commence within the UK in 2018 (Department of Health & Social Care, 2016); I have employed the terms occasionally throughout the thesis when discussing the traditional BSc degree route that the participants undertook. The rationale behind the use of terminology such as apprenticeship or apprenticeship-style in the thesis, promotes, as Lave and Wenger also suggest, a re-examination of the historically narrow reading of apprenticeship as a concept (Lave & Wenger, 1991 p.62) - and is a recognition that the traditional nursing degree route to professional registration includes characteristics common with an apprenticeship philosophy. Principally apprenticeships combine study and work and mix 'classroom learning' with what is often called 'on-the-job' training. As Lave and Wenger (1991) highlight wherever the learning of high

levels of knowledge and skill are required - their examples including medicine, the law and the arts - this occurs in the form of some kind of apprenticeships. Just as in nursing, the training programmes are structured to help the learner gain the skills and knowledge needed to succeed in the chosen area and provide experience in the 'working world'. In theory this context promotes greater opportunities to learn skills and competencies appropriate to practice and helps the learner gain confidence in the specialised working environment and guarantees a greater fitness for purpose.

2.5 Communities of Practice

If learning is reconceptualised as experience rather than as the acquisition of knowledge and skills (Lave & Wenger, 1991), then a key aspect of learning is seen as a means of reproducing and developing 'communities of practice'. A community of practice is a way of describing any group of people who work together to accomplish some activity, or 'practice', usually involving collaboration between individuals with different roles and experience (McDonald & Cater-Steel, 2016; Fuller, 2007). Communities of practice can be seen as a framework which can help explain what a person knows and also why they behave in a certain way. Knowledge is conceptualised as the ability to participate in such a community of practice and learning as being the process of becoming a member of the community of practice via an initial process of *legitimate peripheral participation* (Lave & Wenger, 1991), a concept that will be explored subsequently. Wenger asserts that communities of practice are 'everywhere' with some of them remaining 'largely invisible' (Wenger, 1998) with the concept extremely pervasive; having been utilised as a framework to explore or support a wide variety of initiatives. For example, the term communities of practice, amongst other things, appears to have become emblematic of a new consultancy movement, a knowledge management solution and a toolkit for human resources (Hughes, Jewson & Unwin, 2007). This pervasiveness may compromise the utility of the concept; however Wenger does attempt to retain some coherence and consistency in his articulation of the concept. He claims that communities of practice are formed by people who engage in a process of collective learning and doing; with common goals and enterprises in a shared domain. This can be taken to mean any group of people who engage in mutually agreed endeavours and who learn how to do these endeavours better as they interact regularly (Wenger, 2014).

According to Wenger (1998) practice exists because people are engaged in actions whose meanings they negotiate with one another in a spirit of mutual engagement. The identity of a community of practice is defined by a shared domain of interest, a commitment to that domain

and an implied shared competence and repertoire that distinguishes members from others (Wenger, 2014). Examples of such communities of practice for student nurses may include an adult nursing community of practice, a higher education or university community of practice and also the different communities of practice that make up their practice experience. Pursuance of the shared interests results in engagement of joint activities and discussions and the sharing of information and assistance. Relationships thereby develop, learning takes place and identities shift. A further element necessary for a community of practice is essentially that: it involves those in *practice*. Practitioners, who over time and sustained interaction, share resources, experiences and develop learning by addressing recurring and mutual issues and problems. It is the combination and parallel cultivation of these elements that constitutes a community of practice. The two most obvious communities of practice for all adult student nurses would appear to be defined and differentiated by their time spent in university and their time spent in clinical practice.

As meaning is confirmed and learning takes place, identities shift and there is a developing sense of belonging to the specific community of practice, a belonging which can be defined and further elucidated by the three characteristics of 'mutual engagement', 'joint enterprise' and 'shared repertoire' (Wenger, 1998). Wenger takes 'mutual engagement' to refer to the individual's involvement in a variety of activities and actions, the meanings and significance of which are negotiated among the members of the particular community. Mutual engagement is central to the concept of inter-professional working that student nurses will experience at various stages in their career. 'Joint enterprise' indicates the participation in a common endeavour, which consists of engaging and working together in practice following on from shared and ongoing negotiation of aims and recognition of common accountability. From a student nurse perspective this can be represented, for example by individualised patient care planning articulating a shared view of the most appropriate care required for an individual patient. The third characteristic of a community of practice is what Wenger calls a 'shared repertoire' which includes a complex set of practices, routines, words, concepts and 'ways of doing things' that the community has adopted and created. Membership of a particular community therefore includes recognition of meaning in statements created about that particular world and also the styles by which this membership is given expression.

Student nurses are therefore continually challenged to negotiate the meanings of their experiences as members of different communities of practice both as students of a university and also in the myriad of clinical placements that are so integral to their achievement of fitness

for registration by their professional body. Students bring with them a useful 'constructively naïve' perspective (Lave & Wenger, 1991, p.117) and offer questions and insights that invite reflection on the part of the other members of the community. This ensures that the new student's contribution is, at least occasionally, still recognised. However this contribution has to be valued, understood and supported by experienced practitioners. Trust and respect are viewed as crucial to the effectiveness of the community of practice as a social learning system, with a lack of belonging, use of power and resolution of real or potential conflict important elements for facilitation or inhibition of learning and the move to a more central position in the community of practice.

Those in authority within the community of practice - who can be viewed by the students as having power, influence and privilege - may be mentors, staff nurses or charge nurses, other staff in practice and also members of the university faculty. These individuals need to be respectful of those whose status is on the periphery. If students are to ever become more centrally located in a community, those with authority - and already therefore more central to that community, have to be aware of this dynamic and indicate empathy and a respectful, accepting attitude to students in relation to consideration of their inexperience and peripheral position.

Lave and Wenger (1991) conceptualise this initial positioning of the student and the ongoing negotiation and subsequent learning as *legitimate peripheral participation*.

2.6 Legitimate Peripheral Participation

Legitimate peripheral participation is an attempt to describe engagement in social practice whilst indicating the essential requirement of learning and development. It provides a means of describing the relations between those new to the community of practice and the - in Lave and Wenger's (1991) terminology - 'old timers', that is, others who are already well established in that community. It also provides a means of speaking about the practice and knowledge within those communities and exploring the activities, products or artefacts and identities within them (Lave & Wenger, 1991). On entry to specific communities there is a genuine legitimacy to 'not knowing', which is accepted by the rest of the community; although students may still experience anxiety as they continually recognise their novice status. It is essential that other members of the communities view their inexperience as understandably, fairly and legitimately located as peripheral and not central to the community as the nature and extent of subsequent learning is underpinned by the relationships, experiences and processes which

establish the students' sense of belonging and participation. This can be seen in the changing expectations of student nurses as they progress from the clinically and professionally naive first year student to the third year student who might be expected to evidence the competence of a newly registered nurse. If *peripherality* remains over a specific - occasionally non-articulated - time limit then it is no longer perceived as legitimate and the student's competence is challenged, which may even prompt them to leave the community of practice completely.

As learning is recognized as a social phenomenon so legitimate peripheral participation in ongoing social practice is how such learning is constituted in the experienced world (Lave, 1988). The learner is a core participant in the community of practice from the very beginning, albeit on the periphery (Burkitt, Husband, Mackenzie, Torn & Crow, 2001) and for Lave and Wenger (1991) legitimate peripheral participation is the main mechanism whereby newcomers acquire the competence to become full participants in the social and cultural practices of a community. Legitimate peripheral participation is a means of articulating learning without reifying it as an independent process ontologically distinct from activity (Zaffini, 2018; Hughes, 2007).

The concept of legitimate peripheral participation explains the process that occurs when a learner arrives in the workplace and begins to acquire professional competence supported by those who Lave and Wenger call 'sponsors' or those that might be called in current nursing terminology 'mentors'. Newcomers will usually start as peripheral members in a community of practice because they lack the necessary community-specific knowledge that would allow them to participate in a more central way (Lave & Wenger, 1991). The learner is still engaged in the everyday activities of the community, but as a co-participant and initially on the periphery (Burkitt et al., 2001; Lave & Wenger, 1991). Newcomers move from this position of legitimate peripheral participation towards greater and, in theory, eventual full participation, shaping knowledge, participating in incremental innovative activity as they learn and develop their professional identities accordingly. Lave and Wenger propose that 'peripherality, when it is enabled, suggests an opening, a way of gaining access to sources for understanding through growing involvement' (1991, p.37). Such peripherality, where participation is less than full in a particular community of practice may be legitimate and appropriate as it may even enable fuller participation in *other* communities. Therefore, legitimate peripheral participation *can* be empowering for students as they move towards 'full participant', however, the opportunity to move more centrally should not be hindered or denied or they may remain with limited power or even feel powerless (Lave & Wenger, 1991). Forms of peripherality - evidenced as a form

of non-participation and marginality - can restrict any meaningful participation and indicate a fundamental lack of choice on the part of the students, who may well seek to belong, engage, reinterpret and shift their identity and yet may still not necessarily be accepted in a particular community.

Peripherality may be a mix of participation and non-participation, where non-participation may be characterised by observing or being told what to do or 'shadowing' others. Therefore as the student nurse arrives in the 'authentic context' that is a practice placement, where it is likely that the situation is unfamiliar; they experience the unique aspects of this particular clinical practice and then start to acquire greater 'nursing' knowledge as they start to undertake more complex activities in the particular environment in which they are placed. They will start to use more advanced practices, communicate in a more appropriate and 'community-specific' ways with other members of that community or indeed variety of communities as they overlap. They will start to take greater responsibility for more relevant and essential functions and practices that are central to the community and evidence their development of deeper understanding of the goals of the community by adopting roles that are more fruitful to those goals. As they do this they become legitimate participants but at the same time their peripherality becomes less legitimate. Some students remain peripheral for a variety of reasons either due to their exclusion by the old timers, their struggle with competence or even a reluctance to engage on their part (Nicolini, Scarborough & Gracheva, 2016).

Student nurses therefore learn key knowledge skills and capabilities within that community which enables them to be a competent member of it and in this they are mentored, supported, guided or 'sponsored' by an experienced member or members of the community. Values, attitudes and the practice of the community are modelled by more experienced members and gradually the students participate more and more in this cultural practice, resulting in increasing responsibilities and greater contribution to the development and activities that are valued and found useful by the community (Burkitt, Husband, Mackenzie, Torn & Crow, 2001; Spouse, 2000). As such learning is not merely a condition for membership but is itself an evolving form of membership (Lave & Wenger, 1991). In principle, at least, moving more centrally and eventually gaining membership within a specific community of practice is indicative of improving competence. However competence is more than simply an accumulation of skills and information but entails the negotiation of *ways of being a person* in that context – evidence of their shifting identity.

Behaviours emerge from the context of particular communities of practice as they both enable and disable participation in quality care, yet as indicated by evidence such as the Francis Report (Francis, 2013), learning may not always be a positive thing for patient care as learning to be participants in specific communities might be problematic dependent on the context, values of the old timers and behaviours of those that legitimised or otherwise the peripherality of the student. My undertaking of a critical review of the nursing literature recognises that if unsupportive or even offensive behaviour is manifested to student nurses, or indeed to patients, then this behaviour will potentially be replicated by the students towards patients and also to future student nurses when they themselves are professionally registered nurses.

Critics have argued that Lave and Wenger's (1991) communities of practice are essentially unchanging, with legitimate peripheral participation being the method of giving new generations of newcomers the means to simply *reproduce* the community of practice. It is this perceived limitation that has led socially situated learning to be viewed negatively by some within nursing, as it has been associated with attempts to resist modernisation of the profession (Field, 2004). This criticism views a successful move from legitimate peripheral participation to full participation as a relatively *conservative* idea and more representative of a model of continuity and reproduction rather than transformation. Typically the move to full participation occurs with minimal changes to practice or social relations, as those in the position of legitimate peripheral participants are required to acquire that particular community's subjective viewpoint and learn to speak its language rather than observe, reflect, challenge and promote change (Molesworth, 2017). Therefore, the argument concludes, it is difficult to see how such an approach might help lead to a challenge of poor practice as envisioned for the future of the health service in the UK.

However this view of situated learning as some sort of 'system' or 'procedure' fundamentally misunderstands situated learning. Situated learning is essentially an explanation of how learning happens, and its primary aim was never to advocate what learning *ought to be* but rather to develop an approach which could help reveal learning as it *actually* is (Hughes, 2007). This will be explored further within the literature review.

2.7 The Concept of Practice

The notion of *practice* was of particular interest as this concept seems so integral to the students' understanding, progression, shift or *trajectory* as their experience progresses. Practice in this context is conceptualised as being what people say and do, rather than theory, which is

a *description* of what people say and do. The notion of practice is therefore understood in terms of the act of doing in context (Wenger, 1998). I was particularly interested in the students' views of the roles, procedures, language, tools, symbols and silences that shape the communities that they experience. *Silences* are relevant as Wenger (1998) confirms that what is not said can be as powerful as what is. If practice is concerned with underlying assumptions and shared world views and as much with what is unsaid as well as what is said, shortcuts, unwritten rules, nursing rituals, tacit conversations and procedures (Wenger, McDermott & Snyder, 2002) then these were the issues and their influence on student nurses' identity that I was particularly keen to research further. For example students might experience *silence* in practice on issues that are widely discussed at university and although communities of practice do not exist in isolation, students may find particular disconnect between the communities of clinical practice and university (Crombie, Brindley, Harris, Marks-Maran & Morris Thompson, 2013). Indeed as the essential, specific and focussed expertise and competence is developed even greater *boundaries* might be created (Wenger, 1998). As Wenger, McDermott and Snyder (2002) indicate, any shared practice may be a liability as well as a resource. Nursing or medical terminology may well help efficiency but can also create barriers and the price for efficient practice may also raise significant issues of communication with those that are outside that particular community. In and through the use of language - both spoken and textual - power relations are established, maintained and challenged. Thus in this perspective, what Wenger calls 'shared repertoire' can become conceptualised as shared language and discourse. Similarly, 'situated learning' and 'legitimate peripheral participation' can be framed in terms of access to such communities of language or speech. Inequalities thereby reflect socio-linguistically mediated practices of inclusion and exclusion (Hughes, Jewson & Unwin, 2007). Such considerations of communication may highlight the dissonance often felt by students in linking theory and practice (Bjorkstrom, Athlin & Johansson, 2008) but may also prevent student nurses from seeing that which does not fit exactly within their paradigm and thereby reduce opportunities for poor practice to be acknowledged and confronted. According to recommendations of reports such as offered by Lord Francis and others (Francis, 2013), if poor patient care is to be avoided such recognition and challenge is essential. However, flawed and poor behaviour demonstrated by clinical colleagues can be considered as normal and appropriate by students and thereby maintained and copied.

Other students can feel the need to adopt an identity which sets out not to challenge, but to accept variations of decision-making, even when these are perceived to be inconsistent (Ion,

Smith & Dickens, 2017). Tensions between the apparently differing goals and values within the different communities of practice can provoke concern and anxiety within students who appropriately look to university practice to facilitate the engagement necessary to alleviate such tensions (Tobbell, O'Donnell & Zammit, 2010). However practices of differing communities may also overlap and help students make connections and break down boundaries as complex problems frequently require solutions that are not confined to any one area of practice. For example, students may make sense of their university experience only once they contextualise that information and learning in clinical practice. Therefore the potential for *full participation* in the various communities, both academic and in clinical practice, is mediated by a multitude of complex, potentially opposing factors and highlights why such central participation is neither immediate nor indeed inevitable. The necessary meanings inherent within practice require significant negotiation resulting in a shift in identity (Wenger, 1998). The extent and quality of access to greater participation relates to 'social organisation of and control over resources' (Lave & Wenger, 1991 p.37) and it follows that the nature and scope of what a 'full participant' constitutes and means will vary according to the way relations within the relevant community of practice are structured. It has been argued, however that this articulation of communities of practice ignores the disorderliness and complexity of the interactions which construe communities (Tobbell, 2003)**.** Moreover Hodkinson and Hodkinson (2004) question whether the idea of 'participation' can provide an explanation for learning that has such universal applicability. The claim is that rather than legitimate peripheral participation having the greatest impact on students' learning, a concept such as *relationship* might better capture this phenomenon. Relationships may more appropriately capture the mutual engagement, belonging and acceptance that feature in much of the literature exploring student nurses learning in practice, as they attempt to engage and contribute to the aspired goals of high standards of care in challenging contexts (Sayer, 2014; Fuller, Hodkinson, Hodkinson, & Unwin, 2005). However, it is legitimate to claim that, far from being mutually exclusive, the idea of *relationship* is integral to the concept of legitimate peripheral participation as articulated by Lave and Wenger. The relationships that are developed through social interaction confirm that changes occur in the participation and practice within the community and result in informing and shifting the individual's *identity* (Zaffini, 2018).

2.8 Identity

I propose that an understanding of the concept of identity is fundamental to understanding nursing and the current nursing context. It has been argued that identity is in many ways the major concept in Wenger's analysis (Jewson, 2007). Identity is succinctly expressed by Wenger as consisting of 'negotiating the meanings of our experience of membership in social communities' (Wenger, 1998 p.145). Exploration and greater clarity regarding the range of influences within such communities will therefore provide context for a clearer, more precise understanding of the unique experiences of student nurses and the construction and shifting of their identities.

Wenger portrays identity as inextricably linked to learning, arguing that learning transforms individuals in respect of who they are and what they can do and it is therefore essentially an experience of shifting identity (Wenger, 1998). Learning is not just an accumulation of skills and information, it fundamentally changes who a person is and what they are able to do; it is therefore a process of becoming 'a certain person or, conversely (avoiding) becoming a certain person' (Wenger, 1998 p.215). Knowledge and skills need to be viewed in light of the complex interactions involved and how these interactions thereby contribute to a shift in personal identity. Identity manifests as a tendency to come up with specific 'interpretations, to engage in certain actions, to make certain choices, to value certain experiences all by virtue of participating in certain enterprises' (Wenger, 1998 p.153). Identity is therefore fashioned as a lived experience of participation in specific communities (Jewson, 2007), with shifts in identity an inevitable associated feature of learning as the subjective experience of change (Crossan, Field, Gallacher & Merrill, 2003). As I have discussed, the learning that individuals experience following entry to a given community and their move from what Lave and Wenger theorise as *legitimate peripheral participation* to potential full participation, results in an attendant shift in identity. This again reinforces that learning is not simply an individual event but a process distributed across person, time, place, and activity (Tobbell et al., 2010).

Identity is therefore constantly renegotiated during the course of an individual's life as they register, recognise and subsequently attempt to accommodate the meanings of experience of membership in different social communities. Individuality is therefore, viewed as something that is part of the practices of specific communities (Wenger, 1998 p.145-146). As identities shift there is a developing sense of belonging to the specific community of practice, a belonging

which can be defined and further elucidated by the three characteristics of 'mutual engagement', 'joint enterprise' and 'shared repertoire' (Wenger, 1998).

The construction of identity is therefore a social process and takes place in a mutually constitutive setting of other people, activities, relationships and contexts (Lave & Wenger, 1991). Identity is not a static, stable or indeed linear notion, but fundamentally temporal and enduring. It is constructed in social contexts with participation involving individual shifts in insights and understandings, the creation and conservation of new relationships and the constant negotiation of meaning and identity. The work of identity is, therefore, ongoing and is defined with respect to the interaction of multiple convergent and divergent trajectories (Wenger, 1998 p.154).

Wenger identifies different forms of trajectory:

> Peripheral trajectories - trajectories which do not lead to full participation but do involve identity shifts;
>
> Inbound trajectories - trajectories which suggest the goal of full participation, even when the participant is peripheral in the beginning;
>
> Insider trajectories - even when a full participant, practice continues to evolve, new meanings are generated and therefore identity can further shift;
>
> Boundary trajectories - those which span a number of communities of practice, linking them and brokering practices with them;
>
> Outbound trajectories - trajectories which clearly enable participation in a future community of practice (Wenger, 1998 p.154-5).

Student nurses may identify significantly with the outbound trajectory, realising that participation in the particular clinical practice may enable further participation in the wider clinical environment or Trust and result in more favourable opportunities in the future job market. As such, identity includes aspirational factors. Paechter (2003) also suggests that in moving from one place to another - as adult student nurses continually have to do - also necessitates a shift in identities in order to securely and positively inhabit each location. Therefore the notion of participation and trajectory involves personal shifts in understandings, the construction and maintenance of new personal relationships and the constant negotiation of meaning and identity.

As Wenger (1998) highlights, each new experience therefore requires a shift in identity due to the challenges to the student's competence and their lack of awareness of how to engage with others and lack of understanding of the subtleties of practice as that particular 'community' have defined it. This challenge to identity is present, *at least* with each different clinical placement and also potentially with the differing communities that exist within that placement. The lack of shared references that other participants, particularly mentors, but also other nurses, support workers and other health professionals and also service users and carers use can challenge students' very perceptions as to what 'nursing really is' and whether it might be something different than they think. Their initial non-membership of each of these new communities shape their identity through confrontation with the unfamiliar, and as they develop competence and gain knowledge of how to engage with others, achieve greater understanding of the subtleties of 'nursing' as that particular community view it, they are able to develop burgeoning insight into the shared references that participants use. In this process students do not evidence the passive acquisition of knowledge but actively participate in practices that generate identities and meanings (Jewson, 2007). Therefore identity is essentially defined as a form of competence (Wenger, 1998).

2.9 Criticisms of the concept of communities of practice

The concepts of communities of practice and legitimate peripheral participation have not been without their critics, many of which have relevance both in relation to the current health care context and also to my research. For example, Lave and Wenger (1991) recognise that communities of practice are social structures involving relations of power, and acknowledge that the way power is exercised *can* make legitimate peripheral participation an 'empowering' and/or 'disempowering' experience. Furthermore, they acknowledge that newcomers pose a threat to old timers thus creating a dynamic tension between continuity of the community and displacement of the old by the young as, 'each threatens the fulfilment of the others destiny just as it is essential to it' (Lave & Wenger 1991, p.116). This tension rang true to me with the conversations I had had with student nurses as they attempted to comprehend their participation in clinical practice. However in most if not all of the examples Lave and Wenger offer, communities are described as rather stable, cohesive and even welcoming entities. This assumption of the relatively benign character of community has been challenged as, rather than simply being immersed in the core values of the communities of practice; reflection, critique, dissent and challenge need to be encouraged and space created to support this (Gee, Hull & Lankshear, 1996). This articulation of the community as a *challenge* might be of particular

pertinence to the student nurses experience according to much of the literature as I will discuss further subsequently. The process of change involved in legitimate peripheral participation and the concomitant assumption of the identity of 'novice' can undoubtedly expose the student to significant psycho-emotional processes of adjustment and 'shock'. Not least as participation in communities of practice is not merely a matter of occupational socialisation but also demands and entails a fundamental reconstruction of the self and shift in identity (Goodwin, 2007).

2.10 Conclusion

In this chapter I have critically analysed the value of Lave and Wenger's concept of communities of practice as a vehicle to further explore and gain insight into the experiences and shifting identities of student nurses. The concept, and its related notions of situated learning and legitimate peripheral participation were explored in the context of the current adult student nurses experience in the UK; cognisant of the current professional context, influence and directive. I propose that an understanding of the concept of identity, and its inseparable link to learning, is essential. Therefore recognition and greater insight into the significance of concepts such as practice, participation, identity and boundary have been explored to help further clarify and achieve the aims of this research.

The next chapter highlights a comprehensive review of the pertinent literature relevant to the research aims that was undertaken to further explore the literature as a foundation for the research process and to confirm the unique insights that the proposed research will contribute.

Chapter Three: A Literature review

3.1 Introduction

This chapter provides a review of the literature pertinent to the study. The review allowed the exploration of the current professional, political and social context of the adult nursing student experience and offered the opportunity to explore concepts and relate relevant theory. The review also enabled an in-depth appraisal of the phenomenon of interest: the construct of meaning and identity of student nurses; and a greater insight into what was present in the literature concerning the current context of nursing, the regulatory, higher education and clinical settings, and the key relationships that influence the students' subjective experience and their subsequent shift in identity. A central theme of this research is the exploration of the importance of the students' perceptions of the socio-cultural interactions in their development of learning and their ability to negotiate entry into groups, teams and communities. Negotiation and subsequent participation is essential in the development of an individual student's nursing identity and an understanding of their specific learning is incomplete without considering such social factors (Wenger, 1998; Lave & Wenger, 1991).

The review begins by exploring and critically reviewing the literature of the current professional and political context relevant to student nurses as they embark on their career and progress through their student nursing experience. Internationally nursing, and health care in general, faces enduring and significant demands. Therefore the environment that student nurses experience and learn in is one of ongoing challenge - including a shortage of registered nurses and the resultant absence of mentors and clinical role models; real or perceived lack of resources; considerations of failing or less than optimum care and ongoing debates about the appropriateness and suitability of the current student nurse population - their recruitment, education, experience, assessment and consequent preparedness for practice and registration.

This is followed by a critical appraisal of research pertinent to the adult student nurses' experience and their shifting identity as they progress through their clinical experience and academic studies.

This is in order to establish what was already known, to identify key issues and assess the quality of evidence that currently exists; whilst also identifying gaps in the existing knowledge base.

It has been argued, especially by researchers from a phenomenological background, that beginning with an extensive literature review risks prejudicing any research, as the researcher may then attend only to the data that supports what is already discoverable within the literature

about the phenomenon (Miles, Huberman & Saldana, 2013) or create further suppositions or biases about the topic under consideration (Streubert Speziale & Rinaldi Carpenter, 2011). However the experiences of student nurses has been explored from a variety of perspectives and in a variety of contexts, therefore ignoring what was already known was not an option if I wanted to uniquely contribute to the current body of knowledge and advance findings that might inform education, research, practice, and policy. The literature review undoubtedly influenced the subsequent data analysis and it was important to continue to be acutely aware of that fact. The ongoing review also presented a continued reflexive challenge, due to both my own previous preconceptions of the student experience and my initial and continuing collection and analysis of increasing amounts of data. I constantly considered my thoughts, ideas and presuppositions about the topic in order to increase my awareness and remind myself of the potential judgments that I might make during data collection and analysis. I strove to achieve an 'empathetic neutrality' (Ritchie, Lewis & Ormston, 2014) avoiding conscious, systematic or obvious bias may be the aspiration. However absolute neutrality, even if desirable, is simply not achievable, as there is no such thing as 'objective knowledge' and my influence and preconceptions will therefore inevitably pervade the research to some extent. This is inevitable. My personal and professional history, experience, understanding and perspective had driven my interest in the research in the first place and therefore my beliefs and values had to be made as explicit as possible to myself through the research process. In relation to the conduct of the research, these are practical and technical considerations but also reflect relevant ontological and epistemological implications.

Attentive to such concerns, a literature review was undertaken to help locate the research in the broader scholarship in this particular research area and to critically appraise the available and pertinent literature (Green & Jackson, 2014).

Before describing the search strategy, I recognise that much of the academic research that is explored and critically analysed in this chapter may have relatively limited transferability. By the very nature of the mainly qualitative approaches, much of the evidence is relatively 'small scale' and reflects a very specific context. This caveat does not necessarily reflect on the 'quality' of the research itself, as generally it would be inappropriate to attempt to explore the shifting identity of any population in large scale research.

Research from a varied international perspective is also included, however, unlike in the UK where all adult nursing students are generally educated and trained for the majority of time in the NHS or related organisations - internationally the adult student nurse experience may not be replicated or be too similar, due to a lack of a collective health care system in some other

countries. Therefore it is important to continually be aware that the context of practice, particularly, may be significantly different from the UK, when analysing data from an international perspective. This is perhaps most obvious in the relatively limited time adult nurses spend in clinical practice in many countries compared to the UK.

3.2 The Search Strategy

The aim of any search strategy is to be as comprehensive and systematic as possible to identify and locate the most relevant range of published material whilst remaining focussed on the aims and objectives of the study. The specific and precise research question dictated the hierarchy of evidence that became a guide that supported the iterative process and promoted the development of specific inclusion and exclusion criteria (Aveyard, 2010). (Appendix One: A Literature Search Strategy)

3.2.1 Key words and phrases

Initially key words and phrases included: nursing student experience, adult nursing students, becoming a nurse, nursing as a career choice, fitness for registration, professional identity, communities of practice, and further advanced searches involved combining these words and phrases both together and with other relevant concepts. These further concepts included developing and emerging themes generated by the review; my reflection on the evolving ideas and insights and the early data from the initial focus groups. Examples of further concepts included – older nurses; poor practice; whistleblowing.

The 'Summon' search engine was utilised via the university library resource. Summon allows access to several electronic databases including: Cumulative Index to Nursing & Allied Health Literature (CINAHL); MEDLINE, EMBASE, BioMed Central, RCN, Science Direct, Springer Protocols, TRIP database, Emerald journals, Evidence Search.

This was therefore the chosen means to access relevant and current literature to support my exploration of the subject. This was reinforced by consideration of further professional literature, policy documents and grey literature resources via means such as Google Scholar and utilisation and examination of relevant references and significant citations from the original literature that had been initially generated by the search.

This approach produced substantial literature related to the chosen area of exploration and indicates the depth and complexity of the literature that supports the research exploring what it means to become a nurse. What follows is a critical review of the most significant and

important work that helped inform my ongoing and subsequent analysis of the context of the student nurses' journey and shifting identity.

The main areas highlighted by the review are critically and logically explored in this chapter. These included: the professional context and the expectations and role of the professional and regulatory bodies; 'becoming a nurse'; the changing expectations and experiences of nursing students; and the impressions of the profession by established nurses and others following such events as The Mid Staffordshire NHS Trust review and other related policy documents. There is significant literature also exploring the importance of relationships between students and the established nursing workforce – and the relevance this relationship has to their learning; as well as the ongoing discussions of the theory-practice gap and the occasionally dissonant relationship between university and clinical practice.

3.3 The Professional Context

3.3.1 The Nursing and Midwifery Council

Those who choose to embark on a career as a student nurse in the UK are challenged to recognise and adhere to the professional expectations of what it is to be a nurse. According to the regulatory nursing body, the NMC, although student nurses work under the supervision and support of a qualified professional they must still provide a high standard of practice and care at all times, take responsibility for the care they personally provide and also recognise their essential, wider contribution to the aims of the teams that they are part of, and the National Health Service as a whole (Nursing & Midwifery Council, 2012). There is a professional expectation that student nurses develop into practitioners who are able to advance practice and be key change agents and decision makers with an ability to think analytically, problem solve and make, and act upon, judgements (Nursing & Midwifery Council, 2010). Such demands and expectations highlight the complexity facing nursing students, irrespective of their background and experience, whether novice or more experienced in healthcare, as they further explore their understanding of nursing identity and attempt to establish and confirm what it means 'to become a nurse'.

All nursing practice and experience is undertaken within a setting of an externally prescribed professional context. To become a nurse - or at least be deemed appropriate to legitimately utilise and practice with that title - all student nurses must fully understand the nurses' various roles, responsibilities and functions, and adapt their practice to meet the changing needs of people, groups, communities and populations. They must practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing

that respects and maintains dignity and human rights (Nursing & Midwifery Council, 2012; 2010).

The NMC Standards for pre-registration nursing education, relevant to *current* student nurses, (Nursing & Midwifery Council, 2010) also speak of the necessity for students to be able to respond autonomously and confidently to situations that they may experience in their practice, whether that be planned or spontaneous, in uncertain and fast changing situations. According to the NMC, it is essential that any student nurse is able to build partnerships and therapeutic relationships through safe, effective and non-discriminatory communication; whilst also being self-aware and cognisant of how their own values, principles and assumptions may affect their practice.

The fulfilment of such important responsibilities requires an environment that promotes a legitimate confidence, competence and ability in the student; along with the proficiency to analyse complex problems and make sound clinical judgements. This ability to judge and analyse comes via advanced and up-to-date knowledge and also requires a setting that develops and sustains a significant level of, what the RCN describe as 'self-confidence and self-esteem' (Royal College of Nursing, 2004).

The NMC acknowledge the influence of the European Tuning project (Tuning Educational Structures in Europe, 2009) in their discussions of the standards that student nurses should eventually achieve and be assessed or judged against. According to the European Tuning project the student nurse must eventually become 'a safe, caring, and competent decision maker willing to accept personal and professional accountability for his/her actions and continuous learning' (Tuning Educational Structures in Europe, 2009). To evidence this the NMC utilise a competency framework that students must meet to achieve registration on the professional register (Nursing & Midwifery Council, 2010). To be deemed suitable to use the title 'nurse' each student is presently assessed against the four domains: professional values, communication and interpersonal skills, nursing practice and decision-making and leadership, management and team working.

3.3.2 NMC Standards 2018

The students who participated in this research are assessed against the previous standards of competence; however in 2018 the NMC published new Standards of Proficiency for Registered Nurses and Education Framework: Standards for Education and Training for all UK providers of nursing and midwifery education (Nursing & Midwifery Council, 2018a; Nursing & Midwifery Council, 2018b). These standards may be used from 28th January 2019.

Interestingly in relation to my research aims; one of the key findings from an independent evaluation included the need to improve the confidence of newly registered nurses along with the requirement to address variable quality and consistency in practice placements and mentorship (Nursing & Midwifery Council, 2018a; Nursing & Midwifery Council, 2018b). The new proposed Education Framework uses a model of five pillars of education and training:

1) Learning culture – *valuing learning in all settings*

2) Educational governance and quality

3) Student learning and empowerment

4) Educators and assessors

5) Curricula and assessment

The new standards reiterate several key principles that are priorities for future students – including: that they are protected from behaviour 'that undermines their performance or confidence' (Nursing & Midwifery Council, 2018. Part 1:3.12) and are supervised and supported in practice learning by practice supervisors 'who serve as role models for safe and effective practice' (Nursing & Midwifery Council, 2018. Part 2:3.1) and with current knowledge and experience' (Nursing & Midwifery Council, 2018. Part 2:3.8).

It appears that the traditional responsibility and key role of the mentor – or at least the actual title - is being challenged in the new NMC guidance. Each education institute, practice placement and work placed learning partner must now have 'a nominated person for each practice or work placed learning setting to actively support student issues and address student issues and concerns' (Nursing & Midwifery Council, 2018. Part 2:1.5). There are now different roles such as practice *supervisor* and practice *assessor* which will play significant roles in the support and assessment of student nurses where previously the *mentor* took a central role.

Lord Willis in 'Raising the Bar' (Health Education England, 2015) had proposed that the nursing regulatory bodies may need to radically rethink the philosophies of mentorship and amend the standards requiring one-to-one mentor support for students – not least due to the lack of sustainable funding to ensure the provision of good mentorship. This has challenged the fundamental principle that *all* registered nurses should eventually take on the responsibility of being a mentor as a clear role expectation 'regardless of whether they function as informed role models or are motivated to fulfil this role' (Health Education England, 2015 p.46). This adjustment in principle is resultant from evidence of the poor supervision that many student nurses experience. If the role of a mentor is simply an expectation of *all* registered nurses rather

than for those with commitment and enthusiasm for the role, it is unsurprising that the quality of student supervision is variable. The degree to which the mentor and the practice-learning environment value and respect practice based learning will inevitably impact significantly upon student outcomes, both in terms of learning and progression and also in the desire to complete the course and achieve professional registration (Royal College of Nursing, 2017).

3.3.3 The 'Mentor' according to Nursing and Midwifery Council terminology

It is important to recognise that the NMC previously, and indeed currently until the initial implementation of the new standards in 2019, have a very specific definition and criteria for use of the term 'mentor'. An NMC mentor is a registrant who must have successfully completed an NMC approved mentor preparation programme and has achieved the knowledge, skills and competence required to meet the defined outcomes. They must also be on the same part of the professional register as the student they are to assess and have been registered for at least one year and developed their own knowledge, skills and competence as identified through a Personal Development Planning (PDP) review. The specific role of a mentor is further articulated as a person who 'facilitates learning and supervises and assesses students in a practice setting' (Nursing & Midwifery Council, 2008 p.45). Assessment of a student's competence is part of the NMC mentors' role which is not necessarily the case in many definitions of a mentor.

3.4 Nurse education – the 'political' context

As noted previously, Lord Willis gathered evidence on the 'best methods of delivering pre-registration nursing education in the UK' (Willis, 2012 p.2) and recommended certain fundamental changes in the education of student nurses, one of which was to revisit the fundamental role of mentor.

He also claims that nursing is 'an incredibly self-aware profession' and yet he concedes that nurses need to 'stand up to be counted' (Willis, 2012 p.6) to restore professional pride and provide leadership and solutions to the challenges of poor care and decline in public confidence (Willis, 2012). The report took evidence and opinion from a variety of sources endeavouring to decide whether the current delivery of pre-registration education and training results in students who are fit for professional registration and furnished with the appropriate knowledge, skills and competence for current and future health care. Notwithstanding the evidence of a significant reduction in the amount of registered nursing staff who are willing and able to lead

and mentor the next generation of nurses to help ensure this happens (Care Quality Commission, 2015).

It is also difficult to confirm with any certainty what is meant by a 'self-aware profession' or what 'stand up and be counted' might entail in this context as a proposed basis for further policy development or research. The Willis Report (2012) does emphasise that due to the increasing demands, specialisms and complexities of future health care, current and future nursing students will require greater reserves of *self-determination* and *leadership* if the workforce is to be maintained - or indeed become - both competent and compassionate. The report also confirms the necessity for the great variety of healthcare providers to be 'full partners' (Willis, 2012 p.6) in the education of student nurses if this aspiration is to be achieved. This further confirms the relevance of my research, as it will help clarify whether the experience of a group of adult nursing students across a variety of healthcare environments, and the associated shifts in identity, might indeed engender this greater ability, confidence, self-determination and leadership.

3.5 The Clinical Placement Contexts

3.5.1 'Culture of the workplace'

Willis (2012) claimed that the 'culture of the workplace' is a crucial influence on learning. Similarly, Berwick and the National Advisory Group on the Safety of Patients in England (DH, 2013b) in their report written in response to events at Mid Staffordshire Hospital, as explored in the Francis Report (Francis, 2013), challenges the NHS to change and *embrace an ethic of learning*. Berwick claims that the most powerful foundation for advancing patient safety within the NHS is the potential for being a 'learning organisation'. Unfortunately it is difficult to understand exactly what such an organisation might consist of. Being, or more particularly, simply *claiming* to be a 'learning organisation' does not - by default - ensure any desired, positive outcomes. Berwick does at least attempt *some* clarification by warning against the simply mechanistic imposition of rules, incentives or regulations in organisations. However it is difficult to see how such an unsophisticated view of learning is helpful. Clearly the NHS, like any organisation or community constantly changes and therefore to simply say we should learn from the past is problematic. The present represents a different set of circumstances, a different culture and therefore different behaviours which all represent *learning*. What pronouncements such as Berwick's indicate is a belief that staff working within certain organisations should learn *certain, specific* things - without necessarily clarifying what those

things might be and thereby simply offer a rather unhelpful, nebulous concept of a 'learning organisation'.

Part of this literature review will explore the evidence as to whether adult nursing students are presently experiencing their clinical practice in what might be appropriately described as 'learning organisations'.

3.5.2 Clinical placement experience - student progression and attrition - a historical perspective

Currently clinical placements comprise at least 50% of the programmes for nursing in the UK (Nursing & Midwifery Council, 2018) and clearly, therefore, a clinical practice setting that generates a positive learning environment is very significant for nursing students (Pearcey & Elliott, 2004). The introduction of *supernumerary status* for students and the move away from employment by a specific NHS organisation in the 1980s was supposed to enhance the attractiveness and effectiveness of nurse education by ensuring that students had access to greater learning opportunities whilst in clinical practice; rather than largely being required to undertake, what were seen as, repetitive low skill tasks (UKCC,1986). The aspiration was for clinical placements to support the development of knowledge, skills and competence, encourage commitment and boost student retention upto and beyond professional registration. Clinical placements were, and still are, recognised as essential in the development of students' attitudes and professional socialisation and a major contribution to the formation of a professional identity during the educational process (ten Hoeve, Castelein, Jansen, Jansen, & Roodbol, 2017; Clements, Kinman, Leggetter, Teoh, & Guppy, 2016).

However, attrition rates in student nurses have continued to be a concern, both in the UK and internationally, and it has been suggested that the pressures within clinical practice mean that many practitioners often regard supporting nursing students as additional, non-essential work and that this may lead to an unsatisfactory clinical experience for the student (Rylance, Barrett, Sixsmith, & Ward, 2017; Duffy, McCallum, & McGuiness, 2016). For example Pryjmachuk, Easton and Littlewood (2008) found an association between levels of support found in the clinical placement environment and subsequent student attrition; and although Last and Fulbrook (2003) did not establish a causal relationship, the students' comments about the demotivating aspects of poor support within clinical placements were undoubtedly present in their analysis. The levels of support from established nurses - those that Lave and Wenger (1991) might call old timers - and the facilitation of 'team membership' as perceived by

students therefore appears critical to their progression, learning and motivation to stay and achieve.

3.5.3 The challenges to learning experienced in clinical practice environments

Although Gilbert and Brown (2015) believe *length of placement* is likely to maximise learning, difficulties experienced specifically within any clinical placements are an essential consideration when exploring the experiences and shifting identities of student nurses. As previously stated in the UK, nursing students spend 50% of their degree course in clinical practice, and evidence indicates that many students are attempting to learn whilst experiencing significant challenge in most practice environments.

For example in a survey with over 7700 respondents, the RCN found that just under half (49%) of nursing staff said they had gone to work when unwell at least twice in the past year; with stress and mental health problems accounting for a significant proportion of those health problems. Respondents believe that 'growing workplace pressures' (Royal College of Nursing, 2017 p.4) are contributing significantly to 'sickness, stress and burnout' resulting in low levels of morale and motivation, with nursing staff now less likely to recommend nursing as a career than at any point in the last ten years and 37% reporting that they are looking for a new job.

Whilst this survey mainly sought the opinions of qualified nurses, their answers are, at least in some way, indicative of the pressured, challenging context and potentially unsupportive environment that many *student* nurses are also experiencing. Of the respondents 147 were student nurses and interestingly they appeared much more likely to report having been physically abused in the last twelve months than nursing staff in other roles (Royal College of Nursing, 2017b).

An equally challenging picture had been presented in 2012 when a RCN survey of over 2000 *qualified* nurses indicated around half of them had 'felt unwell due to work related stress' over the previous twelve months whilst 32% had felt unwell due to negative 'relationships with co-workers' (Royal College of Nursing, 2013). The research included 56 pre-registration student respondents, and within this relatively small group, it is noteworthy that a higher proportion than that of the qualified nurses indicated that their levels of stress had increased over the previous year (78%). In a prescient comment one student respondent remarked about their experience on clinical placement and their concerns that their experience was making them ill-prepared for the future: *'not being able to do things as a student and not having a mentor around. Being treated as health care assistant and not being taught skills I need to learn'*

(Royal College of Nursing, 2013 p.53). The authors of the 2017 report emphasise that in many respects the pressure on the clinical workplace environment has got considerably worse in recent years. They highlight a clinical setting where all colleagues are experiencing 'short-staffing, abuse and low morale' (Royal College of Nursing, 2017 p.1).

A similar insight into the challenging environment students are placed is highlighted by Aiken, et al., (2012) in their major international cross-sectional survey of patients and nurses. They confirm that incidents of job dissatisfaction and subsequent intention to leave the profession are not unique to the UK nursing population and are replicated in many countries. Moreover students and qualified nurses' assessment of a *negative work environment* and subsequent job dissatisfaction generally concur with those made independently by service users or patients, with job dissatisfaction among nurses contributing to incidents of quality of care deficits and subsequent increased risk to patients (Aiken et al, 2012; McHugh, Kutney-Lee, Cimiotti, Sloane & Aiken, 2011). A negative work environment may be the result of many variables – not least nursing staffing levels. For example, evidence indicates that an increase in a nurses' workload by one patient alone increases the likelihood of inpatient deaths (Aiken et al., 2014). Similarly, results of the Keogh review of 14 NHS Trusts in England showed that inadequate nurse staffing was an important factor in persistently high mortality rates (Keogh, 2013). This is further supported by a study undertaken in Switzerland which suggested significantly increased surgical mortality was associated with inadequate nurse staffing and poor work environments for all nurses, including students (Schubert, et al., 2013).

Conversely hospitals with more positive work environments, as evidenced by considerations such as appropriate nurse staffing levels and managerial support for nursing care, good doctor-nurse relations, nurse participation in decision making and quality of care being seen as an organisational priority, appear to result in improved outcomes for patients, nurses and student nurses alike. This claim of general improvement in patient care and greater staff and student satisfaction should such positive work environments pertain, is supported by research undertaken by Blackman et al. (2014) and Vahey, Aiken, Sloane, Clarke & Vargas (2004) amongst others. However Blackman et al. (2014) highlight only nurses' *reported* reasons for missed care rather than care that is actually missed and is also only characteristic of nurses working in a specific area of South Australia. Similarly Vahey, Aiken, Sloane, Clarke & Vargas's (2004) survey research in the United States records nurses' *feelings* and admits to offering little in fully understanding how the features of organisations actually affect the

process of nursing care and therefore how these processes may ultimately relate to genuinely tangible and measurable outcomes.

3.6 The Clinical Mentor – the main 'role model' in the student experience?

The clinical mentor appears to play a significant role in the provision of a positive work setting and resultant supportive clinical learning environment, however, there appears to be no international consensus on the definition of mentorship and the term can be used interchangeably with 'supervising', 'preceptoring' or 'facilitating' (Chandan & Watts, 2012). In the UK, the NMC definition of a mentor is a clinical nurse who 'facilitates learning, and supervises and assesses students in a practice setting' (Nursing & Midwifery Council, 2008 p.45). More specifically NMC Standards require all pre-registration nursing students to be allocated an appropriately qualified named mentor who must commit to directly or indirectly supervising 40% of a students' time in clinical practice (Nursing & Midwifery Council, 2010).

However, as I have highlighted, the NMC now propose to replace the term mentor with terms such as practice supervisor, practice assessor and academic assessor (Nursing & Midwifery Council, 2018). Lord Willis had advised that the NMC should review its current mentorship model and standards, and 'amend the standards relating to the requirement for one to one mentor support' (Willis, 2015 p.49). One of the major concerns is around the current expectation that all nurses become mentors, rather than recruiting only those with the ability and enthusiasm to undertake the role. The mandatory nature of the expectation of mentorship is presumed to affect the quality of support and impact on the enthusiasm of the mentor and negatively influence their position as a potential role model. Some students believe that some mentors appear to be simply expected to undertake the role with little preparation or choice in the matter with good mentors who can be viewed as positive role models then being viewed like a 'breath of fresh air' (Pearcey & Elliott, 2004 p.386).

Not least due to such considerations, the NMC (Nursing & Midwifery Council, 2018) have now more clearly separated the *supervision* of students from the *assessment* of students and confirmation of proficiency. However the Standards still insist that education institutions and practice learning partners ensure that all students are continually supervised while learning in practice in a coordinated manner and that practice supervisors serve as role models for safe and effective practice (Nursing & Midwifery Council, 2018 p.6). Practice assessors must have an understanding of the student's learning, work closely with practice supervisors to gather and

coordinate feedback and continue to proactively develop their professional practice and knowledge to fulfil their role (Nursing & Midwifery Council, 2018 p.10). These considerations mirror many of the requirements previously articulated in the role of mentor. The Standards also confirm that it remains the responsibility of *all* nurses to contribute to practice learning as enshrined in The Code (Nursing & Midwifery Council, 2015).

Perhaps not too surprisingly, Jokelainen, Turunen, Tossavainen, Jamookeeah and Coco (2011), prior to undertaking a systematic review, confirmed that the principles for the mentoring of students were, in reality, *rather vague*. As there was no universal agreement on student mentoring in placements, this resulted in a variety of different approaches and different student experiences. Their review presented two main themes 'Facilitating students' learning in clinical placements' and 'Strengthening students' professionalism'. They highlighted the complexity of mentorship and confirmed that it involved integrating both individual and organisational aspects and also the environmental, collegial, pedagogical and clinical attributes present in nursing placements (p.2863).

Despite the accusations of vagueness of the concept (Jokelainen et al., 2011) the exploration of the role of clinical mentor has a very long history in nursing. Clinical mentors, as with the new practice supervisors (Nursing and Midwifery Council, 2018), are frequently assumed to be role models (Felstead & Springett, 2016; Gray & Smith, 2000). Yet it is clear that the ability to role model can be compromised by the pressured context that mentors - and one would, therefore, presume future practice supervisors and practice assessors - and students -find themselves in. As I have previously discussed, pressured workload issues - for all registered nurses and for mentors in particular - and how these interfere with their capacity to mentor students and others, have been reported across a range of nursing settings; with the demands of the clinical workload a significant barrier to effective mentorship (Wilson, 2014; Hurley & Snowden, 2008). Wilson (2014) utilising a phenomenology methodology to interview twelve mentors - who although they worked in a variety of clinical environments, some had only experience of mentoring *one* student nurse - evidenced that some mentors often compensated for the extra demands of mentorship by having to work 'faster (or) working without breaks' (p.317) with limited opportunities for recovery and rest. Similarly Hurley and Snowden (2008), who sent a questionnaire to all registered nurses (n118) on three critical care wards in just *one* acute Trust in the UK, with only 34% response rate; found that those nurses and mentors had difficulty supporting students for several reasons not least that they felt that they were having to supervise

and assess learners on almost every shift and suffering from what the authors call 'mentor overload' (p.272).

An effective mentor might be perceived as being professional and confident with a commitment to preparing future practitioners (Carr, 2008) and frequently seen as reflecting the professionalism and positive characteristics which have also been closely linked to that of a 'good nurse' (Baldwin, Mills & Birks, 2014; Donaldson & Carter, 2005). Although Foster, Ooms and Marks-Maran (2015) confirm that sixteen of fifty-three (29.6%) of the students in their focus groups did not agree that good nurses necessarily always made good mentors. However the focus group participants were from a convenience sample from one university nursing cohort only and led by a researcher known to the participants; all of which might compromise the data and limit transferability. Neither were mentors' opinions sought or included in the study which may have offered a more balanced picture.

Mulholland, Mallik, Moran, Scammell and Turnock, (2005) used a case study approach of five different disciplines including nursing, and concluded, from the rather limited data and from their literature review, that there was little recognition and acknowledgement by employers of the demands of the role of mentor, relative to patient/client workloads. Additionally as mentorship is presently incorporated into the registered nurses' role, this suggests little genuine or significant value is attributed to the role and that there is minimal acknowledgement of the time required for effective student supervision - which is likely to compromise the mentors' commitment to the role. It is noted however that their initial questionnaire to nurses was limited by only nineteen returned respondents (23.8% response rate) and the subsequent numbers contributing to the focus groups are unclear. The focus group participants were also self-selecting and recruited from workshops designed to explore practice based learning and therefore cannot be assumed to reflect the opinions of typical nurses with no such *specific* interest.

Brammer (2006) undertook a phenomenological study with thirty purposively sampled *qualified* nurses in Queensland Australia and identified different categories highlighting how nurses understood their role as a mentor. Some viewed their role as being a Facilitator, Teacher/Coach and/or Overseer/Supervisor and therefore conceptualised their role with students viewed as a future peer and colleague. Others viewed their role more as, what Brammer defined, as Manager/Foreman and/or Authority who saw 'control' as the focus and the student as an added work burden and others, viewed by Brammer as Dissenter/Resister,

whose preference was to generally avoid students all together (Brammer, 2006). Brammer concluded that more formal recognition of the complex ways registered nurses as mentors promoted or impeded the quality of students' learning was required. The sample size is very small, however, and is conducted in only one State in Australia and therefore findings may not be representative of other countries or health care systems such as the NHS in the UK. It is also noteworthy that the views and experiences of *students* were not included - although the qualified nurses' reflections of their previous experiences as students were.

The literature consistently indicates that from a mentor perspective, mentorship can be perceived as a challenging experience for several reasons - not least for those who, as we have seen, do not want to take on the role (Norman, 2015). Presently many mentors are assigned the role rather than choosing to take on the responsibility (Nash & Scammell, 2010) and it is clear that some registered nurses are disinterested in being mentors (Papp, Markkanen & von Bonsdorff, 2003).

3.6.1 Mentors and students – the crucial and changing relationship

Positive mentorship therefore appears to be crucial to a positive learning environment for students. Mentorship in a nursing context is recognised as a complex concept, and seen as much more than simply supervision, as it can involve the building of a relationship that consists of significant nurturing and protective elements as well as its inherently educative features (Foster et al., 2015; Aston & Molassiotis, 2003). Wilson's (2014) phenomenological research indicates that many mentors made significant commitment to the mentor role and highlighted that the mentor/student relationship can be intensely personal and that many mentors are keen to inspire students to pursue their goals by organizing opportunities, being vigilant, leading by example and so on. However it was still recognised that good nurses do not necessarily make good mentors. (Wilson, 2014). Foster et al. (2015) used a convenience sample of final year nursing students (n = 53; response rate = 45%) to explore their expectations and experiences of mentorship and support in practice. Overall students were positive about their experiences and identified themes that they valued from mentors, such as explaining/teaching, support/supervision/help, encouragement, feedback, identifying new learning and assessment. Furthermore, although some previous studies - such as Crombie et al. (2013) - suggest that poor mentorship can lead to students thinking about leaving their nursing programme, students in this study did not indicate that this was an issue for them (Foster et al., 2015).

Gray and Smith (2000) in their longitudinal study of a small cohort of ten students in Scotland found that students quickly lost a rather idealistic initial view of their mentor - students initially believed their mentor would be a supportive person who would be 'exclusively for them', for example - whereas by their fourth practice placement they recognised the competing priorities that had to be managed by their mentors (Gray & Smith, 2000 p.1545).

This realisation of competing priorities can lead to a negative experience for some students who often feel they are viewed as little more than a hindrance and feel the need to foster the 'right attitude' to survive (Crombie et al., 2013). This is part of a strategy to, hopefully, be perceived as less of a burden and results in their engagement in tasks they accept as useful to the ward environment but not necessarily valuable to their learning. The identity adopted was of someone who was non-threatening and non-challenging, who accepted variations of decision-making, even when these were perceived as erratic and inconsistent. For some students there was a perception that the old timers had a concept of the 'ideal student' - the major characteristics of whom were 'white, dependent-free, young and accepting of the status quo' (Crombie et al., 2013 p1284). The adoption of this neutral identity may reduce stress in the short term; however as the course progresses this can result in increasingly resentful feelings and growing reluctance to engage in the type of work viewed as mainly delivered by support workers (Mackintosh, 2006).

3.6.2 Assessment of students - the role of the clinical mentor

As I have noted, mentors, as previously articulated and endorsed by the NMC, carry a requirement to assess the student's progress to becoming a 'registered nurse', against specified competencies and their ability to learn from experience and reflection (Nursing & Midwifery Council, 2010). This has now been more clearly differentiated in the new standards by the creation of the role *practice assessor* (Nursing & Midwifery Council, 2018). However, assessment is not necessarily traditionally part of the concept of a 'mentor' and some students perceive that mentors place too much focus on evaluation and assessment rather than their key role as a supportive role model and facilitator of learning and development (Sharif & Masoumi, 2005). The priority of the assessment role thereby negatively influences the students' general relationship with their mentors (Gray & Smith, 2000). Not least as Hunt, McGee, Gutteridge, and Hughes (2016a) maintain the most important question in the assessment: *Is the student performing to the required standard?* - is underpinned by a system that functions mainly on the goodwill of the mentor and their willingness to give up their personal time and the readiness of others to give their backup and emotional support.

Assessment in student mentoring is therefore also undoubtedly challenging for the mentor themselves, as highlighted by Bray and Nettleton (2007) who distributed a questionnaire and subsequently telephone interviewed nursing, midwifery and medical mentors and mentees. Nursing mentors particularly felt difficulty in separating the professional role of assessment – where it might have been necessary to criticise a student - from the role of mentor as a 'supportive friend' (p.851). Similarly Huybrecht, Loeckx, Quaeyhaegens, De Tobel and Mistiaen (2011) presented the results from a questionnaire of 181 mentors - with 112 responders (62% response rate) - which confirmed that one of the causes of particularly high distress for mentors was when they felt compelled to record a negative assessment which might be at odds with the student's own judgement. Heaslip and Scammell (2012), surveying a convenience sample of 107 nursing students and 112 mentors, devised a practice assessment tool to help participants feel more enabled and discerning in their allocation of a grade for student's practice, however this *still* did not increase their confidence when it came to failing a student.

Confidence can also be challenged by students responding negatively to mentors' feedback. Hunt, McGee, Gutteridge and Hughes (2016a; & b) highlighted that students can display a variety of behaviours - coercive, manipulative or even aggressive. For example 'Ingratiators' were characterised as students who curried favour with their mentors by deliberate efforts such as being charming, obliging, indulging or emotionally exploitative. When faced with not passing a student, mentors were susceptible to high levels of guilt and low levels of fear when students employed these tactics.

'Diverters' were depicted as students who attempted to distract and redirect the mentor's focus by elements unconnected to the area of underperformance - such as illness, personal circumstances, disability or on-going university proceedings. 'Disparagers' were students who challenged their mentor in belittling, denigrating or professionally harmful ways; either by questioning the mentor's reasonableness and competence, or by accusing them of harassment, bullying or discriminatory behaviour. Finally 'Aggressors' were students who were openly hostile to mentors after negative feedback - using verbal or physical threats – either directly or via a third party. It is notable however that students views were not sought in this research.

Perhaps not surprisingly, therefore, mentors still pass students even though they have concerns about the student's competence and/or attitude (Gainsbury, 2016). The reasons for this phenomenon are many, including the emotional involvement that mentors might feel in relation to their contribution in potentially ending a student's career (Hunt et al., 2016b; Sharples &

Kelly, 2007 Duffy, 2003) or the perception that a negative assessment might fundamentally damage the mentor-student relationship (Clynes & Rafferty, 2008) and some mentors are therefore reluctant to offer criticism in the belief that it may upset the student (Woodcock, 2009). Mentors can also feel that they have failed personally should a student be deemed to have done so (Sharples & Kelly, 2007) producing feelings of guilt and self-doubt (Rutkowski, 2007).

Moreover although the assessments require *concrete evidence* of professional values and behaviours, judgments about professional capability can also embrace the mentor's *personal impressions* of the student's enthusiasm or indifference (Webb & Shakespeare, 2008). Perceived lack of motivation in the student was indeed strongly stated as a reason not to take on the role of a mentor (Hurley & Snowden, 2008). *'Good mentoring'* therefore depended on students building a relationship with their mentors, and undertaking a great deal of 'emotional labour' to convince mentors that they were 'good students' in terms of attitudes as well as clinical competence. As Green and Jackson (2014) indicated, the literature appears to suggest that bad experiences in mentoring have a much longer lasting effect on students than good experiences.

Potentially further compounding this tension in the UK, there appears to be an increasing emphasis on assessment, and particularly with the implementation of the NMC sign-off mentors' policy and guidelines (Nursing & Midwifery Council, 2008), it is argued that there is a risk that there has been a dilution of the fundamental supportive and educative aspects of mentorship (Nettleton & Bray, 2008). A 'sign-off' mentor is a nurse mentor who has met additional NMC requirements in order to be able to make judgements about whether a student has achieved the overall standards of competence required for entry to the register at the end of an NMC approved programme (Nursing & Midwifery Council, 2008). The instigation of a principle of sign off mentors in nursing was in part driven by the phenomenon of '*failure to fail'* (Duffy, 2003). Evidence from 27 universities in England indicated a ratio of five academic failings for every one failing in practice (Hunt, McGee, Gutteridge & Hughes, 2012). In further research, Hunt et al., (2016) used a grounded theory approach to explore thirty-one registered nurses' experiences of failing student nurses in their practical assessment in England. They found that although the first stage of a mentor's decision to fail a student focussed specifically on the student's performance; most of the ongoing decision making process revolved around the mentors deciding if they were able - or prepared - to undergo the expected challenges to their decision to fail. This is evidence of the sometimes perplexing relationship *between clinical practice and the potentially differing priorities of university colleagues.*

3.7 The University and Clinical Practice Dissonance

A related concern of some students is that mentors are not necessarily sufficiently aware of the different learning objectives that students at different levels or points in their training might have, and exactly what they need to achieve, and are therefore unable to *authentically* assess the evidence (McCarthy & Murphy, 2008). Such goal oriented assessment of a student's performance requires mentors to have a comprehensive understanding of the goals of the student's placement. However, as I have highlighted, much of the literature indicates that, mentors and other clinical facilitators often have inadequate preparation for the role (Omansky, 2010) or experience workload pressures that limit their capacity for effective clinical teaching and subsequent assessment of learning (McCarthy & Murphy, 2010; Omansky, 2010). Mather, McKay and Allen (2015) confirmed, in their survey of sixty Australian registered nurses, nurse managers and clinical nurse educators that they felt a lack of confidence about facilitating learning in practice that was related to the students' academic programme.

A key role for a mentor is to evidence behaviours and attitudes that a student will recognise and adopt and go some way to ameliorating any dissonance that they might experience between their experience and the expectations - not least those furnished by staff at their university. Curtis et al., (2012) in their grounded theory study interviewed nineteen student nurses and five nurse teachers from a university in the north of England whilst also examining data from NHS patients and staff surveys from the same area to help build a contextual picture of the student experience. They confirmed that the students in their small study experienced dissonance when their expectations of compassionate practice - as explored at university - were confronted with the reality of practice.

Nursing has a long history of such examples of dissonance when confronted by the realities of practice, not least highlighted by the concept of *reality shock* described in Kramer's (1974) seminal work that explored nurses' experiences of moving into the world of work as *qualified* nurses. As Dean of an undergraduate nursing programme at the University of California, in the United States of America she sought to identify the processes, facilitators and deterrents to effective incorporation of nursing students into the reality of nursing work. Kramer defined such shock as a state of anxiety, precipitated by the loss of the familiar, when an individual is immersed into a cultural system markedly different from that which they are used to (Kramer, 1974). Kramer specifically focused on the realities of clinical practice as manifested and dealt with by new graduate nurses, however, she also proposed that nursing students were moving

from the subculture of the school of nursing into the world of clinical practice and *real work*. 'Reality shock' is described as the reactions of those finding themselves in a situation 'for which they thought they were prepared and suddenly find they are not' (p.8). This experience of shock can be felt due to the professional-bureaucratic conflict arising from the differences in culture from the 'idealism' of, what was then, the school of nursing and the 'reality' of the world of clinical practice. She identified that the professional ideals and values inculcated in the schools of nursing were not operational in a hospital environment resulting in a total social, physical and emotional response – *reality shock* (Kramer, 1974).

Boychuk Duchscher and Cowin (2006) equally believe that recently graduated nurses may experience inherent *value discrepancies* between the academic environment and the clinical context into which they then become initiated. This generates feelings of anxiety, insecurity and inadequacy which has also been called *transition shock* and confirming the requirement for greater preparation for students in their transition into a practice environment of continuingly changing expectations (Boychuk Duchscer, 2008).

3.7.1 Clinical Practice and The University - The effect of the 'hidden curriculum'?

As we have seen, assessment of progress of a student nurse and their acquisition of the competencies needed to meet the criteria for registration can be compromised by mentors' lack of knowledge of the NMC standards (Nursing & Midwifery Council, 2010) which will undoubtedly be further compounded by instigation of the proposed new standards in 2018/2019. However, despite these legitimate concerns, much of the interaction between student and mentor, and/or other staff they engage with in practice, might most appropriately be viewed as relating to the often unarticulated or unexplored 'processes, pressures and constraints' which may fall outside the formal curriculum and 'objective assessment' - what is sometimes called the 'hidden curriculum' (Cribb & Bignold, 1999, p.24). It can be via this hidden curriculum that students are socialised into professional behaviours and practice (Allan, Smith & O'Driscoll, 2011). In their four site ethnographic case studies Allan et al., (2011) collected data from Higher Education Institutions (HEIs) and a range of clinical practice settings in acute NHS Trusts – using online survey, observational participation in the clinical areas and documented analysis of the written curricula in each HEI. They found that the learning as expected by the HEIs, which is facilitated significantly by a student's assumed supernumerary status when in clinical practice, is at odds with the reality of their experience. In reality trained staff expected the students to work while they learned and, by the time of their

registration, they were expected to be competent to work immediately as registered nurses. Allan et al., (2011) claim this leads to 'disintegrated learning' with practice knowledge running 'alongside formal, university knowledge' (p.853).

In *medical* education the hidden curriculum has revealed 'haphazard teaching', the reaffirmation of hierarchy by humiliation and a recognition by students that competition rather than cooperation appeared to be the defining professional characteristic (Lempp & Seale, 2004 p.772). However rather than *hidden*, much of these apparently intangible features of practice knowledge are in fact obvious to everyone involved, as legitimate teaching and learning alongside the formal curriculum – a 'para-curriculum' that remains officially unacknowledged in university but contributes significantly to the assessment of students' progression and 'fitness' (Allan et al., 2011).

The hidden curriculum highlights the strategies that students feel the need to utilise to gain best access to learning opportunities in clinical areas when, rather than facilitating access, mentors are essentially 'gatekeeping'. Students identify active learning and facilitating strategies, to a degree*, in spite* of the reality of their clinical context and the supposed supernumerary nature of their placements. Additionally, the hidden curriculum confirms that much learning in the clinical setting is dialogic and informal, often with exchange of experiential knowledge between the student and experienced clinician (Finnerty & Collington, 2013; Lave & Wenger 1991).

3.8 Narratives contrary to the students' understanding of nursing - the realities of practice

All such considerations contribute to the pressured environment that can confront the current adult nursing student as they progress through their undergraduate career. Particularly when confronted by narratives that are contradictory to their understanding of nursing, many students struggle to resist disruption to the construction or re-construction of their professional identity (Jackson, et al., 2011). For example Curtis, Horton and Smith (2012) in their grounded theory study interviewed nineteen student nurses and five nurse teachers from a university in the north of England and also confirmed that the students in their small study experienced dissonance when their expectations of compassionate patient care was confronted with the reality of practice. Furthermore a systematic review of the literature exploring nursing students' encounters with poor clinical practice by Ion et al., (2017) confirmed that one of the four major themes highlighted by the review was that the consequences of encountering and subsequently reporting poor practice appeared to have a lasting effect on students; with consequential

psychological discomfort not uncommon - irrespective of whether they had reported their concerns or not.

Such negative student experiences - *although as previously mentioned most of this research involves small samples and therefore has related constraints to its transferability* - and the resultant lack of attachment to the clinical environment and clinical colleagues inevitably generates significant issues in relation to the construction of a nursing identity (Walsh, 2015; Anthony & Yastik, 2011; Pearcey & Elliot, 2004). As Wenger (1998) suggests learning ultimately belongs to the realm of experience and practice and is essentially a social relationship.

3.9 Being a team member - 'Belonging' and 'inclusion' in clinical placements and the effect on student experience

Gilbert and Brown (2015), in their review of the literature concerning student nurses' experience of clinical environments in Australia, highlight that there has been limited research on the structure of clinical placements and its influence on learning opportunities, sense of belonging and ability to integrate knowledge with practical skills. The clinical experience and context of nursing students in Australia differs from students in the UK - not least in the length of time assigned to clinical placements - and Gilbert and Brown hypothesise that increasing the length of placement time would further maximise learning. They argue that clinical placements afford students the opportunity to link theory to practice whilst also promoting early socialisation into any nursing culture. They also highlight that students often identify that their ability to learn was impacted on negatively by this assimilation process, and only when they were 'considered to be a team member' did they learn new skills or consolidate previously learned skills, which led to feelings that they actually 'belonged' in the clinical settings (Gilbert & Brown, 2015 p.25). Baldwin et al. (2014) similarly highlight that students report that feelings of inclusion and valuing of their knowledge and skills impact on how they respond to their clinical placements, and in turn how well they achieved the associated learning outcomes. Student nurses' learning in the clinical setting is linked to how positive the social 'feel' of the clinical area is perceived by them and how the student role is recognised, appreciated and legitimised by the established community of nurses (Levett-Jones, Lathlean, Higgins & McMillan, 2009).

Levett-Jones and Lathlean (2009) interviewed eighteen, purposely sampled, third year nursing students from two universities in Australia and one in England to examine their experience of

belonging and conformity. They found that the experiences and perspectives of students from each of the sites were very similar; with the interpersonal relationships formed with the established registered nurses exerting the single most important influence on their sense of belonging. For some the development of positive relationships with the qualified nursing staff even took precedence over the establishment of a therapeutic relationship with patients - particularly until they felt they had established a place in the healthcare team. Therefore, joining such a 'community of practice' involves students negotiating with existing old timers and attempting to align to workplace norms to gain acceptance in the community, *potentially at the expense of their own values*. Egan and Jaye (2009, p.109) articulate this as the workplace saying: *'if you do not practice the way we do here, you cannot belong to our community'*. Similarly Liljedahl, Bjorck, Kalen, Ponzer and Bolander Laksov (2016) undertook an observational study 'shadowing' student nurses for fifty-five hours in three teaching hospitals in Sweden. They then undertook ten follow-up interviews with students, supervisors and clinical managers which they believed confirmed that 'belongingness' and membership of the workplace team was always conditional on the implicit expectation of their alignment to ward routines and traditions.

The positive experiences 'belonging' promoted for students included, mentors respecting and honouring them as individuals and an acknowledgement that, although they may presently be a learner of nursing, they are also a nursing professional in their own right. This positive experience can be engendered by working with students in an empathetic yet professional way and implementing actions that promote their growth in the nursing profession; whilst also placing appropriate trust in them and recognising and confirming the student's burgeoning capability (Levett-Jones & Lathlean, 2008). Collective identities are formed as a result of connections and a sense of belonging to a group. This is facilitated by becoming socialised and being 'part' of the profession and enhanced by the construction of a nursing identity. The relationship the student nurse develops with the immediate professional community influences the formation of their sense of nursing identity, especially if this community is a well-defined team that regularly reviews what it is doing, articulates values and translates those values into practice (Andrew, Tolson & Ferguson, 2008).

3.91 Non-acceptance – 'old timer' clinical staff, attitudes and being called 'the student'
It is clear, however that some students struggle to be accepted within the clinical environment, as their participation is not valued by mentors who feel that their supernumerary status cannot

equip them with the requisite skills to become genuine members of the community until they have had chance to work as a qualified nurse (Allan et al. 2011). Nursing students, who fail to gain entry into this elite environment and gain belongingness, experience their clinical placement as outsiders, often with detrimental results to their learning (Cooper, Courtney-Pratt & Fitzgerald, 2015; Kern, Montgomery, Mossey & Bailey, 2014). Walsh (2015) undertook a phenomenological study - of two focus groups only - and utilised communities of practice principles as a theoretical framework and found that students believed that the established clinical team did not always recognise their individual identity; this was particularly evidenced by them frequently being referred to, simply, as 'the student'.

Jack, et al. (2018) undertook a survey of 1,425 student nurses from nine institutions in the North West of England and followed up with unstructured interviews with twenty-two students from across the nine institutions. They again indicate that students' learning is compromised by being ignored, treated unfairly, feeling unsupported and having their supernumerary status disregarded. Conversely, they again confirm that, students learn best when they have a feeling of *belongingness* in the clinical area and recognise and value the enthusiasm of mentors for teaching.

The attitude of established clinical staff to student learning is therefore clearly critical. Brammer (2006) undertook interviews with 30 qualified nurses in Australia and identified variations of understanding of their perceived responsibilities and role in supporting students' learning and development. These differing perceptions of their responsibilities were categorised by Brammer (2006) as being either 'student centred', 'completion of workload centred' or 'registered nurse control' or fourthly, those nurses who preferred to have no contact with students at all. Brammer (2006) also highlighted that this differing approach to students was likewise mirrored in some nurses by a *paternalistic* approach to patients rather than a partnership ethos. Rather than working together with clients, in a more person centred humanised approach - as promoted and recommended to the students by their academic colleagues in university - there was an emphasis by some nurses on simply '*getting the work done*'. This overly pragmatic, inflexible approach was replicated in the ways some old timers approached their role in students' learning which would thereby either promote or impede their development and progress.

3.9.2 The students' experience - Being 'other'

Within this climate any student – irrespective of their experience or expertise - can often feel depersonalized and being what has been described as in some way 'other' (Canales, 2010; Martin, 2008). The prevailing image is of students being marginal and worthy of limited or 'no interest or respect' (Jackson, et al., 2011). They are essentially viewed as transitory visitors passing through, who may or may not make the most of their experience (Levett-Jones et al 2009). Jackson, et al. (2011) claim that relatively little empirical work has examined the experiences of undergraduate nursing students in the context of negative workplace cultures, and even fewer studies exploring how students develop strategies to counter hostile behaviours in the clinical workplace. Undertaken in Australia their qualitative analysis of open-ended survey questions explored the students' experiences of negative behaviours in the clinical environment. They hoped to identify the strategies students used to manage and resist behaviours such as dismissive attitudes of staff or poor support. As I have previously discussed, the clinical placements in Australia are significantly different from the UK with placements varying from one week to a five week block, however the online survey from 231 students highlighted experiences of being similarly 'devalued... and disrespected' which was in stark contrast to their expectations. Students felt marginalized, isolated and excluded. Learning therefore felt devalued and opportunities limited. According to Jackson et al. (2011) this reinforced a position of the student as 'Other' (p.105). *Othering* is an attempt to conceptualise the dynamic complexities of how power is used within relationships (Canales, 2010). *Exclusionary othering* uses power within a relationship as a means of domination and subordination resulting in increased marginalisation, decreased opportunities and exclusion. Whereas *inclusionary othering* attempts to use power within a relationship to build coalitions, engender a sense of community and encourage inclusion (Canales, 2010 p.19).

Similarly in the USA, Anthony and Yastik's (2011) research involving focus groups with twenty-one pre-registration students indicated that although they did occasionally feel included in significant aspects of patient care; often their overriding feeling was one of being unappreciated and considered a nuisance, dismissed and excluded and thereby given what were perceived as less meaningful tasks.

Other nursing students' experiences of negative behaviour while in the workplace include feeling ignored or unwelcome (Hoel, Giga & Davidson, 2007) whilst others experience feeling overwhelmed, disorientated and disconnected from the clinical setting. Thomas, Jack and Jinks (2012) undertook a systematic review of the qualitative literature concerning the experiences of student nurses in adult hospital settings in the UK. They highlight the negative feelings or

loss of self-confidence that is generated by very practical incidents such as the fact that staff were not aware that students had been allocated to the ward and the expressions of surprise when the student appeared on the ward. They also again highlight the negative aspect on the students' learning if their supernumerary status is compromised.

As I have highlighted, from a student's point of view a philosophy of partnership and the generation of feeling part of the team is a key desirable feature of the clinical experience (Martin, 2008). The need to fit in with the team they join and a sense of acceptance is believed to be essential to promote subsequent access to learning via their participation in nursing practice (Allan et al., 2011). Strategies include learning the ward routine and showing a willingness to 'muck in' which leads to a loss of their 'other' or outsider status and its associated stigma, greater acceptance by staff and a reduction in stress (Allan et al., 2011). Therefore it is recognised that whilst becoming an accepted team member increases feelings of belonging and impacts positively on confidence and motivation to learn; it could also mean, the loss of ability to challenge constraints on quality practice and examples of poor practice, with some students even conforming to clinical practices that they knew to be incorrect so as not to 'rock the boat' (Levett-Jones & Lathlean, 2009 p.346).

Conforming to incorrect practices and any loss of ability to challenge remains concerning as the support of challenge remains a major recommendation of all independent reports into poor practices in health care - not least the Report of the Gosport Independent Panel into deaths at Gosport War Memorial Hospital (Gosport Independent Panel, 2018).

3.9.3 Student experience of abusive behaviour and 'bullying'

More than simply being ignored or made to feel in some way 'other', it would appear that some students experience practice in an environment where bullying has actually become entrenched in the organisational culture (Royal College of Nursing, 2015). In fact one in three (31%) of the 7700 nurses and students surveyed said that they had experienced bullying or harassment from colleagues in the last twelve months (Royal College of Nursing, 2017b). Abusive behaviour and bullying can derive from a variety of sources as the students experience the informal alliances that promote abuse behaviour and bullying and exert negative influence on their progress and learning (Blackstock, Harlos, Macleod & Hardy, 2015). Ferns and Meerabeau (2008) undertook a convenience sample of 156 third year nursing students in one pre-registration nursing programme in England with a total of 114 questionnaires returned; with 45.1% of respondents having experienced verbal abuse. These incidents, including threats

to kill, racial abuse or sexually orientated verbal abuse, involved patients in 64.7% of cases, 15.7% involved visitors or relatives and 19.6% involved other healthcare workers. Thirty two students had subsequently reported the incidents, however only four resulted in formal documentation. Moreover students were significantly less likely to report the incidents if they had experienced verbal abuse from a *colleague* as opposed to from another source, such as a patient or relative (Ferns & Meerabeau, 2009).

Thomas and Burk (2009) asked their students in Tennessee to write narratives about the anger that they had experienced, either in clinical practice or at their university. Their anger was provoked mainly in clinical practice and by two main causes. Firstly by their personal experience of derogatory and unfair treatment, including public humiliation and being 'belittled' in front of colleagues and secondly by witnessing the violation of patient rights.

Students may have heard stories of challenging behaviours and bullying even prior to their first ever clinical experience and this can cause significant nervousness and stress. As a means of attempting to address these concerns, frequently the preparation for clinical placement for students includes a focus on professional behaviours and expectations of students in the clinical setting. However activities designed to equip students with the capacity to manage potentially challenging interpersonal interactions with clinical staff can have a paradoxical effect. In seeking to prepare students for the realities of practice such as interactions with staff who may be unsupportive or bullying, it appears that rather than feeling equipped to manage such situations, students' anxiety and fear can, in fact, be exacerbated (Levett-Jones et al., 2015).

3.10 Old timers as 'role models' and their influence on students – 'being a nurse'.

All registered nurses have a professional responsibility to support the learning of the future generation of nurses and take on the duties of a role model (Nursing & Midwifery Council, 2018). However as I have highlighted, this does not appear to be the experience of all student nurses.

For the purposes of their phenomenological study Felstead and Springett (2016) defined the term role model as 'someone who influences behaviour by exemplifying the practical, professional, and/or personal traits expected for nursing and therefore emulated by others' (Felstead & Springett, 2016 p.66). Others have defined a role model as someone who sets a 'positive example and is worthy of imitation' (Perry, 2009 p.37) and role modelling as referring to the 'observation of behaviours or attitudes of someone that one admires and the subsequent adopting of those behaviours or attitudes for oneself'. Bartz (2007) observed that role models 'serve as a catalyst to transform as they instruct, counsel, guide, and facilitate the development

of others' (p.7). Interestingly, role modelling in health literature is predominantly – but not exclusively - represented in relation to the health professionals role modelling healthy behaviours for their *clients/service users*; with research into role modelling in nurse education comparatively limited (Baldwin et al., 2014).

Walker et al (2014) undertook research receiving questionnaire data from 159 students in Australia exploring how students' become 'part of the profession' and how their relationship with their immediate professional community influences the construction of their *nursing identity*. The results indicated that 'good role models' (Walker et al., 2014 p.106) during the clinical learning experience facilitated learning and also enabled the students to piece together what it means to be a nurse; some students experiencing an acceptance and inclusiveness which developed self-confidence and established belonging.

Conversely poor roles models during the clinical learning experience impacted not only on the participant's ability to learn but also their morale and perception of nursing. As I have previously noted, exposure to examples of bad practice and therefore negative role models can lead students to believe that they were, at best, merely 'learning how not to practice'. Students identified some more senior and experienced nurses as 'uncaring' or 'hardened' and yet, at the same time that they criticized them for being uncaring, there was also a tendency to show empathy and rationalize these behaviours. Nurses often discussed their strategies for ensuring that they did not end up becoming 'uncaring' or 'hardened', while others changed their focus from a caring to a more competency focussed philosophy (Mackintosh, 2006). It appears that students can identify when they witness poor care in practice - often more easily than they might identify high quality care - and whilst recognising that some learning can come out of negative experiences - they can become demoralised and suffer loss of focus on learning as the negative feelings generated become paramount and interfere with learning.

3.10.1 The old timers view of the world – the 'golden age' view of nursing?

Loss of focus on the learning required - which includes a critical view of practice, exploration of evidence base and the ethical context of practice for example, may well be more acute in the current nursing student. According to much of the literature, *historically* a student nurse's experience might have been viewed as simply one enacted through routine, rituals and a shared understanding of the skills required within clinical practice. An identity informed by learning the benefit of compliance, honesty and virtue and represented by uniforms, badges and other symbols of prestige and significant hierarchy. Learning needs were viewed as subservient to

organisational needs, with students in the UK essentially viewed as workers - and indeed as paid employees. Ironically this may have been viewed as a relatively safe, comparatively unchallenging place for them to develop their knowledge and skills and subsequently be socialised to conform to a group identity of what it meant to be a nurse (Wolf, 2013; Melia, 1998; Walsh & Ford, 1989;). Brennan and Timmins (2012) claim that the identification and engagement with such tradition and socialisation was lost, to a large extent, with the move of nursing education into the university sector. The key clinical context was thereby significantly replaced with the formal content in the curriculum as the only basis for the students' professional identification and associated nursing values (Horton, Tschudin & Forget, 2007). Brennan and Timmins (2012) further highlight the tensions between the ideal of the compliant student in practice settings - the 'ideal student' as I have described previously and the critical thinker aspired to in the current university setting. The discourse confronting students can create an idealized vision of nurse education in the past with 'interpreted nostalgia' constructing a golden past. Whilst ignoring the inevitability and complexity of a constantly changing health care context and the subsequent related need for nursing to change, this approach encourages a strong and persistent group identity for those who were there, to the inevitable exclusion of those who were not. Divisions are created, giving those who can claim a stake in the past a sense of belonging and excluding others who cannot, an obvious group being current nursing students (Law & Aranda 2010; Dingwall & Allen 2001). This collective identity can regard newer students as lacking traditional values held so dear by the group. Which can result in accusations - by old timers about current and future students - of an absence of a genuine vocational view of nursing, a lack of pride in their work and a focus on considerations such as financial income rather than the *purported* traditional nursing values of the past (Gillett, 2014; Strangleman, 2007). Such nostalgia effectively divides the profession by idealizing the past and reinforcing negative feelings about the present and constructs two group identities, namely *traditional caring nurses* and *current educated nurses;* with any changes in nurse education thereby seen by the nostalgic as a criticism of their own abilities (Meerabeau, 2004). The implication is that there was a time when nurses undertook work, more 'hands-on', expressive and emotional caring work which by implication is far more highly valued than the perceived values of current nursing students (Gillett, 2014). Cowin and Johnson (2015) claim that what were once thought of as the defining qualities of a nurse have evolved from stereotypes such as 'angel of mercy' 'paragons of virtue' and 'doctor's handmaiden' to that of a 'healthcare professional' and 'good communicator'.

The period considered a 'golden age' inevitably varies according to who is constructing the memory. Yet, the argument claims, in spite of any societal, professional or demographic changes and even if what has been traditionally considered 'nursing work' might be quite ill-defined, *the needs and requirements of service users remain fundamentally unchanged* (Darbyshire & McKenna, 2013; Law & Aranda, 2010). However this argument underestimates how the changing roles of nurses, changes in how patients' needs are met and *who* helps meet those needs, impacts significantly on current students.

The universities contribution to students' professional identity in encouraging 'knowing care givers' with independent, rational critical thought (Stacey, Pollock & Crawford, 2015), may conflict with the traditional expectations of a practice setting simply requiring an organised, efficient worker (Leducq, 2012; Grealish & Trevitt, 2005). Critical thinking or developing the ability and desire to consider the wider influences on healthcare that affect the day to day decision making in practice, for example, may be limited by a more traditional experience or view of nursing (Stacey et al., 2015). In this challenging context, students can be seen by colleagues and particularly ward managers as superfluous, burdensome and time consuming. This is further emphasised by a student's supernumerary status, which although there ostensibly to protect them, can result in compromising their ability to 'learn through working', as mentors and others view them as in some way outside of the nursing team and therefore unessential (Donaldson & Carter, 2005). As a nurse manager opined 'only when they qualify, that's when they start to learn' and 'In some ways, the first newly qualified band 5s seem like second or third year student nurses of previous years' (Allan et al., 2011 p.850).

Such debates can be seen as opposing positions in a pro- or anti-intellectualist discourse in relation to the current and future context of nursing. Accusations that nurse education is failing to promote appropriate capability, criticality and flexibility amongst the nursing workforce, for example has a long history and shows little sign of abating (Darbyshire & McKenna, 2013; Watson 2006; Kenny 2004; Clark 2000; Watson & Thompson 2000). Not least as current education philosophies are often blamed in the media – and even in the political arena - for any examples of care failings in the health service, lack of compassion or apparent decreased standards of care generally in the current nursing workforce (Chapman & Martin, 2013). An exclusively degree level entry to the nursing register in England has been equated with a 'collapse of standards' and even the 'debasement of language' (Gillett, 2012) There is a perception that students are unwilling or unable to engage in fundamental 'caring' activity as a result of intellectual ability (McKenna, Thompson, Watson, & Norman, 2006; Watson, 2006;

Watson & Thompson, 2000). According to reports in the media university-educated nurses are '*too posh to wash' or 'too clever to care'*. Similar concerns have also been expressed by service users with phrases describing students and recently qualified nurses as 'over-educated' 'over-technical' 'over-paper worked' and 'over-career' with a concern that the 'right people' are not becoming nurses and that many are 'missing out' as they may not reach the required academic level but were the 'most fabulous' (Griffiths, Speed, Horne & Keeley, 2012 p.112). This suggests the notion of a 'born nurse' who requires minimal qualifications and a particular character rather than an education (Gillett, 2014), as opposed to the 'academic' nurse who is 'above herself' (Meerabeau, 2004 p.291) and who is too educated to care or value 'softer' nursing qualities such as empathy, listening, a non-judgmental attitude and individualised care.

However there is no empirical evidence to support the validity of these claims, and indeed research suggests, that graduate nurses have better decision-making skills, better critical skills and are more likely to be the critical thinker that reflects and recognises and understands service user need and works with them to create optimal nursing care (Griffiths et al., 2012). Similarly such skills reduce the likelihood of undertaking practice without critical reflectivity and therefore perpetuating ritualistic behaviours and practice based on the foundation of established norms. Norms not critically considered and impeding any reshaping or improvements in practice or indeed 'whistle blowing' where necessary should poor practice exist (Brennan & Timmins, 2012).

Moreover although an 'anti-intellectual bias' may have been perceived amongst qualified nurses and nurse teachers from the former NHS-based schools of nursing (Miers, 2002) it would be incorrect to assume that nurses educated under the previous hospital based system didn't equally feel 'ill-equipped for the job of being a staff nurse' (Gillett, 2014).

An era extolling the overriding primacy of expressive and emotional work, where '*caring'* was positioned centrally in nursing practice has been accused of being a myth, as according to academics such as Dingwall and Allen, (2001) such work was never a *central* part of the nurse's role, nor ever actually that highly valued. Therefore an aspiration to return to an imaginary past, with the emphasis on such aspects of nursing, results in a scenario where potentially 'nurses are trained to do a job that did not exist in the past, does not exist in the present and may never exist in the future' (Dingwall & Allen, 2001 p.72).

Furthermore even the tenability of such a model is questioned in the current economic and social climate with such philosophies of work are seen by healthcare planners and managers as

at best a luxury, and where work consists of the more instrumental and physical aspects of caring rather than such expressive or emotional aspects (Pearcey, 2007). In an age of cost-containment, students experience the professional and managerial values that operate and dominate in some practice settings (Wright, 2004). This may, yet again, appear incompatible with their initial lay beliefs about caring and they are forced to modify those beliefs accordingly or leave the nursing course if they come to the conclusion that the situation adversely affects their ability to be the nurse they expected to be (Chambers, 2007). As I have discussed previously, the values that espouse holism, caring and so on, perpetuated through the educational curriculum may not be applicable to the realities of current practice and students can quickly recognise these as desirable but not actually achievable (Pearcey, 2007).

A culture of fast throughput targets and objective nursing outcome measurements imposed on patient care has been termed 'McDonaldisation' (Ritzer, 1998) and refers to student's experiencing the urgency of current practice with its need to apply more task-centred than person-centred care in order to meet these targets (Curtis et al., 2012). This is an ethos where tangible outputs dominate in a high technology and cost-constrained environment where 'getting through the work' (Pearcey, 2007), can be seen to having overtaken professional values such as compassion (Bradshaw, 2009).

3.11 Does the wider image of nursing impact on current students?

Many of the old timers who the students work with may have a specific idealised view of nursing from the past - however does nursing also have other problems with its image that may impact on the experience of the students? Miller and Cummings (2009) undertook a systematic review which appears to confirm that nursing has an image problem particularly with *gifted* pupils or students as they aspire to careers that they, and others, consider prestigious; and that such students, their significant others - parents or school career advisors - are presently unaware of the potential for positive careers within nursing. As I have described nursing, and therefore the students who choose to take it up as a career, can be associated with weakness, powerlessness, dependence and lack of knowledge (Francis 2013, Front Line Care 2010). Nurses may also contribute, to an extent, to the poor perception and status of the profession, confirming the observation of nursing as a profession with a poor view of itself or not 'contributing enough to uplifting the image of the profession' (Ali & Watson, 2011 p.316) and with some nursing students not appearing to have a very positive image of nursing. For example, Cho, Jung and Jang (2010) found, in their longitudinal study, that Korean nursing students did not view nurses as having autonomy, creativity or 'social reputation' (Cho, Jung

& Jang, 2010 p.185). They also viewed nursing has having a relative lack of independence compared with other health professions, or other professionals such as high school teachers for example - a perception that did not appear to change significantly as their experience as a nursing student progressed.

ten Hoeve, Jansen and Roodbol (2014) claim from their review of the literature - eighteen studies having eventually met their inclusion criteria - that the public image of nursing is 'diverse and incongruous' (p.298) and influenced by stereotyping. Nurses are viewed as lacking autonomy; prized for their virtues rather than their knowledge although more recent *films,* for example, appear to portray nurses as stronger and more self-confident than previously - although the more stereotypical images of nursing remain persistent, they claim. Congruence appears to exist between the public image and nurses' self-concept, in that nurses who perceive their public image to be negative are more likely to develop or experience a poor self-concept - whilst, in turn, nurses' negative self-concept and presentation appears to further influence the public's opinion.

Similarly Takase, Maude and Manias (2006) received data from a questionnaire completed by a convenience sample of 346 Australian nurses (response rate of 36.7%) attempting to explore how nurses' perception of their own image compared with their perception of their *public* image. They found that the nurses in their study perceived themselves statistically significantly more positively than how they believed the public viewed them; with a conviction that the public did not recognise or understand current nursing roles. Moreover the nurses who perceived that the general public had a lack of understanding of nursing, nurses' roles and general contribution as a profession appeared to be more likely to have an intention to leave the profession. Donelan, Buerhaus, DesRoches, Dittus and Dutwin (2008) took data from two national surveys in the USA and found that the public were more positive about a career in nursing than the nurses themselves, with the public most frequently naming 'highly knowledgeable, qualified, skilled' as qualities highlighted.

3.12 First year students - a particular experience

So how might all these considerations impact on the experience of the current adult nursing students as they progress through their course? Several researchers have explored the experience of first year nursing students specifically. Evidence generally confirms that students in the first year experience significant stress, anxiety, feelings of being overwhelmed, inadequacy and even fear (Holm Kaldal, Kristiansen & Uhrenfeldt, 2018; Molesworth, 2017; Higginson, 2006). These unfortunate feelings again relate to the dissonance they feel as they

witness the inconsistencies between their initial expectations and their subsequent individual lived experiences (Porteous & Machin, 2018). Some first year students express disillusionment and loss of ideals as they progress through their education (Pitt, Powis, Levett-Jones & Hunter, 2012; Bolan & Grainger, 2009). They can be confronted with the 'realities' of nursing, unexpected performance demands, difficult and unsupportive interpersonal relations, inadequate role preparation and the recognition that there might be more of a focus on routine and specific tasks, as opposed to an emphasis on patient-centeredness and caring which may have attracted them to the profession in the first place (Wray, Barrett, Aspland, & Gardiner, 2012; Andrew et al., 2008; Pearcey & Draper, 2008). A perceived inconsistency between theory and practice can be highlighted at this time (Levett-Jones, Lathlean, Higgins & McMillan, 2009); along with a lack of clarity about placement expectations and potentially significant misconceptions about roles and responsibilities, not least their own (Levett-Jones, Pitt, Courtney-Pratt, Harbrow & Rossiter, 2015; Andrew et al., 2008).

This initial first clinical placement experience may provide the first introduction to the attitudes, behaviours and values of the established old timers, whilst also confirming the essential knowledge and skills that are required to progress (Levett-Jones & Bourgeois, 2015). Students speak of requiring a 'settling in' period as they initially feel uncertain, lost and unsure as they struggle to learn about the staff, patients, culture and practices of the clinical area. This can impact negatively on their ability to learn; as we have seen, only when they are considered to be a 'team member', do they learn new skills or consolidate learned skills (Grobecker, 2016; Malouf & West, 2011).

A number of studies have, therefore, identified that nursing students frequently experience high levels of stress on this first clinical placement (Turner & Lander McCarthy, 2017; Shaban, Khater & Akhu-Zaheya, 2012; Moscaritolo, 2009). Common clinical stressors concern the relationship between student and mentor and/or staff, practical assignments and workload, perceived lack of knowledge and skills and also clinical events such as witnessing the death of patients (Cowen, Hubbard & Hancock, 2018; Cowen, Hubbard & Hancock 2016; Burnard, et al., 2008;). Students who struggle to adjust to their role during the first placement are also at risk of diminished self-esteem and depression (Gilbert & Brown, 2015) - with this experience cited by some students as a factor in their thoughts about leaving the nursing programmes (Melincavage, 2011).

However a mixed method study with 96 out of 256 first year students (37.5% response) from the first cohort of a new nursing degree completing an on-line questionnaire, indicated that

although most felt some level of stress the vast majority were still positive about their first year experience (Gale, Ooms, Newcombe & Marks-Maran, 2015). The main causes of stress for this one cohort of students in this one university was having to juggle conflicting commitments of work, study and home.

It is clear that such concerns can be experienced at an even earlier stage by some students. For example Levett-Jones et al. (2015) created a 'readiness for practice' survey at an Australian university to gain insight into students' perceptions and concerns *prior* to their first clinical placement. 144 students (55%) responded with twenty-six students (18%) commenting on the culture of nursing and apprehensions about the inhospitable clinical learning environment, as they had been 'forewarned' about unsupportive nursing staff.

3.12.1 The experiences of students beyond their first year - 'cynicism and negative attitudes'

Much of the concerns expressed above are confirmed and replicated in other student groups – irrespective of which year they are in. For example evidence indicates that younger students in the UK have been found to be more likely to leave nursing programmes than older students (Pryjmachuk, Easton & Littlewood, 2009; Anionwu, Mulholland, Atkins, Tappern & Franks, 2005)

If a prerequisite for students to flourish is that they receive support and feel accepted and appreciated and have a sense of belonging (Levett-Jones & Lathlean, 2008) and feel subsequently empowered (Bradbury-Jones, Sambrook & Irvine, 2011) then some students, probably most particularly those in their first year, unsurprisingly struggle as the reality of their experiences negatively impact their learning, performance and professional growth (Khater, Akhu-Zaheya & Shaban, 2014).

According to Pearcey and Elliott (2004), in their small qualitative study - seeking the opinions in two focus groups of fourteen nursing students from years three and four of a UK BSc Nursing Sciences programme - whilst students can feel undervalued*;* their experience appeared to increase their determination to behave differently once they were registered nurses themselves, with some students determined to avoid the development of cynicism and negative attitudes that they witnessed in experienced nurses and occasionally in their mentors. Nonetheless Pearcey and Elliott (2004) indicated that the students' interest in nursing as a career was directly influenced by their observations of trained nurses and the nurses' attitude to them as students.

Witnessing negative traits in qualified nursing staff and poor examples of care led some students to an increasingly disillusioned view of their registered nurse colleagues and also occasionally a growing 'sense of cynicism or hardness' within themselves (Mackintosh 2006, p.959). Mackintosh (2006) used a longitudinal qualitative design and interviewed sixteen pre-registration student nurses randomly sampled from one cohort of fifty-two volunteers. The students were interviewed twice with semi-structured interviews undertaken within the first six-nine months after entering nurse training and then six-nine months prior to completion of their course. By the second interviews all students expressed some level of disillusionment with the nurses' role as a carer; often as a consequence of poor examples of care that they had witnessed from qualified nursing staff. Students spoke of ward staff losing 'sight of their reason for doing the job' and subsequently treating it as 'just a wage' (Mackintosh, 2006; p.958). This echoes other research where students experience the negative attitudes of staff who solely see nursing 'as a job' or merely a list of tasks or qualified nurses who 'simply can't be bothered to actually talk to patients' (ten Hoeve, Castelein, Jansen & Roodbol, 2017; Pearcey and Elliott, 2004 p.385)

As I have previously described, some students attempt to reject this implicit scepticism and express a determination to personally maintain a caring ethos; however other students' reactions indicated a 'growing cynicism' - for example expressing that some patients were not 'as poorly as they make out' (Mackintosh, 2006 p.958). Moreover some students had come to the conclusion that this 'hardening process' was necessary to avoid 'emotional burnout' and was essentially the creation of 'defence mechanisms to shut stuff out' (Mackintosh, 2006 p.959).

3.12.2 'A caring trajectory'? Learning to 'care less'?

Despite the diverse set of personal attributes, experiences and expectations of students there appears to be broadly similar concerns in students relating to their practice experience and any strategies they employ to attempt to manage these concerns (Curtis et al., 2012). A range of defensive strategies appear to be utilised against the distress that can be inherent in the nursing work. Many students learn for example to 'demarcate' home from student life and develop the 'ability to switch off' (Mackintosh, 2006 p.958). Student nurses report that, rather than creating a connection and bringing aspects of themselves to any caring relationship, they develop an identity at work that includes switching off/withdrawal and subsequent loss of caring and a depersonalization of individuals and situations (Mackintosh, 2006). They also witness similar behaviours in their old timer colleagues and recognise and learn the effectiveness of such strategies. For example, Bridges, et al. (2012) - in their synthesis of sixteen primary studies

exploring *qualified* acute care nurses' experiences of the nurse-patient relationship - found that, rather than actively employ approaches to build a therapeutic relationship between themselves and service users, some nurses actively disengage from that relationship in an attempt to 'protect' themselves, whilst also reducing their capacity for caring.

This has been characterised as a shift in identity towards an 'occupationally specific view point', which entails a student becoming proficient in a new role at the expense of earlier ideals (Mackintosh, 2006).

It may be that student nurses have to learn to care less in order to cope more effectively. Bolan and Grainger (2009) indicated that although students maintained the image that nurses are kind and compassionate throughout the programme, this view decreased significantly from admission to the course and final graduation. Some students accept this as an inevitable part of the socialisation process and the price that student nurses have to pay in order to be accepted by other staff. Murphy, Jones, Edwards, James and Mayer (2009) in a quantitative, single cross-section study of two nursing students cohorts in one university in Wales indicate there is a statistically significant difference in the means in 'caring behaviours' between first year and third year students; with third year students scoring lower than first years. One potential explanation, according to the authors, is that acceptance by other nurses depends on learning the common values and adopting appropriate behaviours to function within that clinical staff group.

This recognition may mean that students perceive a need to take greater responsibility for a personal system of regular self-care, or 'responsible selfishness' that helps reduce feelings of anxiety and stress (Bush, 2009 p.27). Students thereby learn to reframe stressful situations as positive learning experiences (Grafton, Gillespie & Henderson, 2010). This may also encourage the students to focus on the development of their personal and professional identities rather than worrying about 'pleasing the teacher/mentor' or simply prioritising 'getting it right' (Gillespie, 2013 p.344).

A 'caring trajectory' which hypothesises that students commence their course full of idealism and eagerness to care for patients only to find difficulty in 'coping with reality', becoming disillusioned by lack of time and challenged by the evident work ethic and the preoccupation with 'getting through the work' has a very long history (Spouse, 2000; Smith, 1992). Students at the beginning of their career may define nursing by use of words such as caring, nurturing, teaching and promoting health; however by the end of their undergraduate course some have become more sceptical and disillusioned, as coping with the reality of practice pressures and the maintenance of ideals has led to feelings of personal disappointment and professional

dissatisfaction. There appears to be a related 'loss of idealism', a loss of enthusiasm and reduced ability to engage in the 'emotional labour' of care and the nurses' role as a carer (Murphy et al., 2009). Some third year students feel that they had been 'indoctrinated' 'moulded' or 'conditioned' by the education process (Cook, Gilmer & Bess, 2003).

3.12.3 A shift in caring attributes - so when does it happen?

There are conflicting views, therefore, of when this change in caring attributes occurs. For example a 'loss of idealism' has been identified at twelve months into the course with a statistically significant difference in caring behaviours also being highlighted between students in the first year and their third year (Murphy et al., 2009). Or does disillusionment about caring take hold during or prior to the second year of study? (Watson, Deary & Lea, 1999). Loke, Lee, Lee and Noor (2015) in their quantitative cross-sectional survey of first and final year diploma student nurses - amongst others such as qualified nurses and nurse lecturers - in Singapore, indicated a statistically significant reduction in caring behaviours in third year as opposed to first year students. The shifting views of students was also explored by Day, Field, Campbell and Reutter (2005) who undertook a longitudinal study of student nurses in Canada where fifty students were interviewed from a cohort of 353 and a further 81 completed open ended questionnaires. They found that in year one a sense of confusion existed with students as they initially struggled to internalise the values of nursing and felt particularly vulnerable to external sources who questioned their choice of nursing as a career. By year two the students had moved on from using words such as 'caring' and 'compassionate' and instead had begun to more comprehensively describe clinical situations where such attributes had been important. By the end of the course the students recognised the complexity of the nursing role – including teacher, advocate, researcher, change agent and resource and spoke in terms of the importance of holistic care rather than merely speaking of specific tasks or skills.

Loke et al. (2015) differentiated between two co-existing dimensions to caring - 'instrumental caring' which is essentially about achieving physical health and comfort and 'expressive caring' which is defined as more about meeting psycho-social needs and promoting emotional status - whilst recognising these are inextricably linked and equally important factors in determining health and wellbeing. They interpret this as a shift of students' concept from expressive caring to a more instrumental caring approach and view this as in some way an educational success as students move from what they believe are essentially 'layperson's ideals of caring' (p.428). Similarly McAllister, Lasater and Stone (2015) speak of novice students

having to let go of ill-fitting attitudes and biases as they progress to becoming a professional nurse. Murphy et al. (2009) similarly highlight the movement from a lay image of nursing as demonstrated by a junior student with their more idealised version of nursing to a more 'professional view' or tempered idealism as might be conceptualised by final year students. The developing and changing view may also be exemplified by an initial emphasis on caring in the first year being replaced by a greater emphasis on areas such as the biomedical and the technical aspects of practice by point of registration (Safadi, Saleh, Nassar, Amre & Froelicher, 2011). Such evidence and other seminal examples of nursing research have offered evidence that while the educational process for nursing students does undoubtedly modify caring behaviours, the direction of the change is not always consistent and can be both positive and negative (Watson et al., 1999; Smith, 1992; Melia, 1987).

3.13 Future nurse recruitment – the implications for mentors and student experience?

As we have seen, being a mentor is not necessarily seen as a 'badge of honour' not least due to the increasing number of registered nurses being trained (Health Education England, 2015 p.46). The recent lifting of the cap on commissioned nursing places in the UK may well affect this further should, if as anticipated, the result of this initiative be more student nurses on pre-registration courses. This is also in the context of the changing mentorship requirements of new roles such as Nursing Associates and new 'on-the-job' apprenticeship routes to becoming a registered graduate nurse amongst other initiatives (NHS England, 2018), along with the removal of the mandatory requirement for all registered nurses to take on the specific responsibilities of mentorship as practice supervisors or assessors.

From 2009 to 2014 there was a 33% increase in the number of people applying to study nursing in the UK with 40% of those applicants accepted onto a degree course at a university (Royal College of Nursing, 2015). However more recent Universities and Colleges Admissions Service (UCAS) data indicates a 23% drop in the number of students applying to study nursing in 2017 - described by UCAS as 'the most notable decrease in applicants' (UCAS, 2017). Irrespective of trends in the recruitment of student nurses – numbers continually fail to address the shortages of qualified nurses and this poses continued challenges for policy makers and planners in high and low income countries alike (Li, Nie & Li, 2014; International Council of Nurses, 2012). Despite attempts to plan, all countries continue to experience cycles of shortages and surpluses within all health professions and most notably nursing. In the UK for example there were 3,106 fewer nurse training places in 2014-15 compared with 2004-5; a 19% decrease

(Morse, 2016). However since 2012 there appears to have been an increase in the number of full-time equivalent nurses and health visitors by 5,700 - having initially been a fall in 2011 and 2012, and yet there remains a shortage of 40,000 nurses across the UK (Full Fact, 2017). Similarly in the UK, 8% of organisations surveyed by Health Education England in January 2014 reported between 100 and 250 nurse vacancies, in part due to a limited pool of qualified nurses to recruit from, with the qualification of nursing students failing to meet the shortfall (Care Quality Commision, 2015). Moreover, of 105 NHS Trusts in the UK, who responded to a Freedom of Information request in 2013, eighty-one either had already or intended to actively recruit nurses from overseas in the following twelve months (Lintern, 2013). More recently, NHS partnership schemes such as 'earn, learn and return' schemes aspire to recruiting up to 5,500 international nurses from countries such as India, the Philippines and Jamaica (Ford, 2018).

The resultant potential for lack of permanence or consistency of supervision for student nurses gaining clinical practice experience in those areas is likely to be significant in their development, progress and ongoing identity formation. This is further compounded by the fact that some organisations have seen at least half of the overseas nurses they actively recruited leave within two years (Merrifield, 2015). This uncertainty within the clinical environment can only be increased whilst the impact on health and social care services of the UK leaving the European Union remains impossible to forecast (McKenna, 2016).

One proposed solution to a shortfall in nursing students was to remove the limit on the amount of training places or *rationing* of places as some have called it (Stubbs, 2015). One of the results of which is to offer nursing students access to the standard student support package of tuition fee loans and support for living costs, rather than receiving a National Health Service bursary as was the case previously in the UK (DH Workforce Development Team, 2016). The real impact of these initiatives are yet to be seen; however they are not without controversy. The RCN (RCN Labour Market Review, 2016) warned that the move away from bursaries to a student loan system and current and ongoing public sector pay restraint may still limit the numbers prepared to take up the extra places provided by universities through the new system. They claim that nursing has become less appealing and a more uncertain career choice for potential students due to making nursing 'like any other degree' but not recognising the fact that a registered nurses' salary is £8000 less than the median graduate salary (RCN Labour Market Review, 2016). Similarly some have predicted that demand for healthcare courses may reduce by at least 6% following the removal of bursaries (Conlon & Ladher, 2016). UCAS figures for the first wave of applicants hoping to start university courses in September 2018

show that the number of students wanting to study nursing have fallen again by 13% on the previous year - although acceptances for nursing courses are the second highest ever (UCAS, 2018). Should the initiatives be successful, the headline figures still neglect to consider the resultant implications of significantly increased numbers on appropriate quality placement availability and sufficient mentor/practice supervisor numbers to support learning for increased numbers of students. Moreover there is evidence to suggest that older applicants have been particularly reduced which will disproportionately affect certain services where shortages are at their worst and the student experience will be further compromised (Maguire, 2018). The further implication being that mature students are more likely to remain in the profession, an additional significant benefit given the high level of attrition from nursing courses (House of Commons Health Committee, 2018).

However it is perhaps inevitable that such negative predications will be made by organisations that fundamentally disagree with the proposed changes and other sources foresee a less pessimistic future, indeed predicting a 'significant expansion' in nurse training places (Merrifield, 2016).

Despite a variety of such strategies, the on-going fluctuation in nursing numbers remains a global concern (Centre for Workforce Intelligence, 2013; World Health Organization, 2006) and the growth and sustainability of the nursing profession is dependent on the ability to both recruit and retain the next generation to the profession (Health Education England, 2015; Willis, 2012). This is also in the environment that sees - for the first time in recent history - numbers of nurses leaving the NMC register outstripping the numbers joining. Between 2016 and 2017, 45% more UK registrants left the register than joined it for the first time (Nursing & Midwifery Council, 2017c).

3.13.1 Recruiting and retaining the next generation to the profession

Recruitment of student nurses clearly remains problematic. Unfortunately evidence also continues to indicate trends of growing attrition rates among nursing students. Across thirty universities throughout the UK for example, 21% of those who embarked on the three-year degree in 2008 did not complete it in 2011 (Royal College of Nursing, 2015). Health Education England's Reducing Pre-Registration Attrition and Improving Retention (RePAIR) project aimed to reduce unnecessary attrition and identify areas of best practice in retaining student nurses. Initial results from RePAIR show that 30% of students who were due to complete in either 2015/16 or 2016/17 failed to complete within the standard time period (House of Commons Health Committee, 2018). Attrition from nursing and other health professional

courses is often seen as a far too simple one. A complex set of influencing factors including problems with clinical placements, dissatisfaction with academic workload and/or feelings of a lack of support or personal concerns and issues, amongst other considerations, all contributing to an individual student's decision to leave (Royal College of Nursing, 2015; Council of Deans, 2013). It is important also to differentiate between those that *actually* leave and those that may consider leaving. According to results from an online survey by Hamshire, Willgoss and Wibberley (2013) 47% of the 999 students who commented on the specific question, indicated that they had considered leaving their current programme. Three distinct themes were analysed which appeared to generate a consideration to leave - difficulties with clinical placements, dissatisfaction with academic workload and support and personal concerns and challenges. Although 1080 students responded to Hamshire et al. (2013), this is an estimated response rate of only 11% which raises the possibility of this not being a representative sample (Bryman, 2015). Similarly like all survey research although the contributors were able to add comments, surveys are unable to probe in detail or further explore the complexities inherent in such considerations and decision making (Polit, Beck & Hungler, 2000).

As previously discussed, students' experiences on their first placement particularly and the processing of their resultant feelings appear to be key determinants of their decisions to withdraw or stay. James and Chapman (2010) in their small phenomenological study with six students from the same university in Australia found that they had all considered leaving due to feeling like a burden to clinical staff, not being valued or included as part of a team and being made to feel uncomfortable when receiving feedback.

However Crombie et al. (2013) in an ethnographic study utilising document review, non-participant observation in practice settings, focus groups and interviews with a self-selecting group of 50 second year student nurses at one university in the UK, found that experiences in clinical practice had the greatest influence on students wanting to stay as a student nurse. Mentors, other clinical staff and placements generally having the greatest impact on any decision to stay or leave rather than other considerations such as academic course work or assessments, for example.

James and Chapman (2010) also indicated that a first year students greater familiarity with a clinical *mentor* appeared to facilitate confidence building and a greater use of initiative in the clinical setting, with acceptance and inclusiveness being essential to enable the student to develop the confidence needed to establish belonging and to construct their nursing identity.

3.14 Conclusion

As was recognised at the beginning of this chapter the literature indicates that much of the relevant research is understandably, relatively small scale and reflects a very specific – often international - context. However a critical exploration of the relevant literature indicates a particularly challenging, and in many ways confusing, environment for student nurses. The modern health care context requires that student nurses are facilitated by the curriculum and participation in the clinical environment, to ultimately achieve a position where they are able to play a unique role as champions of quality, accept managerial and professional accountability for high quality care and take a lead role in the organisation of local health services (Care Quality Commission, 2015; Front Line Care, 2010). The literature shows this aspiration for students is often problematic, as the professional, political and social context of health in times of austerity, political uncertainty and various care scandals challenges the environment for students and registered staff and service users alike.

Evidence indicates that the students' involvement in the clinical learning environment relies on participation supported and facilitated by established 'old timers' and particularly by key roles such as mentors to promote progression and reduce the potential of disillusionment and attrition. However, much of the research indicates that many students are discouraged by the dissonance they experience between the values espoused by the staff of the university and the reality of the principles adopted in clinical practice. This results in the students remaining boundary figures on the periphery of practice and utilising a variety of strategies to cope and attempt to increase their inclusion and belonging. These coping strategies can also cause dismay as their identity shifts in unanticipated ways and they consider their future selves and attempt to maintain their values and principles that made them choose nursing in the first place. It would appear that this experience can be common to all cohorts of student nurses but can be particular pertinent and acute for first year students.

Therefore this research will explore and endeavour to understand such a context and its influence on student nurses perceptions and their participation in clinical practice. The far reaching implications of such a complex set of circumstances emphasises the need to further explore the shifting identities of current nursing students as future professional registrants.

Undertaking a detailed analysis of the wide ranging existing literature informed my thinking and crystallised a more focused view of the specific research aims. My proposed research will offer insight into the shifting identities of student nurses in the UK in a time where the demands for change are as acute as ever and the current nursing student is challenged in several national policy documents to 'change the culture of the health service' (Nursing Times, 2013) by

playing a personal role in the facilitation of a caring, leading, educated, assertive, patient-focussed nursing workforce.

The aims of the research were therefore:

To explore the shifting identities of pre-registration nursing students across a BSc adult nursing programme

To understand the subjective experience of students participation in university practice

To understand their participation in clinical practice

To explore student understanding of nurse identity – what it means to be a nurse

To contribute to the nursing literature surrounding student learning.

Chapter Four: Methodology and Methods

4.1 Introduction

This chapter explores the methodology of the study and describes, explains and justifies the methods utilised to support the process and achieve the proposed aims and outcomes of the research. The chapter explores the rationale behind key decisions that were made during the research. These decisions concern such areas as research design and the choice of a focus group and interview approach, recognising and accessing appropriate participants, the difficulties encountered and the strategies devised to ensure solutions to these difficulties, and the addressing of any ethical considerations generated by the study. Details of the methods to generate, record, transcribe and subsequently analyse the data which support the underpinning methodology are explained and examined, as are the measures taken to ensure the approach was coherent, logically credible and valid.

This chapter is presented in four main sections, although there is inevitably significant connection and overlap throughout the chapter. I initially discuss the main methodological, epistemological and theoretical considerations that prompted the decisions made throughout the research process. This is followed by a detailed review of the method - what was done, how it was done and why and so on. Thirdly, the ethical considerations and implications inherent in such research are critically reviewed, followed by a review of the real and potential difficulties, challenges and limitations of the chosen research methods.

4.2 Reiteration of the aims of the research:

To explore the shifting identities of pre-registration nursing students across a BSc adult nursing programme

To understand the subjective experience of students' participation in university practice

To understand their participation in clinical practice

To explore student understanding of nurse identity - what it means to be a nurse

To contribute to the nursing literature surrounding student learning

4.3 Methodological Rationale

This research is a qualitative, exploratory study. To meet the research aims and explore the shifting identities of student nurses it was clear that research within the qualitative paradigm would be most appropriate. The justification of this approach is that qualitative research promotes a focus on social experience, how it is created and how it gives meaning (Streubert Speziale & Rinaldi Carpenter, 2011). Social experiences construct an individual's reality and qualitative research methods allow exploration of such ways of knowing as this reality changes over time (Ritchie et al., 2014). This underpinning philosophy directed the chosen methodology and method, the areas of subsequent exploration, the questions asked, observations made and the resultant approach to interpretation and analysis (Burns & Grove, 2016). Qualitative research generally takes the perspective and accounts of research participants as a starting point (Denzin & Lincoln, 2017) and aims to provide in-depth and interpreted understanding of their social world by learning about the sense they make of their social circumstances, their experiences, histories and changing perspectives (Ritchie et al., 2014).

A consideration of socio-cultural theory might suggest an ethnographic research methodology, however in ethnography major significance is given to the careful *observation* of events, practice or rituals which reveal elements or aspects of the rules and culture of the community. Ethnography, therefore, presupposes a period of time in the field with the specific group that the researcher wants to get to know. My research is underpinned by a similar subjectivist epistomology and attempts to elucidate meaning and understand the interpretations, significance and motivations and values of the student nurse participants. However, the research aims of this thesis are, essentially, concerned with the participants' *self-perceptions* of their identity, the complexity of their context and how they perceive it. Achievement of the research aims also demanded a requisite number of participants that would gain sufficiently meaningful insight into as broad a range of different identities as possible which, if this were to include observation of the participants in the field, would have been very difficult as a lone researcher. These, and other considerations, both theoretical and practical, meant that an ethnographic approach was therefore disregarded.

Philosophically a phenomenological approach was also considered as I was interested in conscious experience as understood by the student nurses - their subjective experience. My investigation was indeed concerned with the experience of the students and their perceptions, thoughts, memories, emotions and volitions. However, as I have indicated in the introduction

to the thesis my on-going difficulties in my considerations of the concept of identity had generally been from a broad historical mind-body dualism perspective. I had come to recognise that my deliberations might remain problematical if I retained an overall philosophical standpoint attempting to explore the ontology of how the mind and body are related. Phenomenological research considers the subjective character of what it is like to have a certain type of experience - what is it like to be a student nurse on a BSc adult nursing course for example - and I believed that this might potentially reduce the significance of the social aspect of identity that I considered necessary both to best meet the research aims and also to aid in the development of my own insights and anticipated shift in learning.

Such considerations concerning the research aims led me to more specifically explore social constructivism as a guiding methodology. Philosophically, social constructivism resonated with my considerations, not least the postulation that understanding, significance and meaning are developed in coordination with other human beings. Ontologically speaking, social constructivism assumes that reality is essentially constructed through human activity, as members of the group, society or community create and develop the properties of that group, society or community. Reality, therefore, does not exist, in some way in advance, "out there" waiting to be discovered. Reality does not exist before social invention and individuals make sense of this reality and thereby create meaning through their interactions with other individuals and with the environment they exist in. Human beings explain and rationalise their experience by creating a model of their social world and recognising the way it prevails and functions. From an ontological point of view, meaningful reality is constructed through interaction between individuals and their social world and this social context can therefore only be *known* and understood from the standpoint of the individuals who are participating in it (Crotty, 1998). To experience a world is to participate in it, simultaneously encountering it and influencing and shaping it at the same time (Scotland, 2012)

Similarly the origins of an individual's knowledge are found in their interactions with other people and their surroundings, prior to any kind of "internalisation". Knowledge is represented as a human product that is socially and culturally constructed and meaning is again created via interaction with others and the environment that the individual exists in.

Vygotsky states that cognitive growth occurs first on a social level, and only then can it occur within the individual (Karpov, 2014). The construction of knowledge and the making sense of others, occurs on a social level and thereby allows individuals to learn as they relate themselves

to their circumstances (Newman & Holzman, 2103). Learning does not take place *within* an individual or be passively developed by external forces; meaningful learning is a social and active process and occurs when individuals are engaged in social activities, such as interaction and collaboration (Daniels, 2016).

Lave and Wenger's (1991) work on situated learning also argued that learning, particularly learning through an apprenticeship-type model is primarily a social activity, rather than an individual phenomenon and that knowledge can be viewed as practical competence gained through participation and engagement in social enterprises of particular *communities of practice.* Like Vygotsky, Lave and Wenger (1991) argue that learning is a function of the activity, context and culture in which it occurs.

Both Vygotsky and Lave and Wenger therefore articulate related explanations on the nature of knowledge and how individuals learn. Learning occurs as individuals construct their own understandings or knowledge through interaction with, and reflection on what they already know and believe, balanced against and influenced by the ideas, events, people and activities they have contact with in their day-to-day activities (Daniels, 2016).

Crucially, therefore, for all learners, not least the participants in this research, the facilitation of learning and teaching requires an environment of collaboration, peer support, reciprocal value and regard. This is essential for learners to socially interact legitimately and confidently with the members of the group or community with more knowledge and experience and thereby subsequently develop the understanding essential to their engagement within that group or community. Vygotsky hypothesises that via the concepts of watching and learning from others and the sharing of values and beliefs with others, learners experience a learning environment that is supportive yet positively challenging to the learner's thinking and - via interactive dialogue - facilitates the active achievement of their own understanding (Gredler & Shields, 2008). The role of the expert - a mentor for example - is crucial, as they help create an appropriate environment for the learner to start to develop their own expertise by the facilitation of their own considerations and the arrival at their own conclusions. Vygotsky developed the concept of the "zone of proximal development" (ZPD) as the difference between what a learner can do without help and what they can achieve with guidance and encouragement from a skilled mentor or partner. Therefore movement occurs in the zone of proximal development as a result of social interaction - as evidenced by collaboration, guidance, advice or facilitated problem-solving (Newman & Holzman, 2013).

Tasks within the zone of proximal development which are beyond what the learner is able to do and require guidance and encouragement from a knowledgeable person, teacher or mentor therefore require significant and appropriate insight into the specific circumstances of the individual learner, what their learning requirements are and knowledge of what is necessary to learn to achieve any specific learning outcomes. To successfully structure a student's learning therefore it is essential to evidence congruence between theory and practice (Daniels, 2016).

The concept of *scaffolding* supports leaners to construct new knowledge, building on existing knowledge with the assistance of others to guide the learning, acquire knowledge and ensure tasks become unachievable. The process of scaffolding is also assisted by strategies such as modelling, feedback, questioning, instructing and cognitive structuring. This requirement further highlights the need for mentors and all facilitators in the clinical area to have an awareness of and commitment to the process of scaffolding and other strategies to optimise student nurses learning.

Lave and Wenger's (1991) research on apprenticeships can offer a view on how the zone of proximal development might help construct or re-construct our view of development and the function of educators/facilitators - and indeed mentors - in the development process. Each new experience requires a shift in identity in individuals - in this case student nurses - as learning is a social process involving behaviour, context, personal beliefs and meaning (Lave & Wenger, 1991). Learning is the subjective experience of change (Tett, Cree & Christie, 2017; Crossan et al., 2003) as individuals learn how to engage and participate with others in their social world or 'community' (Wenger, 1998).

Wenger's work, with Lave and also independently (1991; 1998), is principally explored within the context of community. However my main research interest was, crucially, in the *perceptions* of the participants. Therefore, as I was attempting to utilise methods that would help explain perceptions, meanings and actions and yield understandings of behaviour from the student nurses' perspective, such considerations led me to *focus groups* and *interviews* as the chosen approach of data generation.

As I shall further explore later in this chapter, researching students from the university where I worked was dismissed as an option due to the pre-existing relationship and its inevitable influence on the dynamic of the group. However it would be naive to ignore the implications still inherent in the fact that I was a lecturer researching the experiences of participants who were students. Qualitative research, however, recognises that any narrative is inevitably only a

partial and particular telling of 'what happened' and 'why' (Silverman, 2016). This 'fracture' as Silverman calls it, is further increased by the process of analysis - coding, categorisation and so on - transcribing, publishing and, indeed, subsequent reading and understanding by others. Therefore it is understood that how the participants in the focus groups and interviews responded to me, my role as academic, researcher, nurse and my gender, age, perceived class, race and so on, should be viewed as both a practical consideration but also an epistemological or theoretical one. A researcher, by definition, has an awareness of the proposed aims and outcomes of the research, and will have constructed a related broad focus group guide to support discussion as necessary (See Appendix Two: Focus Groups Guide). However, although the researcher will have a strong sense of the issues to be explored; consideration and awareness of the interaction between participants in focus groups can help reduce any unjustifiable influence by the researcher and allow them to essentially 'listen in' to the critical aspects of the discussions of the members of the group (Gray, 2018). I therefore needed to be skilled at creating a relaxed atmosphere and able to generate informality in what is ultimately a formal interaction. I was aware that I needed to encourage group interaction when necessary and support participants to respond to *each other* not to their perceived expectations of me as the researcher or facilitator of the group. The facilitator's role is to 'moderate the discussion' and draw out passive participants as issues spontaneously emerge prompted by the stimulus of different peoples' contributions. Some tangential discussion is also inevitable, and conflict may then occur which I would need to manage sensitively, without cutting off participant contribution too abruptly, as this would have been likely to compromise the commitment and trust between myself and individuals within the group (Bowling, 2014).

4.4 Sampling

In every stage of the research process all decisions should be driven by the explicit and unique aims of the research. The fundamental aim seeks to provide an understanding of a specific phenomenon, and therefore a sampling strategy was chosen to provide the most relevant and applicable data in relation to the research aims (Parahoo, 2014). Research in the qualitative paradigm generally uses non-probability sampling as random selection is not involved. A non-probability sample is deliberately selected to reflect particular features of the sampled population (Ritchie et al., 2014). Due to the aims of the research a purposive sampling approach was utilised. Such approaches are designed to increase the scope or range of data that is generated as well as increasing the likelihood of uncovering an array of multiple perspectives (Denzin & Lincoln, 1998). They are also designed to illuminate both variation and also

significant common patterns (Holloway & Wheeler, 2015; Emmel, 2013). As it was essential to gain insight into the experiences of students from each of the three years of the undergraduate BSc adult nursing course, the sampling strategy involved the purposeful selection of participants from different cohorts of students from each of the three years. This was to ensure that an element of a whole population was selected - an element or sample whose experience was pertinent, relevant and representative of adult student nurses in each of the three years at this particular university at this particular time. This approach is thereby able to provide data to help explore the specific research question (Braun & Clarke, 2013).

Purposive sampling techniques are often used in combination with other strategies to add richness and depth to a study (Emmel, 2013). The primary sampling strategy was, therefore, also supported and supplemented by a snowball sampling approach. Both purposive sampling and snowball sampling approaches confirm a *criterion* based principle (Polit & Beck, 2016). In both approaches participants are chosen because, in the judgement of the researcher, they can provide insight and information that can shed light on the specific aims of the research.

Snowball sampling is when participants who have already taken part in the study refer the researcher to someone else they know with knowledge, insight or experience of the phenomenon in question (Braun & Clarke, 2013). Therefore following the initial recruitment of a sufficiently large and appropriately experienced sample and the facilitation of the initial focus groups, the students involved were asked if they were able to suggest others in their cohort who might be prepared to contribute to future focus groups. Whilst this is a legitimate and well recognised sampling strategy, and was successful in recruiting other participants; one of the drawbacks of such an approach is that by its very nature it is probable that participants will refer their friends or acquaintances and are therefore other potential contributors who are likely to have similar experiences, knowledge, beliefs, attitudes and values as themselves (Polit & Beck, 2013; Holloway & Wheeler 2010). Moreover self-selection can result in participants only attending the focus groups because they had 'issues they wished to air' which are often negative (Pearcey & Elliott, 2004). However, as further explored in the 'Themes' chapter, it became clear that the students, in this research, generally balanced any negative comments or criticisms with insight, understanding and often empathy with the wider issues faced by the registered nurses, and other colleagues, who they worked with.

All sampling strategies have limitations, whether dictated by the decisions made by the researcher and their unique interpretation of the requirements of the study, or by more

pragmatic resource issues. However any sampling strategy or plan must be robust enough to be judged on its appropriateness and adequacy. For example, for any group interview studies there are two levels of sampling to consider; one to develop a sampling strategy for the *groups to be included* and another to consider the sampling of the *particular participants* who will be recruited to those groups (Green & Thorogood, 2014).

4.5 Sample Size

It is important to justify and legitimatise the unique choices within any research rather than looking for a standard generic prescription. Therefore rather than simply judging the adequacy of sample size quantitatively - solely by the number of participants - in qualitative research the sample size is dictated by *adequacy* and the need to reach sufficient depth and richness of data (Braun & Clarke, 2013). Rather than advocating a specific number, for qualitative studies it is the generation and provision of rich and exhaustive data that is most important; with adequacy determined by the sufficiency and quality of data generated by the study. However thorough and focused initial consideration is still required, as *the* critical aim of any sampling strategy remains maximising the opportunity of producing data to answer the specific research question. Following such consideration therefore, for each year the focus groups were planned to result in approximately fifteen participants which would represent in the region of 10% of each year of the cohort and characterise the general balance and mix of age, race, gender and so on, and therefore be representative of the cohort. This would then be further supported by undertaking three one-to-one interviews from each year/cohort.

The specific details/numbers of each focus group and interviews completed are detailed in the Table below.

TABLE 1

Focus Groups & Interviews
n=40 - Total participants in the 11 focus groups across all 3 years **n=9** - Total participants in interviews across all 3 years
First Year
n=15 - 4 focus group participants in year 1 **n = 3** - Interviews in year 1

Focus Group	Participants	Duration	Venue	Additional Comment
FG 1	6 (1 male)	63 Minutes	Campus	Approx. half way through their first year – all had experience of university and various placements in clinical practice. Variety of previous backgrounds & previous experiences in caring context. None had come directly from school – therefore might be considered 'mature entrants'. 1 participant had come via an Access to Nursing Course. Vignettes disregarded due to ease of interaction and amount of data generated
FG 2	2	72 minutes	Campus	Both mature students – neither with previous employed caring experience. Approx. six months into the course and had experienced university and clinical practice
FG 3	3 (1 male)	65 minutes	Campus	All 3 mature students. All had experienced university and clinical placements
FG 4	4	63 minutes	Campus	2 participants straight from A levels – one from middle management in banking sector and the fourth via Access to Nursing Course

Year One Interviews n=3			
Interview No.	**Duration**	**Venue**	**Additional Comments**
Int. 1	68 minutes	University Library	The female interviewee had previously contributed to focus group number two
Int. 2	69 minutes	University Library	The female interviewee had also previously contributed to focus group number two
Int. 3	60 minutes	A quiet venue chosen close to the interviewees home	The female interviewee had previously contributed to focus group number three

	Second Year			
n=12 - 3 focus group participants in year two				
n = 3 - interviews in year two				
Focus Group	**Participants**	**Duration**	**Venue**	**Additional Comment**
FG 1	3	35 Mins	Campus	3 female participants who had been on the course for over twelve months. 1 participant had recently transferred from another university – however had experience of university and clinical practice based at her previous university
FG 2	5	45 mins	University Library	5 female participants from the January Intake Cohort who had been on the course for over 12 months. 3 students were mature and 2 were straight from school. 1 student had recently transferred from mental health branch at the end of her first year.
FG 3	4	52 mins	Campus	4 female participants who were exactly half through the course. 2 participants were mature students whilst the other 2 had come to university straight from school. 1 participant had started on the 2nd year having used the accreditation for prior learning (APL) process having previously been an assistant practitioner in a nursing home.
	Year Two Interviews n=3			
Interview No.	**Duration**	**Venue**	**Additional Comments**	
Int. 1	82 mins	A quiet venue chosen close to the interviewees home	The female interviewee had been unable to contribute to any of the focus groups but had contacted me via the Shifting Identities of Student Nurses Facebook Page as she was keen to contribute to the research	
Int. 2	46 mins	A quiet office in the student's placement environment	The participant had contributed to focus group number 3	
Int. 3	45 mins	In a quiet office in the library on campus	The participants had contributed to focus group number 2	

Third Year				
n=13 - 4 focus group participants in year 3 **n = 3** - Interviews in year 3				
Focus Group	**Participants**	**Duration**	**Venue**	**Additional Comment**
FG1	4	56 mins	Focus group took place between lectures in a quiet classroom	Four female participants all mature students
FG2	1	41 mins	Classroom on campus	Students who had expressed an interest in contributing had been unable to attend. The student had limited paid caring experience prior to her accessing the course
FG3	5	54 mins	Quiet room on campus	Five female participants a mix of experiences and ages
FG4	3	48 mins	Took place immediately following focus group three in the same quiet environment.	Three participants – one of whom had had two years previously as a support worker in an acute hospital. The other two had no previous paid caring experience
Year Three Interviews n=3				
Interview No.	**Duration**	**Venue**	**Additional Comments**	
Int. 1	64 mins	Quiet room on campus	Participant was previous contributor to focus group 3	
Int. 2	54 mins	Quiet room on campus immediately after Int. 1	Interviewee was the contributor to focus group two. She had now been a staff nurse for two weeks and had worn the "blue uniform" of a qualified nurse for one day	
Int. 3	42 mins	Quiet room near to the participant's home.	Participant was previous contributor to focus group 3	

4.6 Data Collection

The chosen method of data collection must be rigorous, credible and trustworthy and it must match the methodology offering a fair and full opportunity for the participants to provide rich and detailed information relating to the research aims and objectives (Bryman, 2015). Rigour in qualitative research essentially means accurately representing the participants experience (Streubert Speziale & Rinaldi Carpenter, 2011). Credibility in this research was further

confirmed by the one to one interviews endorsing that the themes and findings from the focus groups were true to the participant's experiences.

As evidenced by the requirement to further utilise snowball sampling, the recruitment of what was deemed an appropriate sample of participants was not trouble-free. Issues before data collection could commence - and for data collection to proceed - included difficulties of access, complicated initial contact, arrangement of venue and security as a visitor to the university, bringing together a working timetable for each of the groups and the engagement of students from each year. These, and other 'practical' issues, are further explored later in this chapter.

As a result of such difficulties of access, and despite the considerable support of the academic colleagues and administration staff, some of the groups were constituted of a less than optimum number according to the theoretical evidence for 'focus groups'. For example one group consisted of only two first year students and another, despite significant planning and preparation, just one third year student. If a group is very small it loses some of the qualities of being a group, however according to Ritchie et al. (2014) paired interviews and triads can be an effective hybrid of in-depth interviews and group discussions and are particularly useful for in-depth discussion among colleagues or people who know each other well.

4.7 Focus Groups

Focus groups continue to be popular in health research not least as 'group processes' are often used as an approach in the education of health professionals and service users and also match the team/group context of practice (Green & Thorogood, 2014 p.130). A focus group is a small group brought together to discuss a particular issue under the direction of a facilitator who has a specific aim and list of topics to discuss. However certain authors would suggest certain, specific criteria must pertain for the activity to legitimately be called a 'focus group' (Denzin & Lincoln, 2017; Kreuger & Casey, 2015; Kitzinger, 1995;).

For example, a focus group might be expected to usually include six to ten people, as larger groups can potentially preclude all participants from having the chance to speak and a smaller group size may make group members feel as though they cannot speak freely or feel they have to speak when they consider they have nothing to offer. This reinforces the need to create an environment of support and security as a facilitator, particularly when the number of participants is relatively small.

Similarly, traditionally focus group participants will not have met each other previously. However Green and Thorogood (2014) speak of a 'natural group' approach which recognises circumstances where participants already know each other in an informal group. This natural group may provide an even more 'naturalistic' setting than a 'traditional' focus group as it resembles in many ways the kind of interaction participants might have in their professional lives and allows even greater access to how people talk to each other about particular topics and issues. It also allows insight into how knowledge about health and professional identities are produced and reproduced in 'natural' social situations, creating a more 'natural environment' as participants are influencing and being influenced by others just as they are in 'real life'.

However - despite a well-facilitated group having the feel of an everyday discussion - such groups can never be viewed as truly 'natural'. Not least as it is not 'natural' to be aware that any comments or utterances that are made will be viewed as research data. The student nurses involved in the focus groups of my study, although invariably and, indeed, purposefully, peers and acquaintances, and, in fact, occasionally friends outside of the focus group, and therefore comfortable and relaxed in each other's presence; were also inevitably within an unconventional environment. Undeniably there is still a formality inherent within such groups - whatever their title or description - as the participants are invited to attend expressly for research purposes (Gray, 2018). Therefore, despite some of the potentially problematic theoretical considerations, I shall refer to the groups of research participants as *focus groups* throughout the thesis.

Focus groups, natural groups or any group interview are designed to maximise interaction between participants and between facilitator and participants. It is the interaction that provides access to shared group values, perceptions, identity and culture (Coe, Waring, Hedges & Arthur, 2017). Data are generated by interaction between group participants as they present their own views but also listen, reflect on the views and experience of others and thereby consider and reconsider their own view and standpoint further. This prompts and triggers further material as participants ask questions, seek clarification, confirm opinions, sharpen and refine responses and thereby reveal more on a deeper and more considered level (Bryman, 2015). This was evident from the discussions in the various focus groups as thoughts, ideas and opinions were being developed, crystallised and becoming more fully formed during the actual process of the focus group and the interaction between the participants. In their response to others, participants reveal their general view of the subject of study and more of their own

frame of reference on their shifting identity. This synergistic and spontaneous group interaction is subsequently used to generate data. The insights into the social constructions, shared meanings, normative influences and collective as well as individual self-identity are the way in which experience is perceived and the world understood. Shared experience is, therefore, particularly important to encourage disclosure (Creswell & Plano Clark, 2018).

Sensitive issues may also be more readily discussed within group settings (Stewart & Shamdasani, 2015). However this may depend on the cultural group values and the nature of the group itself. In this particular research there was a risk that sensitive disclosures may have been made which were potentially impactful on participant's lives and careers beyond the research context and therefore raise significant ethical difficulties. Ethical considerations are discussed in greater detail later in this chapter.

With focus groups, Kidd and Parshall (2000) believe that there are three criteria of reliability: these are stability, equivalence and internal consistency. Stability mainly relates to focus groups that are convened more than once, with stability becoming an important issue when group membership changes from one meeting of the group to the next - this was not the case in this particular research.

Equivalence describes the consistency of the moderators or coders of the focus groups. This research has very high equivalence as the same facilitator led the discussion across all groups, completed the majority of the transcription and undertook all of the analysis. Similarly internal consistency is high as I took sole responsibility for conducting the analysis and facilitated all the focus groups.

Validity of a focus group approach is partly used to describe a form of content validity. In other words, how convincing is it that what the participants have shared is valid information (Kidd & Parshall, 2000)? The composition of the group can help to increase the validity of data as the key feature for participant selection is their experience and membership of a specific adult nursing cohort - as opposed to participants from a variety of different cohorts and/or different years within the same focus group - validity is enhanced. Validity is similarly increased by conducting multiple focus groups, whilst ensuring participants of differing characteristics are in separate groups thereby further justifying the principle of utilising separate focus groups from each of the three years of a nursing course.

4.8 In-depth interviews following the focus groups

Focus groups were not originally conceived as a stand-alone method and to enhance the findings and confirm the conclusions of the study data, triangulation is often recommended (Tadajewski, 2015). This was achieved by means of subsequent in-depth interviews with this combination of strategies intended to overcome some of the limitations of a single approach (Streubert, Speziale & Rinaldi Carpenter, 2007).

In-depth interviews also allow greater rapport to be developed and can offer the participant greater opportunity to be heard. They offer further potential for obtaining access to, and describing, participants' lived experiences and are a way of uncovering and exploring the meanings which underpin participants' behaviours, perceptions and identity (Kvale, 2007). There is an argument that such qualitative interviews should always be unstructured to allow and facilitate free expression rather than being too influenced by structure - not least a structure that is imposed by the researcher (Smith, Flowers & Larkin, 2009). However, as the interviews are the second stage in this research, it is not only legitimate but essential that the structure is influenced by the themes uncovered and explored in the focus groups in the first stage of the research. Therefore utilising an interview schedule linked to themes detected from the focus groups and exemplified by quotations from the relevant and related cohorts constructed a flexible agenda and frame for questions whilst maintaining a suitably open format (See Appendix 3: Interview Schedules). Despite the schedule, the participant's contribution remains most important and therefore *listening* remains the necessary pre-requisite for the researcher (Brinkmann, 2013).

4.9 The process of analysing data in interviews and focus groups

In interviews, and perhaps more particularly in focus groups, although the context may appear 'naturalistic', this should not be implied as some kind of privileged insight into authentic views (Brown, 2015). Data requires analysis vis-à-vis the context in which they are produced and the local meanings of that context. The 'opinions' or 'views' need to be situated within the interactive context within which they are produced. Opinions are voiced and comments made on the contribution of others - perhaps the interviewer or another member of the focus group - for a variety of reasons *other than to provide data for a researcher* (Kreuger & Casey, 2015). Participants might also be 'presenting' themselves in a certain way for many reasons – impressing their colleagues, impressing the researcher, antagonising the researcher, ameliorating conflict or reiterating routine cultural tropes. Although this potential should not

be underestimated, I was given no reason to suspect that any of the data was in anyway compromised due to such incidences. Therefore, like all data, focus group and interview data require significant attention to the ways in which talk is used in particular settings. In fact the more 'natural' a focus group is, the more difficult it may become to analyse the data as this might include participants talking over each other, interrupting key discussion points, audiotape being difficult to transcribe, difficulty in identifying speakers and so on (Gray, 2018).

The method of analysing data in both focus groups and one to one interviews is an iterative one and an important initial stage of this process is transcription (Braun & Clarke, 2013). All but three of the transcriptions were undertaken by myself with the remainder transcribed by an administrative colleague. I transcribed the tape recordings of the focus groups and subsequent interviews close to the time the focus group or interview took place to reduce the likelihood of omission errors. For those transcriptions that I did not undertake myself, I re-read, checked against the recordings and confirmed their representativeness as soon as possible following return from the transcription. It is important to avoid the term 'accurate' in this context, the transcriptions need to be thorough and high quality however, as Braun and Clarke (2013) advise, with each step some information is lost or changed in some way; it is therefore a *representation* rather than what might be considered 'accurate', 'pure' or 'raw' data.

Certain choices are made by the transcriber about what to preserve and how to represent what they hear. I experienced the transcription process as part of the developing familiarisation, engagement and immersion in the data and therefore an integral part of the analytic process. I endeavoured to make the approach as thorough and meticulous as possible with the aim being to produce as clear and complete an interpretation of *what* was expressed as possible. Transcription is not a simple impartial interpretation of words but more a 'selective arrangement' produced for the purposes of analysis (Braun & Clarke, 2013). The transcripts were returned to on many occasions to increase *reliability;* as despite the fundamentally *subjective* nature of the process the task is indeed *objective* in the sense that the description is presented in as much depth and detail as possible. This process helps ensure that the participants' views are represented fairly and portrayed consistent with their meanings and that emergent themes are developed which are matched against the aims and objectives of the study (Silverman, 2016).

4.10 Thematic Analysis

When analysing focus group data Kidd and Parshall (2000) argue that neither the individual nor the group exclusively constitutes the unit of analysis, however both might be a focus of analysis. This again recognises the importance of a group effect in analysing data and how the group context influences participants (Brown, 2015). However, as I shall discuss later in this chapter, thematic analysis as an approach can occasionally be accused of missing that unique aspect of interaction, continuity or contradiction within focus group data.

Notwithstanding such discussions it was clear that the process of transcription and the reiterative process of reading and re-reading and immersing myself in the data, from the focus groups and also the subsequent one-to-one interviews, was all part of the analytic process. Through this method, distinctive themes became clear. Although some sort of 'thematic analysis' is common across many qualitative research methods this approach has only relatively recently been recognised as a distinctive method with a clearly outlined set of procedures for the social sciences (Braun & Clarke, 2006).

Thematic analysis does not prescribe methods of data collection, theoretical positions or epistemological or ontological frameworks but does provide a systematic yet flexible method for data analysis. Themes are data driven, as concepts and ideas that underpin the data or any assumptions and meanings in the data are identified. In any research there is rarely a clean separation between data collection and analysis and, therefore as advised by Robson (2011), an analytical standpoint was maintained throughout the study; rather than a rigid linear approach that left any analysis until after the completion of data collection. Analysis and re-analysis of initial data can offer significant meaning and highlight major themes related to the research aims quite early in the research process. As Braun & Clarke (2013) suggest although a systematic and thorough approach is essential, attempting to follow a precise and rigid 'set of rules' is outweighed by an 'analytic sensibility'. By this they mean that the skill of reading and interpreting data through the particular theoretical lens of a chosen method can promote greater depth of analysis of the content - beyond what might be obvious - to patterns and meanings of broader theoretical concern. Immersion in the focus groups and interviews and becoming intimately familiar with the content gave me an overall impression of the data and due to this increasing familiarity, data 'coding' was possible whilst data collection was still ongoing and potential patterns and themes were discerned and refined as further data was collected and analysed.

Braun and Clarke (2013) believe the initial themes that present themselves are likely to reflect things that are most significant to the researcher. I had to be aware of any potential preconceptions I may have had as a nurse, as a nurse teacher and as a researcher. In a practical sense it was important to attempt to be open and reflexive about my own views and previous experience and how that might influence the participants and create assumptions on their part of what I might be expecting or what I viewed as the 'right thing to say' and therefore influence their responses. Being seen as open, honest and reasonable demonstrated good faith and a promise of fairmindedness. However, although it was the participants' perceptions, thoughts, opinions and insights that were key to meeting the research aims and I was seeking to clarify my understanding of their experiences; it was always through the lens of my own experiences, context and assumptions.

The words are essentially data that require active and critical analysis to help develop thinking about what the data mean. Such a process prompts insight into how the participants might make sense of their experience and why they make sense of their experience that way; the assumptions being made as they talk about their perceptions, their world and the shift in their identities revealed through the discussions and individual accounts. These initial insights are the preliminary steps in the process of coding and the identification of anything of interest or relevance featuring in the data that relates to the research question (See Appendix 4: Initial Codes Identification of Concepts & Ideas).

A code is a word or brief phrase that captures the essence of why a specific piece of data may be valuable. Coding is an evolving process as understanding of data increases and existing codes are adapted to integrate new material and create *categories* and identify *patterns*. Therefore codes were linked, recognised and categorised and then eventually developed into themes, as larger patterns of significant features, most meaningful to answering the specific research question, were identified across the dataset. Themes are the result of an active process - identifying, linking and organising concepts into units or categories and capturing patterns of significance and importance in relation to answering the research question. The identification of a number of important themes highlighted those that were most meaningful and important to answering my specific research questions and were not necessarily the most frequently highlighted ones. Themes are discrete and make sense individually whilst also fitting together to form the overall analysis. Their development is a selective process which tells a specific and particular story and answers the research question; rather than attempting to represent everything that is said in the data.

An iterative approach of reviewing and revising the themes became part of the quality assurance measures ensuring that the narrative I was relaying was faithful to the data. Reorienting the central concepts, collapsing a number of themes together or splitting a large broad theme into a number of more specific or coherent themes can also be necessary to ensure the themes are coherent with each other and relate to and genuinely address the research aims. This process, thereby resulted in a deeper analytic, interpretive understanding of what had been identified in the data. Themes become more clearly defined and distilled to an essence; their uniqueness, focus and purpose is highlighted providing a rich coherent and meaningful picture of the dominant patterns in the data. Extracts from the data were selected to illustrate the different facets of each theme and an account created around these extracts which told the narrative of each theme. Extracts were drawn from across the data, and from a variety of participants where possible, which showed the relevance of each theme and evidenced the spread across the data. The extracts are part of a rich and detailed description and interpretation of the theme and an integral part of the analysis. (See Appendix 5 for an example of this - Developing Themes: Developing the student narratives - Year Three).

4.11 Access to participants

Previous discussions in this chapter exploring the epistemological and theoretical underpinnings of the chosen methodology, have also offered the occasional insight into the practical steps that I undertook to ensure an appropriately robust methodological approach to ensure the meeting of my research aims. I shall now discuss such considerations of method further.

To gain access to data relating to the shift in identity of students, explore differences and commonalities in experience and gain detailed insight into the different understandings and perceptions of as wide a range of students as practicably possible, it was important to recruit participants from each of the three years of the nursing degree. Access to a group or groups of undergraduate adult nursing students across each of the three years of a nursing degree was therefore essential.

My role as a principal lecturer at a university allowed me relatively straightforward access to various cohorts of students. However such a pre-existing relationship between researcher and those who they are researching can increase the likelihood of influence or potential coercion and therefore be both ethically problematic and lacking in robust validity (McConnell-Henry, James, Chapman & Francis, 2010).

Therefore, with the assistance of my supervisor, contact was facilitated with the Course Leader of the Undergraduate Nursing BSc Course at another university. This proved to be provident and a meeting was arranged to discuss the rationale for the research and if access to undergraduate students might be possible. The practicalities of access were discussed along with potential strategies for ease of facilitation. A list of key names and email addresses of nurse lecturers who had specific cohort responsibilities was offered, intended to help facilitate access to the various cohorts across each of the three years.

4.12 The Shifting Identities of Student Nurses Facebook Page

At the same time I had established a Facebook page called The Shifting Identities of Student Nurses to further facilitate information sharing and recruitment. Use of social media and other 'virtual' techniques are a growing area of exciting opportunities in qualitative research and the generation of qualitative data (Braun, Clarke & Gray, 2017). This was an integral part of a strategy designed to engage potential research participants, generate additional discussion and data and also clarify the main aim of the research to others thereby contributing positively to the overall consent process. Many current students are very conversant in the use of technology generally and social networking sites in particular in educational activity (Waghid, Waghid & Waghid, 2016) not least as a positive means of communication (Akcayir, 2017). The Facebook page included a video of myself explaining the purpose of the research and requesting assistance from willing participants across the three years of undergraduate nursing.

https://www.facebook.com/Identitynursing/

4.13 Contacting Students - the Initial Steps

This type of approach can lead to significant difficulties - not least its relatively time consuming nature and its reliance on the commitment of others. However, the responses to subsequent emails to academic staff at the university were generally very positive and most colleagues indicated they were keen to assist. It was agreed that I would construct an email that would be sent to all undergraduate adult nursing students via the course administration and support team.

This was also supported by a more direct and 'personal' approach as I was invited to meet several groups either preceding or following a timetabled lecture. By this means I was able to meet potential participants face-to-face and answer any questions or concerns immediately. The rationale for, and purpose of, the research was explained and how participating might allow the students to share their perceptions and experiences, reflect on their current context, review

their progress, changing views of themselves, developing views of nurses and nursing and their shifting identity. The provision of any further incentives to encourage participation might be innocuous but can be seen as contentious and might be accused of 'biasing' any response, constituting inducement and compromising informed consent (Grant & Sugarman, 2004). Therefore only the above 'benefits', along with the opportunity to meet others and to discover more about the topic was hoped to be satisfactory incentive for a positive response from sufficient students to generate an adequate sample.

Students who were willing to participate were able to offer initial thoughts on potential times to meet again and also able to offer their student email addresses. It was agreed that I would contact them subsequently to confirm the timing of the proposed focus group. On two occasions, groups of students were keen to meet immediately as they had a significant break before their next lecture. We were able to access a suitable quiet and private room on campus on both occasions and the groups were able to convene immediately. I had prepared for this opportunity and had recording equipment, consent forms, participant information sheets and focus group guides with me at all times.

Arranging the times and venues for the other groups was assisted by support from the course administration team in the school. Although contact was made by email by myself, clarity and confirming of timing and venues was also ensured by the administration team. Prospective participants were also sent an information sheet (Appendix 6: Participant Information Sheet) to further clarify the purpose of the research and allow them additional time to consider their consent to participate.

It was an interesting experience as the students were far more aware of the surroundings, room arrangements and campus geography than I was. This required significant time management and exploration and frequent reconnoitres to ensure the smooth running of the groups. This was essential, not least to indicate appropriate respect to those who were prepared to offer their valuable time to help progress the research. Undertaking focus groups in an environment that is known to the student may help promote greater security and comfort to the groups and thereby engender greater involvement and honesty in the contributions of each member of the group (Kreuger & Casey, 2015).

4.14 Arrangements for the subsequent one-to-one interviews

The students who were willing to contribute further had offered their e-mail addresses at the time of the focus groups and I was able to contact them directly. This process resulted in in-depth, semi-structured interviews with nine participants - three students from each year. All but one of the participants had previously contributed to one of the focus groups and were therefore likely to recognise the development, and relevance of the interview questions that had been generated from the coding and thematic analysis of the focus group data. The one participant that had not previously been involved, had been unable to attend any of the focus groups with other students in the second year, but was very interested in the research aims and was keen to contribute. The interviews were conducted in previously arranged, private environments either within the university campus or off site at a private meeting place of their choice. The shortest interview lasted forty-five minutes whilst the longest eighty-five minutes. The length of the interview was determined by the participant and concluded when they felt that they had had opportunity to explore in sufficient detail the key themes that had emerged from the focus groups.

4.15 Ethical Considerations in Recruitment, Data Collection and Analysis

Research involving human participants inevitably raises significant ethical considerations (Tingle & Cribb, 2014). This is further increased by research that explores the experiences of participants who are not only potentially exposed themselves but also reflecting on and divulging their experiences in environments where they are involved with particularly vulnerable patients and service users.

Ethical approval for the study was therefore sought and gained from the University School Research Ethics Panel. This consisted of a submission of a proposal articulating the key aspects of the research to a panel of experts. The proposal included: consent form, participation information sheet, vignettes (Appendix 7: Vignettes) that I had created to help support discussion should they be needed and recognition of any health and safety considerations. The proposal is designed to highlight that the researcher has explored the complex ethical considerations of the research and has taken reasonable steps to reduce any negative impact on participants and others and presumes a recognition of underpinning ethical principles. Formulaic or ritualistic observation of ethical codes may blunt an awareness of method specific dilemmas that could arise within a qualitative research approach (Murphy & Dingwall, 2001) and a contextual and situational approach to consideration of what might be best for

participants has been suggested (Ritchie et al., 2014). Although research is never conducted in isolation from established ethical codes or governance frameworks it is the supporting values rather than strict codes that should dynamically guide research decisions (Ryen, 2016). Such values are famously articulated by Beauchamp and Childress (2013) when they define the underpinning principles of health care ethics as autonomy, beneficence, non-maleficence and justice.

4.15.1 Autonomy

The promotion of autonomy is necessary in all research to ensure a truly ethical approach. Autonomy can be evidenced in a variety of different ways. For example the importance of the principle of *informed consent* highlights the necessity of self-determination and self-sufficiency and confirms that all participants contributed voluntarily and gave their consent freely and un-coerced (Freer, 2017). Participant decision making assumes competency in the individual concerned and only follows after being fully informed about the nature of the study, both verbally and in writing, before agreeing to take part. Similarly all participants should be informed that they are able to withdraw from their commitment to the research at any time. Any such withdrawal can be complicated with interactive group methods such as focus groups and, accordingly, all participants were advised that if they wished to withdraw after the focus groups had taken place there would need to be a discussion on whether their specific data could be extricated and subsequently used within the study or disregarded as data. Similar discussions also preceded each interview, with the right to withdraw consent to use of some or all of their data emphasised to all participants (Appendix 8: Consent Forms).

It is noted that no participant, after signing their consent and agreeing to contribute to the focus groups and subsequent interviews, chose to withdraw from the research.

Although informed consent is undoubtedly a core principle of *most* research, questions may still be raised about how informed is informed and how the researcher might assess if a participant is *fully* informed. Balancing the risk of too little information and too much information - which might run the risk of overwhelming and putting off potential participants. Broad key messages include informing participants of the purpose of the research and its aims; the background of the researcher; what participating might involve; the subsequent use of the data; confidentiality and anonymity and the voluntary nature of participation.

4.15.2 Beneficence and Non-maleficence

Beneficence (or the principle of doing good) and non-maleficence (the principle of doing no harm) are related but can both be quite difficult to assess with real precision. What does the idea of 'doing good' really mean particularly in relation to research involving human beings and undertaken by a researcher who is in a role that might be viewed as relatively powerful and with authority. As a researcher it is important to continually consider and reflect on the purpose of the research and the underpinning principles inherent within that. The benefits of this research are clear to me as a researcher; particularly as this specific research is in partial fulfilment of a PhD. However the benefits to those who willingly consent to contribute is less easy to articulate and discern. It is clear that this particular research may benefit the participants by allowing them to reflect on their experience and also potentially benefit from peer support inherent within the focus group method. Similarly the reflection and support gained from their contribution to the research may empower them to review their experience, their current and future practice and encourage a recognition of their shifting identity.

Non-maleficence or the principle of doing no harm is equally complex. A definition of harm in such circumstances is both multi-faceted and also unique to each individual involved. Contribution could cause damage to the participants' reputation should they divulge practices that are contrary to professional standards or are identified as inappropriate professional practice. Moreover reflection on challenging past events, witnessing poor practice or circumstances where events did not go as planned can also be difficult and potentially harmful. The Participants Information Sheet contained information of sources of support via the Student Union in the unlikely event that participation in the research caused them any distress.

4.15.3 Confidentiality – the ethical context

Although not a specific ethical concept, confidentiality is an important consideration in the broader ethical context and relates to several ethical principles. For example respect for, and maintenance of, confidentiality needs to be ensured as part of the strategy to maintain the participants' reputation thereby reducing the likelihood of harm. Participants were therefore reassured that information and any transcripts or field notes both digital and written would be kept secure. All transcripts and signed consent forms were stored in a locked filling cabinet within a secure office. All electronic data stored as audio files and Word documents were also maintained as securely as reasonably practicable. The Dictaphone used was locked in a drawer when not in use and the computer and laptop were password protected. As part of the consent

process these security measures were explained to participants and it was further confirmed that the audio files would be kept until the study was complete and then would be retained no longer than five years when they would be destroyed.

Research and most particularly qualitative research that may include discussion of vulnerable individuals and also involves professional and regulatory expectation on the part of the participants can never be viewed totally in isolation from that professional and regulatory context (Nursing & Midwifery Council, 2012). Therefore discussion of the potential limits to confidentiality, dependent on what might be divulged, was again an integral part of ensuring truly informed consent with each participant. Focus groups have greater potential for breaches of confidentiality, accidental or purposeful, especially where participants have connections beyond the research study. Prior to commencing the focus groups it was confirmed that disclosure of information, description of actions or accounts of any practice that may represent a breach of the NMC Code for nurses and midwives (Nursing & Midwifery Council, 2015) or that fell below the standards expected of an aspirant professional or that indicated a breaking of the law might necessitate further action. This circumstance might demand that information be passed to the university or the NMC or both. Any researcher who is professionally accountable to the NMC can therefore face a dilemma due to their professional regulatory status and their related responsibility to patients, other professionals, students and society at large. Although 'trust' is at the heart of a necessary and positive ethical relationship between the researcher and participant, deliberate breaking of confidentiality might be deemed necessary in some circumstances (Ryen, 2016). The researcher must balance a desire to encourage participation and the generation of high quality data with empowering participants to make decisions about whether they take part and what and how much to say. This consideration is necessary in *any* study however the degree of emphasis given to disclosure in advance may depend on the vulnerability of the group and the sensitivity of the topic (Ritchie et al., 2014). A recognition of personal and professional accountability is at the heart of professional registration and therefore makes such consideration integral and apposite with research that explores the development, learning and shifting identities of student nurses.

4.15.4 Anonymity

Informed consent also needs to include an understanding of any assured anonymity for all participants. However just as with the principle of confidentiality this is similarly limited in some contexts. As discussed, focus groups by their very practice, nature and philosophy

compromise the principle of assured anonymity to an extent. A strength of the focus group method is the principle of shared ideas and mutual support within a group and therefore the traditional expectation of anonymity - at least within the group itself - is unachievable. However ground rules articulated and agreed by each participant at the commencement of each focus group confirmed the importance of all involved maintaining confidentiality and promoting anonymity beyond that unique group and unique set of circumstances.

Moreover, on transcribing of the data all effort was made to protect the participants and those who may have been mentioned in the interaction of the focus group from subsequent recognition. All recognisable reference to individuals, Trusts, specific wards or units was removed and participants were only referred to with pseudonyms or by being assigned a unique numerical tag.

4.15.5 Justice

Justice is notoriously hard to define. It is a concept that in the context of research relates to ideas of equity, individuals being treated fairly, ensuring all participants' voices and opinions are given equal opportunity and consideration and ensuring, as far as possible, that the opinions and views of the participants are reported and explored in a way that represents their intended and 'true' meaning.

Adherence to the principle of justice is essential throughout the whole research process – from the initial selection process ensuring equality of opportunity of contribution whilst also ensuring no coercion; through the fair and supportive facilitation of focus groups and interviews and during the data analysis process and subsequent publication and dissemination of research findings.

The strict adherence to such ethical principles engenders a trustworthiness, fidelity and reliability that should also bring a greater reassurance to any external scrutiny. As a researcher it is essential that trust is engendered as far as possible between the researcher and participants and that the researcher recognises their responsibilities to safeguard the rights of the participants. Whilst the researcher attempts to present an authentic representation and analysis of the data to meet the aims and objectives of the research, this should not be at the expense of the wellbeing of the participants.

Trust between researcher and participants promotes an environment of security that is also more likely to encourage honesty and candour. The sacrosanct assumption within informed

consent is one of veracity and genuineness, with the responsibility to be truthful and honest to the participants, endeavouring to clarify any concerns or queries participants may have.

4.16 Limitations of the chosen research methods - real and potential

Many of the benefits of a focus group approach have been highlighted throughout this chapter and include the fact that they are relatively inexpensive, flexible, can be stimulating, collaborative, assist in information recall and capable of producing rich data (Streubert Speziale & Rinaldi Carpenter, 2007). However there are also limitations or disadvantages to a focus group or group interview approach. One issue is the extent to which participants in a focus group are likely to be self-selecting; it is likely to attract participants who are confident about talking in groups and are relatively assured about their ability to articulate their point of view. Focus groups or group interviews might therefore be unlikely to gain marginal views or 'hard to reach groups'. Moreover a group dynamic and power hierarchy may govern who speaks and when and how much they speak; with strong personalities dominating and others reticent to speak up. The facilitator needs to be alert to this and challenge it whilst also maintaining an environment in which all participants feel safe, encouraged and supported.

This can result in what might be called 'groupthink', a process that occurs when certain members of the group have a major control or influence over all other group members and thereby exert a pressure on them to conform to what might be viewed as socially acceptable viewpoints – at least within that specific cohort or group - and thereby not speak of their divergent views or experiences (Kreuger & Casey, 2015). Similarly local cultural and political considerations can limit the range of views expressed. Students might be keen to represent the university, group or cohort in a generally positive light. Here the role of the facilitator is essential in not allowing individuals to dominate the group and ensuring that everyone has a chance to contribute and also ensuring that the discussion is not allowed to be taken too far from the original topic and research aim.

There were also significant practical difficulties in the provision of the focus groups that might similarly be viewed as limitations of their use. Some of the potential issues include: planning how participants were sampled and recruited – which resulted in quite small sized groups on a number of occasions; the provision of, and access to, an appropriate venue; how the data might be recorded and potential IT mishaps; ice breaking and getting participants to focus and interact for example.

Within this sample the participants were of different ages and social backgrounds although they were all students at the same university, which may be viewed as a limitation of the research. Similarly there was a relative lack of male representation, with only two male student nurses represented in the sample. Both of the male students were in their first year and attended two different focus groups, therefore there was no male voice in either second or third year focus group or the subsequent individual interviews. However as nursing in the UK remains an overwhelmingly predominantly female profession it is therefore legitimate and appropriate that such a gender mix was present in the sample. Each of the students had had a variety of different experiences prior to commencing the course - including diverse 'caring experiences' and inevitably had had different opportunities and experiences since their commencement on the course.

As I have previously discussed, the interaction of the group members is such an important aspect of the data generated from a focus group. This again indicates the essential contribution of the facilitator. However relying on this interaction could be perceived as a weakness as the quality of the interaction thereby takes on inordinate significance and will become problematic should the group interact in only a very limited way.

The apparent priority of interaction has also led to claims that focus groups can create a difficulty in accessing detailed *individual* narratives (Brown, 2015); this consideration further legitimised the subsequent use of one-to-one interviews. However interviews themselves, no matter how formal, still rely upon interaction and collaboration and are therefore virtually impossible to free from factors that could be construed as contamination due to interviewer influence, inaccuracy of understanding or incompleteness of transcription. This again indicated the importance of reflexivity on my part in recognising the need for mutual trust and respect and exploration of the relationship between myself and the participants. How that relationship might affect what was said, how it was said, what the participant was attempting to convey and equally importantly what I was attempting to ask and perhaps, unconsciously, expected or even hoped to hear (Streubert Speziale & Rinaldi Carpenter, 2011).

Other potential concerns are that research questions are not the same as interview questions. Focussed and concrete questions need to be prepared to generate appropriate data from an interview, even though they will be based on the research questions that might be more general and abstract. As previously described the interview questions in my research where dictated by the themes discerned from rigorous analysis of the related focus groups and were often directly

seeking further comment and opinion on quotations derived from a thematic analysis of that data. I was therefore confident that the quotations and supporting prompts guiding the interview would pass scrutiny. Braun and Clarke (2013 p.85) suggest several questions to ensure the logic and legitimacy of such interview prompts. These include: what is the interviewer trying to discover with this particular question and will it generate this information? Does the question help answer the research question? Are there assumptions embedded in the question? Is the question likely to be meaningful to the interviewee? As my questions were a planned component of multi-method approach and were generated by the robust thematic analysis of focus group data; I was confident that the questions fulfilled such criteria.

Thematic analysis as utilised in the research has been criticised for several reasons. For example, it has been argued that such a thematic analysis might not preserve the fundamental interaction of the focus group (Silverman, 2016); as the focus is on themes or patterns across the dataset and therefore following the iterative and progressive nature of analysis the interactive component is lost and is not retained as a key aspect of each individual theme. Similarly this approach tends not to provide a sense of the continuity or contradictions that might occur within individual narratives or accounts and therefore individual participants 'voices' can be lost (Braun & Clarke, 2013). Braun and Clark (2013 p.335) further claim that thematic analysis presently has limited specific 'analytic etiquette', by this they mean that it is not an approach that is necessarily claimed, defined or 'owned' by a specific group of academics which, they assert, can lead to a variety of differing approaches between researchers even though they may claim to be utilising the same approach.

4.17 Conclusion

This chapter has reviewed the methods utilised to support the study. The chapter initially explored the underpinning epistemology with the theoretical considerations and decisions justified and explained. The rationale behind choice of research design is described and defended and the relative merits of focus group and interview approaches are critically reviewed. The choice of sampling strategies are defended and the practical solutions to data production and transcription are critically explored. The chosen method of analysis that supports the underpinning methodology is critically reviewed, explained and justified.

The chapter includes a discussion of the ethical issues in the specific research context - with discussion of the potential influence of power relationships inherent in this particular research.

The potential limitations within the research process are also discussed and defended where appropriate.

Chapter 5: A Narrative Presentation of the Data

5.1 Introduction

The research presented in this thesis maintains a specific and consistent ontological and epistemological position and due to this underpinning philosophical standpoint it was clear to me that one of the essential components of the final thesis needed to be a presentation of the richness of data in a format that best highlights the students' perceptions of their experiences and their shift in identity. My perspective dismisses any claim that the researcher stands in a neutral, objective position merely attempting to present and/or analyse 'what was said'. The participants are giving 'narrative form' to their experience and the complexity of their reality – and capturing these narratives indicates how they as individuals experience certain events and confer their subjective meaning onto these experiences. Narrative in research may be a term that subsumes a group of different approaches, however all approaches rely on the written or spoken words of individuals. Therefore, the purpose of this chapter is to present and explore the richness of the data as narratives, in order to properly represent and do justice to the perceptions, experiences and realism of meanings, as well as recognising and valuing the time and commitment of the participants. This approach helps address the research aims as it promotes capture of the perceptions and subjective experience of the students in their participation in the various communities of practice; whilst gaining greater insight into their shifting identities and understandings of what it means to be a nurse.

The analytic narrative illustrates the key stories from the data, moving beyond mere description to make an argument in relation to the research question (Braun & Clarke, 2006). The identification of concepts in the raw data as codes and the linking of codes as categories and identifying patterns from those categories are a means of "thematising meanings". The themes represent a level of meaning discovered within the data that capture something of key importance in relation to the research question.

Throughout the iterative process of thematic discovery and identification the underpinning foundation of Lave and Wenger's (1991) concepts of communities of practice and legitimate peripheral participation informed the data analysis process. The data from the focus groups and interviews confirmed that the student nurses were engaged in - or attempting to be engaged in - a process of collective learning with others who theoretically at least shared a concern or passion for the thing that they did - i.e. being a nurse. The shared competencies indicative of a community of practice and that might therefore help define and distinguish the uniqueness of

nurses and nursing practices were discussed, dissected and accepted *and* challenged throughout the data. The experience of the students within the communities of practice, and their interactions with their mentors and other established clinical colleagues as they endeavoured to learn how to be better student nurses and ultimately better registered nurses, was a recurring thread that supported my analysis of how the students defined and re-defined their nursing identity

In this chapter the first year narratives are presented in greater detail than in the subsequent two years. This is because the experiences, perceptions and meanings include a degree of commonality across the three years and are therefore explored in greater detail when they are first identified and interpreted in the narratives of the first year participants.

The chapter is presented with exploration of the data from the focus groups and interviews initially offered discretely year by year with the analysis of the themes then being the means of bringing the whole of the narratives together in context in their representation of the meanings that underpin the participants shifting identities.

The narratives also include some analysis and interpretation, as this was a means of providing them with a greater sense and clarity whilst also ensuring enhanced intelligibility to the reader. The narratives also include some headings and subheadings – this again is intended to offer greater lucidity to the reader rather than implying that the headings and sub-headings are representation of themes or further sub-themes – although they undoubtedly correspond on occasions with the codes and categories that were revealed by the iterative immersion in the data.

5.2 Confirmation of the main themes

As described in the previous chapter a systematic process of thematic analysis generated the identification of a number of themes that captured the most significant patterns in the data relevant to answering my research question. Determination of the importance and relevance of the themes was not simply related to the frequency of occurrence, but rather the priority of the themes following from a selective analysis of the data that told a particular detailed story. The isolated themes are independent, distinct and clearly defined but also fit together to form a clear focus and purpose towards the overall analysis and addressing of my research question (Braun & Clarke, 2013). The fact that the themes fit together in such a way is again indicative of how Lave and Wenger's (1991) work provided a structure and theoretical perspective to the iterative process of data analysis.

The main themes are

1) Becoming a nurse
2) Engagement with 'old timers'
3) The University – Practice Dissonance

In this chapter, therefore, I will provide a broad narrative which seeks to understand the complexity of the subjective experience of student nurses' participation in the various aspects of their practice across a BSc adult nursing programme; to explore their shifting identities and gain insight into their understanding of what it means to be a nurse.

5.3 Background

I propose that discussion of the current health care context; generated in some ways by apparent 'failures in care' highlighted by documents such as The Francis Report (Francis, 2013) has challenged nurses, and others, to fundamentally explore what it means to be a nurse. Moreover professional, political and media discussions have frequently implied a particular, fundamental flaw or insufficiency in the education, training, values, insight or identity of the current nursing students. This suggests that to avoid further examples of such 'failures to care' nursing needs, in some way, to ensure that the future nursing workforce embody a set of values that represent an essential and consistent view of what nursing is and what it means to be a nurse. For some members of the nursing profession, for example, these values and behaviours are often currently articulated by the so called 6Cs of nursing – care, compassion, competence, communication, courage and commitment that are the bedrock of the vision and strategy for nursing, midwifery and care staff 'Compassion in Practice' (Department of Health, 2012).

Adult nursing students at Universities in the United Kingdom undertake a course which is divided into 50% theoretical study and 50% practical clinical experience. The theoretical component includes lectures and seminars - some with students from other fields of nursing - and time spent in smaller groups and the clinical skills laboratory exclusively with adult field students. Within the university where the research took place, a student's practical clinical experience includes working within a specified local NHS Trust on a variety of placements. Adult nursing is focused on the care of people from the age of 18 years and above and can offer students experience of caring for people who need immediate help and support in hospitals or community settings or assisting people to recover and manage more long-term conditions. Promoting good health and assisting people to care for themselves or members of their family or community is also a key focus that student nurses gain insight into throughout their three-year course.

The first year students participating in the research have additional support whilst on their clinical experiences by a system of allocating associate lecturing staff to first year placement areas. First year students are visited by these members of staff whilst within their placement areas to help ensure progression and the delivery of an appropriate and supportive learning environment; and to encourage the provision of appropriate learning opportunities to enable the achievement of set learning outcomes.

5.3.1 Academic staff in practice

The university where the research took place, emphasise that many of the academic staff are not only registered nurse teachers but often still work within the clinical setting when not teaching. This is believed to help maintain clinical competence and thereby make staff better placed to support students on their learning journey. The issue of clinical competence and subsequent alleged credibility has been the source of much debate for many years within nurse education (Leonard, McCutcheon & Rogers, 2016; Price, Hastie, Duffy, Ness & Jacqueline, 2011; Ousey & Gallagher, 2010). This debate has included concern of the lack of precision, clarity and consistent use of the terms credibility and competence themselves. Interestingly during the focus groups and interviews several students highlighted the fact that some university staff still worked in the clinical setting and appeared to value it, not least as a potential defence against any accusation from mentors and other clinical staff that the university did not really recognise or understand the current health care context.

> Yr1 FG2 *'right everything they told you at uni forget it, ... this is what really happens'*

The students believed that academics continuing to work in clinical practice in some way contributed to a greater understanding of their own student experience; and also further legitimised learning in university as of equal relevance to their progression as the learning that occurred in practice.

> Int2 *'You are told at uni that them on placement know best and the mentors are there to teach you and this and that and a lot of our lecturers are still working people...'*

However as Ousey and Gallagher (2010) have argued the great, and increasing, diversity of nursing roles make it impossible for educators to maintain expertise and therefore offer credibility in all of those roles and aspects of nursing practice. Leonard, McCutcheon and Rogers (2016) also argue that being 'in touch' through clinical practice risks limiting education to simply replication of what is known and reducing the facilitation and development of new knowledge to challenge, transform and extend practice.

5.3.2 Practice Education Facilitators

A further role designed as a supportive link between the university and clinical placements is also offered to all nursing students by Practice Education Facilitators (PEF), whose responsibility is to provide additional support and advice to mentors and students within clinical areas and proactively promote a quality learning environment, improve communication and enhance the pre-registration students' experience. Within the research, several students discussed their experience with their PEF, questioning the *objectivity* of the role; should students feel the need to question the support they were receiving from their mentors or have concerns about practice standards generally. In previous chapters I have discussed the value of Lave and Wenger's work on communities of practice (Lave & Wenger, 1991) and the insights thus afforded when exploring and understanding the subjective experience of student nurses, their learning and their shifting identities. As Wenger highlights, identity is produced as a lived experience of participation in specific communities and the learning required and derived is through participation that is structured to allow access to practice for others, in this case nursing students, who are, at least initially, non-members of these communities of practice (Wenger, 1998).

The PEFs, along with mentors and others, have a significant role in facilitating the participation of student nurses and therefore are instrumental in the on-going reconstruction of their identity as they progress and move into what is inevitably, at least initially, unfamiliar territory. As Wenger (1998, p.167) explains participation is a very complex notion and can include a range of differing forms including full participation or an 'insider' or full non-participation or 'outsider'. Wenger further articulates the notions of *peripherality* and *marginality* that I found of particular value when analysing the data within the study.

5.3.3 Peripherality

Lave and Wenger's approach to knowing and learning and the theoretical framework of communities of practice was again insightful in conceptualising the data during the analysis. Whilst some degree of non-participation is inevitable for student nurses, the source or rationale behind such non-participation may be different and also crucial to the learning and identity formation of the student. Wenger claims that *peripherality* which entails non-participation *might* still be positive, and indeed, necessary to enable less than full, yet enabling participation. The principle of supernumerary status of nursing students in practice may be viewed as a type of legitimate peripherality for example. As I have discussed in a review of the relevant literature, the value of supernumerary status for student nurses as a framework for learning,

progression, development and achievement of competence is at least controversial with some members of the nursing profession (Allan et al., 2011). Moreover the reality of supernumerary status in the experience of many student nurses is also disputed:

> *Yr2 FG3* '*On the placements we were just basically used as a healthcare assistant for free - you could go through the whole course like that*'

> *Yr1 FG1* '*You do get used as a HCA, you just do*'

Peripherality may also be influenced by the specialties that the adult nurses gain experience of during their progression as a student. These specialities, at this university, may include high dependency; intensive care; cardiothoracic and cardiology nursing; emergency nursing; care of the elderly; renal nursing; theatre nursing; community nursing and many more. Student nurses' transition through their training can be viewed as a journey, and indeed according to Wenger (Wenger, 2010) all learning can be viewed as such a journey with the forming of identities coming to reflect the landscape of that journey.

5.3.4 Participants

The participants, as student nurses on a BSc adult nursing course were all ostensibly engaged in a process of collective learning in a shared domain of interest – two of the elements that help constitute a community of practice. They came from different backgrounds with many differing demographic profiles. Their ages ranged from 18 to 45; with a range of cultural backgrounds and previous healthcare experience. Some students had no previous clinical experience whereas others had more than three or four years experience as a healthcare assistant or in other support roles. There were only two male participants in the year one focus groups and all other focus group and interview participants were exclusively female.

According to Braun and Clarke (2013) there is rarely a clean separation between data collection and analysis within qualitative research, and immediately following the first focus group and each subsequent focus group I was immersing myself in the data. This involved repeated listening, transcription and subsequently reading and frequent re-reading of the material. All students who were prepared to contribute further via individual interviews had offered their contact details as part of the original consent process. Following initial analysis of the data, therefore, I then undertook three individual interviews from each year to further explore, confirm and gain greater depth of insight and understanding of the data. All but one of the participants in the interviews had contributed to the original focus groups. One participant contacted me via messaging on the Shifting Identities of Student Nurses Facebook page and

expressed her interest and desire to contribute despite her inability to attend the original focus groups.

5.4 Rationale for exploration of the students' narratives

As identity in practice is a way of *being* in the world and arises from participation in communities - being a practitioner with a shared repertoire of resources and experiences - it is therefore constantly re-negotiated and on-going rather than an already existent trait of personality (Wenger, 1998). Exploration and analysis of the shifting identities and changing views and stories of student nurses would therefore offer insight into how they live and work every day; what they perceive or say about themselves; what others think or say about them, as their identity is negotiated and defined in their lived experience of participation in their specific communities. It is these narratives, relationships, roles and positions discovered in their participation in practice; along with their continually changing realisation of their effects on this community and those within it, that produces their identity and which is highlighted and explored in my research. A meaningful pattern was determined from the data related to the differing attitude, insight, appreciation, and role of the students within the various communities of practice as they made their transition through years one, two and three. Whilst some significant change, development and differing perception is evident, analysis of the data also indicates that in many ways a consistent experience also exists and common concerns persist for all students in each of, and throughout the three years of the BSc.

Prior to further, more specific and detailed analysis of the main emergent themes from the data I will initially offer an overview of the students' narratives and experiences from each of years one, two and three.

5.5 First Year Narratives

> *Yr1 Int2* *'You are told at uni that them on placement know best, listen and they will teach you ...but then you go out in the field they say 'ignore uni do it this way' - but uni has told you to do it another way - and then you're in that sort of 'well hang on a minute - you're telling me that these people are the right people to teach me but they are now telling me to ignore what you said! - what do you do?'*

The complexity and potential uncertainty confronting first year students is highlighted by this wonderful quotation - almost a riddle - from a student nurse interview as she wrestled with the unpredictable and apparently contradictory advice from university staff and mentors.

I undertook four focus groups with first year students, which included 15 students - 13 female - from a variety of ages and included several students with no previous clinical experience and

others who had spent several years in a variety of support worker roles. By the time of the focus groups all of the students had experienced both academic time in the university and also at least one clinical placement in a variety of settings such as acute hospitals, community placements, outpatients, general practice surgeries and district nursing.

5.5.1 The initial 'intensity' of the first year

The first year students, almost universally, spoke of their surprise at the challenge, difficulty and hard work that the first year had brought so far. They used words such as 'hectic', 'daunting', 'intensity' consistently throughout their narratives. Recurring phrases also included 'thrown in at the deep end' and 'a lamb to the slaughter'. Anthony and Yastik (2011) in their small focus group study with twenty-one nursing students in the USA found that the students felt that it was essential that they were given a 'heads up about what they were about to face' so they would be better able to cope and also be able to avoid taking personally the negative comments and experiences that they appeared to feel were inevitable:

> FG1 *'fastest 12 months of my life'*

> FG2 *'the first month was pretty horrendous'*

All students seemed to recognise and accept this intensity and commitment, and did not believe or expect that this would change over the next two years:

> FG3 *'you just sign your life over for the next three years'*

> FG3 *'to get through the next three years you've got to accept that you have to erm, yeah, curb time with some people and they may not see you for a while, though that's just how it is. You do literally just sign your life away'*

Some students felt that such a challenging introduction, although stressful, was valuable, or even essential, to ensure they were prepared and ready for their future nursing career:

> FG3 *'I'm really enjoying it but it's intense, a good intensity.... It would give you false hope wouldn't it?... Yes all very soft - and I kind of think we wouldn't be prepared for placements as much as we were.... I think that intensity is probably a good thing because when we qualify it is going to be tenfold more intense and we're going to have to be ready for that'*

5.5.2 Surprise at academic level

The majority of students, including those with previous higher education experience, also expressed surprise at the academic level expected. Several of the groups questioned the legitimacy and consistency of the marking which they believed to be '*very harsh*'. They expressed surprise at the priorities, rules and regulations of their new environment and

struggled particularly to understand what they perceived as the disproportionate amount of marks assigned to considerations such as appropriate and consistent referencing for example:

> *FG4* *'I actually had a moment after the last essay that we did that made me think - you know... - it's not about getting 80 or 90% in the written pieces as long as I understand when I internalise it, what it is, what it means. The fact that I haven't referenced properly... that for me, on the academic side takes away from the learning..'*

Several describe themselves as being '*overwhelmed*' by the expectations of the academic component of the course and being disappointed with their results so far:

> *FG1* *'it's been a bit of a blow to be honest. I did the access course before and I was getting distinctions and doing really well and I've come here and just scraping to pass'*

However, some students again believed this was probably both temporary and also a level of intensity and commitment that was necessary:

> *FG4* *'at first I thought if this is what it is like permanently then I'm not going to be able to complete it'*

> *FG1* *'three heavy months, three really heavy months. Now like you say we have been ...erm...we know we want to do it. It is just like, you knew that impetus was right and you then think 'I know what I need to do to get those grades now'*

5.5.3 Clinical Placements shock and surprise?

Their experience on clinical placements had caused similar shock and surprise:

> *FG1* *'I think when you do go onto placement you do get thrown into the deep end'*

> *FG3* *'you don't know what you are doing and it's being thrown into the deep end'*

> *FG1* *'you are going in blind aren't you?'*

Some students relished this and found that the experience of being 'the new kid on the block' was relatively stress and trouble-free; however the majority felt this a particularly traumatic period:

> *FG1* *A* *'I love it, you get in there and be friendly and show you are willing to work adequately, to learn and take on board what people around you are saying and you find that you quickly kind of come part of the team'*

> *B* *'I hate it''*

> *C* *'Sometimes you are not gonna, no matter how hard you try they won't accept you'*

> *FG1* *'I find it stressful going to placement and I'm quite a confident person'*

> *FG1* *'So I always stress at the beginning of a placement and think, oh well I hope I get on ok here because as you've said if you get on with them you feel like you can ask to go on more spokes....If you don't ...you won't ask'*

'Spokes' are other clinical environments offering learning opportunities in areas linked to their main, placement area or 'hub' - spokes are accessed via arrangements and negotiation with their mentors and others.

> FG1 *'yeah yeah and even when they look at you and you think - 'oooh shouldn't have said that ... But as a student it is your place to ask questions...'*

This confirms the legitimacy of viewing the students experience as a form of journey, with identity therefore seen as a *trajectory*. Understanding something new is not an independent, unique act of learning but an event on a trajectory, something which gives further meaning to practice. The developing identity and participation, within and across communities of practice, means that individual identities form such trajectories (Wenger, 1998). The concept of trajectory highlights that identity is complex and essentially temporal, ongoing and shifting as the student progresses through the course. Wenger (1998) theorises that in the context of communities of practice there can be a number of different types of trajectories, several of which help inform understanding of the student nurses' experience of shifting identity. This will be further discussed subsequently.

5.5.4 The role of a student - roles, responsibilities and relationships

Whether on a *peripheral* trajectory or *inbound* trajectory (Wenger, 1998) - their experiences had either confirmed an uncertainty, or resulted in a struggle to understand what their exact role as a student was:

> FG2 *'...that is one thing that I found really hard (yeah - general agreement) knowing my role as a student nurse'*
>
> FG1 *'I feel like some, like, even some HCAs have got... who have been working at the job for like 10 to 15 years but never went for the nursing... they then just... tut - 'look at her... student nurse trying to tell me what to do' and stuff like that. That really worries me because obviously as you get in the second and third year you take on more responsibilities don't ya and telling the older HCAs what to do; I think I'm going to have a problem with it. Especially as I've said before the ones that are like 'I've been doing this job for 15 years who are you to tell me what to do' and who am I really?'*
>
> FG3 *'I was more bothered about getting on with the HCAs than the qualified nurses and when I got there I thought 'they are running this show'*

This feeling of surprise and uncertainty was compounded by the expectations of clinical colleagues:

> FG1 '*and some of them expect too much of a first year student'*

FG1 'they took me into an intermediate meeting and said 'you are hesitant to do stuff'. I'm like 'what d'ya mean? I'm new to this, I'm nervous and I'm not hesitant to do anything whatsoever'. That broke my heart'

FG4 'I feel less confident than before (laughs)...erm with the practical side of it I didn't feel confident anyway and when we've talked about flourishing I wouldn't say I have flourished on placement at all'

FG3 'I didn't have a clue what she was on about and she was like - 'have you not watched Holby City?' - She was like - 'what are your credentials? How did you get here?''

As I have previously discussed, legitimate peripheral participation characterises the process by which newcomers become included in a community of practice, whereby participation describes their engagement and resultant learning in practice (Lave & Wenger, 1991). Some trajectories may remain peripheral and never lead to full participation, however *peripheral trajectories* which, although they may never lead to full participation, could still be very significant to an individual's identity by facilitating access to practice of a specific community. By the very nature of student nurses' relatively transitory clinical placements, a peripheral trajectory may often best capture their experience. Perhaps not surprisingly, in a qualitative study with fifty second year students in London, UK it was highlighted that a culture of kindness and respect for patients, staff and students generated a greater desire in students to return to certain, specific placement areas rather than them having a particularly close involvement in the delivery of care or the particular area's clinical speciality for example (Crombie et al., 2013).

5.5.5 The perceived inconsistency of experiences - marginality, non-participation and trajectories

The inconsistency in the experiences of the students is influenced by a number of factors. These include: whether the student has previous caring experience; the attitude of their mentor; or the acuity and busyness, or *type* of clinical placement. They feared, however, that the impact of this inconsistency on their experience, and consequent learning, was not recognised by their mentors, other clinical colleagues or, subsequently by staff at the university. They believed that their ability to contribute to clinical work, progression towards achievement of clinical competence and also future academic assessments particularly Objective Structured Clinical Examinations (OSCE) was compromised by this inconsistency and the apparently arbitrary allocation of placements. For example, an initial placement on an outpatient area, as opposed to an acute ward placement in a hospital, left some feeling unfairly treated and even more vulnerable, stressed and concerned about their progress and ability to be fairly assessed.

FG2 'I know people who have been on community and have never done an early warning score you know considering that is what our OSCE is based on you would think you would give them a placement at least where that is something they would be doing'

FG1 'It has all been new to me, whereas everyone else has been like 'right you have got to be with the nurse' 'you have got to be with a nurse' I have been like an HCA a lot coz I didn't have a clue'

This highlights that, at least in the student's perception, this experience is a different form of non-participation, articulated by Wenger (1998 p.165) as *marginality*. Marginality again prevents full participation for individuals within the community, however it is the *non-participation* aspect that is important rather than the negotiated participation as articulated in peripherality. In marginality participation is still restricted but without any negotiation or assessment of the best interests of the learning of the student nurse:

Yr1 Int3 'I didn't want to be known as... the student that squealed - you know what I mean I know it sounds pathetic - and I shouldn't have been treated like that - I know I shouldn't as a grown woman - I know I should have had a lot of apologies I know I won't get them but unfortunately that is just the way it is'

This student also spoke of how she had returned to an even more vulnerable, almost 'childlike' state on leaving the particular placement where she had felt unsupported and intimidated and then seeing her mentor subsequently in the hospital corridor and felt that she had to be secreted into the toilet by her friends to avoid the trauma of meeting the mentor again.

5.5.6 Challenging poor practice

Such feelings of intimidation and lack of support can compromise the students' willingness to challenge poor practice. Whilst recognising their role in advocating for patients, promoting quality care and highlighting examples of poor care, first-year students recognise a set of circumstances that both increase their vulnerability and also reduce the likelihood of them, or others, whistleblowing or challenging less than optimum practice:

FG4 'it is not always easy going to your mentor on your ward if you have got an issue because what you are going to say on week 3 can effect what is written in week 9 in your PAD document'

FG2 'it does make you very apprehensive to stand up and also question other staff nurses as well - as you think if you say something you are going to rock the boat and that is not what you want to do'

Int1 'you think – why are you the only one who is bothered about these people getting good care....thinking God what if I end up going to a ward that is really bad and you think 'would I speak up?''

> *FG3* *'yeah but it also makes you scared to stand up and if you have done something wrong you are scared of the repercussions..... You have not actually caused harm there but you would not want to admit it in case you got a telling off'*

The students experience echoes the concerns articulated by Berwick (2013) as he highlights that if individuals and groups lack the capacity or capability to actually make a system better or improve a situation then it can become that the major overriding aim is merely to *look* good.

However reassuringly one of the students who had expressed initial concern that they might not feel able to speak up did also say:

> *Int1* *'it's like this thing about picking your battles sometimes you do need to do that...I think if there was anything I was really unhappy with and I didn't feel I was being supported then I would say something – only because I've learned that the worst thing you can do is not ask for help...it just makes things worse'*

As I have noted the Practice Education Facilitators (PEF) role is to help create a safe and productive learning environment by supporting students and registered staff and mentors in the provision of quality practice. However, the role and impartiality of the PEFs is also questioned as students feel that their priority in any highlighted circumstance of poor practice or instance of student concern would inevitably be with those who they ultimately saw as their colleagues and employers - the staff employed by the Trust. The peripherality of the student is confirmed by such narratives and is indicative of the different communities encountered by the students and the fluidity of membership of those communities:

> *FG4* *'they didn't want to hear the criticism as it was their Trust almost and people that they knew and worked with - and that's why I contacted someone from the university and not from the Trust even though they are supposed to be impartial'*

> *Int3* *'I went to uni and told them...and K (mentor) panicked and rang the PEFs and so then when I came to work they were all waiting for me in the office and I was like 'Oh hello!' and they were like 'How are you getting on S? – well can I just say you couldn't ask for a better mentor – she wants you to do so well'... and you think well you've already stuck up for her - so what am I just going to sit here?..'*

Students fear that should they raise any controversial issue or indicate that their support in the learning environment is insufficient, then this will result in a reputation that would be difficult to shed:

> *FG3* *'there is that fear, like, is this going to follow me around? The fact that I have changed my placement - who does she (mentor) know? When I get my next placement is she best mates with her? I know that sounds proper paranoid, but everybody knows somebody'*

> *FG3* *'it's true though ....and that's how it becomes and you think well there is no point saying anything .... and if I move what's to say that I'm not going to get on a placement that her*

cousin or.. do you know what I mean? So I thought I might as well stay there - put up and shut up'

5.5.7 The clinical context that can lead to non-participation

It could be argued that, the context that might generate non-participation *can* be an opportunity for learning and appropriate for students who may be on an *inbound trajectory* (Wenger 1998). With *inbound trajectories* newcomers are joining the community with the prospect of becoming full participants in its practice. The relationships, roles and responsibilities within the well-established clinical teams and communities often generated support:

> FG4 *'I felt like I worked there when I left'*
>
> FG3 *'you do most of your learning in placement... On placement in nine weeks - I think I learned more in that nine weeks than I did before Christmas which was sixteen weeks wasn't it?'*
>
> FG4 *'..before I started placement I had a bit of a wobble thinking I wasn't cut out for this...but being on placement secured the idea that I did want to be a student nurse'*
>
> Int1 *'On my first placement I had a really good mentor and I got on really well with the ward manager – and she was a Band 7 so she was like the Ward Sister - ward manager really - really, really fantastic'*

In such situations identities are invested in future participation, even though the present participation is peripheral. There is an understanding by all concerned that presumes, if not *full* participation, then at least an appreciation of the *potential* for full participation in the future. Full participation is not a present goal and therefore clearly articulated and negotiated *non-participation* is both an enabling and positive approach even though the student nurses trajectory may remain essentially peripheral.

> Int2 *'I've been to lots of different places - done loads of spokes and seen nurses doing things that I didn't even know was a nurses job.... I think people who I spent time with at uni, their instinct is - a nurse is on the ward, talk to the patients, look after the patients in acute care - but it's not! Like I've been to the dialysis place it's **all** nurses not health care assistants so **everything** is a nurses job.... and it was amazing'*

However others were caused both anxiety and confusion, as they attempted to participate and thereby further understand their nursing identity and what it meant to be a nurse:

> FG1 *'it was like 'Tut - she's asking again what we want her to do' - you know what I mean and I even said 'do you want me to do the cleaning?' They were like 'No! - Because we've got a cleaner and HCAs and if the student nurses clean it looks bad on us''*

Peripherality or marginality therefore renders non-participation either enabling or problematic. It has been argued that generally participation is presented as somewhat unproblematic in Lave and Wenger's work (1991;1998) with the mere presence in a community establishing

legitimacy. This presumes that the learning inherent in practice and how that constitutes identity, happens in a fundamentally benign way and indicates a limited recognition of the potential for those practices to restrict and compromise, rather than enable, new and existing members (Tobbell, 2003).

> *Int3* *'…. (staff) could be a lot more supportive – instead of just saying 'Use your common sense get on with it'. Well what is your common sense?'*

> *Int1* *'erm.. it is a bit difficult – you don't want to upset the person you are working with – there is no need to be rude about it – but at the same time it makes me really worry and really anxious when – hang on a minute - am I doing something that I shouldn't be doing – something that might put me at risk of being struck off?'*

5.5.8 The Registered Nurse and the HCA

Irrespective of their experience - positive or less so - students still had difficulty in clearly differentiating the work of the registered nurse and the HCA. The students recognised a distinct difference between the two roles and their responsibilities; yet the lack of clarity of their role and the blurring of clinical responsibilities caused anxiety and stress. This contributed to their peripherality as they felt their progression and clinical competence was compromised and learning opportunities missed. Those with limited or no previous healthcare experience particularly recognised the legitimacy and appropriateness of their qualified clinical colleagues placing them to work with the HCAs as a means of developing essential, fundamental skills. This could be legitimately viewed as a necessary initial *peripherality* that assists in greater, future enabling participation.

However, the long term benefit of this was questioned as to how far this strategy could positively support their ongoing development as they struggled to distinguish the uniqueness of nursing identity:

> *FG1* *'you expect to have to do some of it but when you are doing it every day and **not getting the clinical experience of being a nurse** it's a bit too much I think'*

> *FG1* *'I don't want to come across as too posh to wash because I'm not, and I do do it, but when you are not learning anything else…'*

> *FG1* *'I was treated as an HCA but at the same time I got the chance to do a lot of clinical related **stuff outside of HCA duties**'*

> *Int1* *'Yeah you don't underestimate the value of an HCA – but there are those HCAs who are on a power trip and that really do feel – 'well what you are doing – how is that any different to what I do?''*

Students were often surprised how responsibility for work was often differentiated and delegated to the HCAs. Whilst recognising the essential role performed by HCAs this challenged their view of what it was to be a nurse:

> *FG1* *'they were able to tell me lots of things that have happened case wise, patient wise. And the detail that they observed is far more than you realise. I learnt a lot from the HCAs on my ward'*
>
> *FG1* *A 'They spend a lot of time with the patients don't they the HCAs'*
>
> *B 'Nurses don't have time do they? All the paperwork and everything don't they'*
>
> *Int3* *'they wouldn't be able to do anything if it wasn't for the HCAs'*
>
> *Int2* *'yeah HCA army we call them' (laughs)*

Therefore even though the students were at a very early, novice stage in their professional development they were already looking forward and becoming anxious and concerned that their experience was not preparing them for when they were qualified and what they would be expected to do as registered nurses. When asked to explain what they believed the difference was between a healthcare assistant and a registered nurse they did not find this easy and their articulation of the registered nurses role tended to relate to certain specific *skills* and *techniques* rather than more general areas such as quality of care and governance, promotion of evidence-based practice, accountability or leadership, for example:

> *FG1* *'we need to do med rounds and all that stuff'*
>
> *FG1* *'I did get to put an N/G tube in but it's only because I asked'*
>
> *FG4* *'Yeah and wiping their bums when they need it'*

This confirms the work of Gidman, McIntosh, Melling, and Smith (2011) who found that students adopted a narrow clinical skills perspective in relation to their view of nursing practice and competence, particularly novice students or 'starters'. The study surveyed 174 student nurses from one university in the UK, within the first six months of commencement and also following their first practice experience. They also subsequently undertook two focus groups with 15 students recruited from the questionnaire responders.

One student in my research did further explore their perception of the role however:

> *FG 4* *'Decision making as well. There's a lot of decision making on care plans and obviously it has to be documented and that decision has to be made and it's not always for a doctor to make a decision - medication and treatment it is - but from a holistic care point of view the decision sits with the staff'*

Similarly one student in an interview offered a perception of nursing in a significantly more well-rounded way:

> *Int1* '*you are there to protect your patient is the big thing for me...... it is like collaboration really but essentially as a student nurse I am there to make sure that that person's needs are met - all of their needs not just that they have got an injury and its cleaned. It's everything I suppose – it's all about their, you know, person centred care and holistic care*'

5.5.9 The assessment of essential skills - 'the student card'

The articulation of what nursing is, by the vast majority of first year students - as being essentially a series of skills or competencies - was compounded by further concerns about the assessment and documentation process of these skills which they felt to be unwieldy and not fit for purpose and yet another potential area for anxiety and criticism:

> *FG1* '*I went on lots of spokes and never took it* (*documentation*) *with me or got it signed or anything. And your mentor is like 'well you should have done' and it's like well yeah I.... Well I haven't got it. And literally when you're saying to me 'look this patient is going down to blah de blah will you just go with them'... you can't ....when the porter is there already you can't say 'Oh well hang on a minute let me just go get my documents''*

However, students quickly recognised a dynamic of team-working and influence within the community that they were placed. There was recognition of the influence of mentors, yet students also identified the learning opportunities offered by many other colleagues:

> *FG2* '*the biggest surprise for me has been where my 'I'm a student card' gets me (oh it gets you everywhere) the minute I mention I am a student it's 'come on then''*

> *Int3* '*as soon as you say 'oh I'm a student' aww honestly their eyes light up and it's like 'come on' - all my mentors have said - do it because as soon as you are qualified that card doesn't work so use it while you can*'

Others had a less positive experience. They felt that they had to push for every opportunity to undertake any of the clinical skills which they viewed as so valuable and essential to their learning, development, assessment of competence and progression to becoming 'a nurse'.

> *FG1* '*she really didn't know what she was doing with me. So I ended up with the HCA doing all the HCA work....... they don't give you opportunities do they? You do have to push for them but it was like 'I'll do the meds round with you later on' and later on never came*'

> *FG3* '*my mentor told me numerous times 'I'm nobody's friend and I don't get paid for this.....' she said 'it's just put on us you know I'm the only full-time member of staff down here and therefore I've been given this job. I'm getting punished so (whispers) you will be getting punished''*

> *FG1* '*I don't know if it's down to the fact that they were doing the mentorship qualifications at the time, I was their first, their guinea pig student*'

5.5.10 The training and expectations of mentors and qualified staff – 'Old timers'?

Being a 'guinea pig student' highlights a further consistent theme from the data, as students were convinced that their experience, progress and learning was influenced, usually negatively, by the length of time their mentor, and other registered staff, had been qualified and the type of training they themselves had undertaken:

> *FG1 'My mentors were both Dip HE qualified and they often said 'we didn't do it that way we had a skills book that we had to tick off in your first year....' ours is very reflective based and because they didn't see me taking notes... and I'm like 'well I'm going home and doing it at night' and they said 'well you are the first student without a book' - it was like a bit of discouragement at that meeting and when I went home I thought - should I really even be here? - Then because it... 'scuse I don't want to swear... it felt really.. I felt really discouraged and upset that day'*

> *Int3 'My first mentor I think qualified in the 60's so she'd never been through university training and you could see...the way she spoke - and you do notice a difference in the younger ones – particularly my last mentor was in her early 20's and just finished a degree a couple of years ago and she could totally relate. She could understand me and was a lot more supportive'*

> *Int2 '..she said 'I know you shouldn't do this' – but on the other hand at least she was aware that she shouldn't be doing it whereas some people are not aware and do it regardless'*

Students therefore felt challenged on the legitimacy and validity of their educational programme. This was at the same time as being expected to have significant skills and knowledge, particularly in relation to the more specific clinical aspects of care. Whilst being confronted by accusations of the inappropriateness and unworthiness of their training they were at the same time expected to have a level of competence, particularly in clinical skills, that they felt was unfair and unreasonable:

> *FG1 'I think as well the way your mentor is trained comes into play. If you have an older nurse and they didn't do any university study or didn't do any theory side they expect you to get straight in there and start doing it'*

> *FG2 'Depending on how long they had been qualified ... was dependent on what they think you should be there to do as well'*

> *Int2 'you get the whole – Oh Yeah uni has told you this but in reality let's be honest we sort of have to do it like this...'*

Gidman et al. (2011) also confirm that support from newly-qualified registered nurses was highly valued by students, both new starters and also students who were about to qualify, as they considered them to be generally more approachable, enthusiastic and motivated, both in their practice and in their attitudes to students. The students felt that those that had been nurses for longer were less likely to provide a positive learning environment for them and they

believed this attitude to students was also reflected in their general conduct and the care they subsequently offered to patients:

> FG4 *'I think maybe they get towards the end of the nursing career and it's not very high on the list of priorities being a mentor'*
>
> FG2 *'Some of them...a lot of them do lose their skills - from my experience anyway and they become quite bitter about it don't they?'*
>
> FG1 *'you lose your passion don't ya?'*
>
> FG1 A *'....they have been in the job that long that they have lost the care...'*
>
> B *'burnt out?'*
>
> A *'Yeah burnt out basically'*

The students already indicate insight into the experiences and behaviours of the registered nurses who they work with and believe they recognise why some of them may appear to have less enthusiasm for their job than others:

> FG2 *'yeah I think you can understand sometimes why some of the NHS staff are a bit beaten down because they are trying to do things right but then the other half of the ward can be not doing things right and it is fighting a losing battle sometimes - shocking it is'*

This also made students worried about their own future:

> FG1 C *'it's really scary to think it could happen to anyone of us (A 'I'm sure it will') cos we have all the passion and yet you never know when it might happen.....'*

Therefore the students' view of what nursing was had already undoubtedly changed to a varying degree. Even students who had previously been healthcare assistants were still surprised by what nurses did, what they didn't do and most particularly by the responsibility of the role:

> FG1 *'My background is a healthcare assistant, going into nursing I think it's not really changed but it just made me realise how much nurses do'*
>
> FG1 *'you know what I found most shocking, the huge responsibility of nurses, massive you know, patient's life and death, everything. Your accountability... then finding out how much you get paid (laughs) - responsibility that's a real eye opener (yeah definitely yeah)'*
>
> FG3 *'the biggest thing for me is I need to start thinking about what I would actually do and why - so I can actually back it up I think that is coming out of that safety net and thinking... It is scary yeah'*

This realisation of the responsibilities of the role had also challenged their previous view of those who chose to take up nursing as a career:

> FG4 *'I don't know what it was like for you but only the girls who didn't do very well at school went to nursing school'*

> _FG1 'A lot of people say only thick people care but that's just not true'_

Several students, on recognising the level of responsibility of a registered nurse, were fearful and reluctant to take on the roles and responsibilities that may now be viewed as an integral part of many registered nurses duties:

> _FG1 E 'you can, like, work your way up to, like, minor surgery'_
>
> _A 'Do they? Jesus whoa I won't be doing that. God!'_
>
> _Int1 'I wouldn't want to be a ward manager – the things they have to balance is just like crazy'_

Although others struggled to understand the reluctance of some nurses to take on greater responsibility, especially as this might lead to improved patient care:

> _FG2 'I can't understand why you would not want to be trained to do something to help the person you are looking after. And they went - 'it's too much responsibility, if they infect it then it's their fault', so it's one less responsibility - and they don't want it... and I'm like 'Really?' And I'm like, 'can I do it as a student trainee? I'll do it''_

5.5.11 "Why do you need a degree?"

Students frequently described how their mentors and clinical colleagues questioned the legitimacy of degree level study to 'be a nurse':

> _FG2 'I've had a nurse actually say to me why do you need a degree? (others yeah yeah) when I trained you didn't need a degree why do you need one now?'_
>
> _Int2 'But yeah I do think your mentor has such a large influence on your (pause) attitude because as much as you need to do this, that and the rest of it - you pick up the attitudes that they have because that's where you're going into – so you think oh well it was acceptable to think like this – it is acceptable to do this type of thing - she's been a nurse for 30 years that's clearly acceptable - but it's not because nursing 30 years ago is not what it is now and I think that that's what a lot of the older lot are like - they are like you can't learn anything at uni an essay isn't going to help you look after somebody - that's all you get all of the time'_

This scepticism is not exclusive to qualified nurses however:

> _Int1 '...I've come across people even now who say 'I don't think we need that' – people on the degree that believe that they don't need the degree.'_

Two students echoed such concerns themselves:

> _FG1 A 'I could go into a district nurse team tomorrow and could learn that job properly but without a degree........ yeah I'm not seeing that university is capable of giving you those skills, I think what you learn is all part of being in a profession, you learn them from your colleagues; you learn how to get on with people; you learn how to get things done; you learn organisation, communication...'_

B 'I agree – almost in full - I learn by doing..... So I get much of it from practice but with the backup of the theory'

However several students recognised the apparent contradictions of many of their qualified clinical colleague's comments:

Int2 'Yeah but then they get annoyed when they question you on placement and they ask you about this report, that report and you say no – they go ffft – and so you think – 'hang on a minute you've just had a go at me for studying it and now you're saying you should know about it! – You can't have it both ways can you? .... so they are saying forget all that but then expect you to know it (laughs)'

Int3 '...obviously we are still in training and they expect ...because you have got all of the theory - and so it's 'Yes you <u>should</u> know how this works and how to do this' – sometimes they do expect a lot and they do question ya ... they will say 'what's this do? Do you know what this is? And it's like Oh God!'

5.5.12 The communities of practice - university and clinical practice dissonance

The experiences confirmed at least two distinct communities of practice – those of *university* and *clinical practice*. When questioned whether they believed that the university and the Trusts were fundamentally advocating the same values and philosophies, few students believe this to be consistently the case. First-year students are often challenged by the conflict between what is taught at university and their experience in clinical practice. This apparent dissonance between the espoused values of the two communities and the reality of the student experience, also highlights their view of themselves as change agents and advocates of good practice:

FG3 '...we have been shown this way – 'well we don't do it like that here' – 'yeah that's why they are teaching us to get rid of that'....yes it is totally different'

FG2 'I think it is the university's job to give us the kind of ideal best way of doing things ideally'

FG3 '..they are teaching us how things should be....but it just doesn't happen as much as you try'

The recognition that the university felt the need to emphasise good, or even ideal, practice has negative connotations however, as the adverse potential ramifications of poor practice are emphasised rather than the positive outcomes of good practice:

FG4 'I think it's just they have to instil this scare tactics in students so again they set the right standards and that these are the expectations.'

FG2 'all we get told is if you do this you will get struck off and if you don't do this this will happen'

FG3 'the university do quite a lot of scaring'

5.5.13 A new breed of nurses – nurses of the future

Despite this fear and the use of 'scare tactics', many first year students retained a view of themselves as significant change agents and regularly used phrases such as 'new nurse', 'new breed' and 'new stuff', for example. They felt a responsibility to change practice in a positive way and felt that this would almost inevitably be against the wishes, ambitions, willingness and interests of some of the nurses who they saw had been in clinical practice for longer periods of time:

> *FG2 'you learn what you don't want to be like when you qualify'*

> *Int2 'they keep saying don't they - at uni - that we are a new breed of nurses and we are because they are training us better and they are giving us the better tools to hit the ground running. We are a new breed of nurses compared to what is there'*

Foley, Myrick and Yonge (2013) highlight that this challenge to the status quo and the questioning nature of the newer students can be part of the generation of negativity towards them by more established staff.

Moreover many students ultimately recount a very positive narrative of their experience throughout the year. They recognise, proudly, their positive effect on the experience of some patients and the support and understanding that patients can offer in their development and increased confidence:

> *FG2 'yeah it was really like - God you do have a big impact on these people, because sometimes you think they don't see you - but they do. They don't really treat you really any different than anybody else so that was really good.'*

> *FG3 'They kind of look at you like you are Bambi don't they? This fragile frail little thing that needs a little bit of nurturing they are so nice to you from the get go'*

> *Int1 'I did have one patient that said you can tell you are a student because you take such good care – because you are so delicate with me'*

> *Int3 'Members of the public and the patients are generally really like – 'how far along the training are you? How are you getting on? Everything alright? Are you enjoying it? – I think that is really nice'*

> *FG3 Q 'do you feel more confident now than you did six months ago?*

> *'I do yeah definitely (oh yeah)'*

5.5.14 Overview

Exploration and detailed analysis of the substantial data from the focus groups and the interviews with first year students allows access into their perceptions and experiences and significant insight into the complexity of their understandings, burgeoning and genuine recognition of the complex role of the nurse and their shifting identities as they become involved in the various established communities of practice. Their authentic experience particularly confirms their peripherality - both legitimate and planned and also more prohibitive marginalisation - not least in their frequently challenging relationships with more established colleagues. These challenges appear especially felt in their relationships with 'old timers' whose academic backgrounds are often substantially different from theirs and frequently confirm their impressions of university and clinical practice being essentially two differing communities of practice. Despite these challenges, however, their experience still clarifies their perception of what 'becoming a nurse' entails. In fact it elucidates their growing appreciation of what is required to become a nurse of the future – a nurse that current and prospective patients and service users need - a *better* nurse.

5.6 Second year student narratives

Understandably as the students' progress into the second year of their course they retain an overriding consideration of what the genuine identity of a nurse is - what does this mean to them as they aspire to 'become a nurse'

There is a growing respect for the work, competence and contribution of some of the nurses they have worked alongside:

> FG1 *'Nurses on the wards - if it's a specialist ward they are amazing, their knowledge is crazy good'*

> Int1 *'I sometimes don't think they give the nurses on the ward the credit they deserve'*

> Int2 *'..they like inspired me in some way - I have this lovely one now she's positive all of the time she's never negative and that's the person I want to be'*

As Wenger (1998) highlights although students have their own unique identities, their observation of and participation with more experienced colleagues allows them to envision their own futures. Their future potential selves are embodied and exemplified by the nurses that they work alongside.

5.6.1 The role of the student nurse II

The students have now had at least eighteen to twenty-four months experience on the BSc nursing course and yet, similar to the first year students, there remains a lack of clarity and certainty about a fixed, specific student nurse identity.

> FG3 A *'You don't know who you are do you when you are a student nurse?'*

> B *'You know - it is wearying because everywhere you go you have to be like – 'can I do this for you' 'can I do that for you' - half the time you feel like, you know, being a bit of a kiss ass and the other half the time you feel that you're just getting in everybody's way. You know so you don't really know where to put yourself and it is really difficult'*

Nursing may still be expressed as principally a series of tasks - as arguably encouraged by the competency-based assessment evidenced in the Practice Assessment Document and the NMC standards.

> FG1 *'You now try to figure out what you are wanting to get out of your placement - almost make a list. If it's a first placement think 'right can I do a medicine round?' 'Can I do this?' 'Can I do that?' And maybe have five things on your list that you really really want to do'*

However this is now in the context, at least to an extent, of a greater understanding, acceptance and confidence:

FG1 'Sometimes it is hard to know what you want to achieve because you have not done it before but going in to the second year I think you have a better idea of what you do want to achieve'

Int2 'I think I am working on myself to become a confident nurse. I think if you had met me a year ago I probably wouldn't be as open - and like I'll probably be shy but I think every year I set my target to be a bit more, to speak a bit more and I analyse myself and say how can I accomplish this. Because I still feel I'm not there yet because I have a person that I want to aspire to be while still keeping me - and every year is just like a different goal to achieve'

FG1 'When you go on a new placement - I know we are still always new but - you kind of turn up and think I'll be all right though because I survived the last two'

The choice of the word 'survived' still indicates the challenge and difficulties experienced by some of the second year students. However the learning that has taken place is recognised, often with a feeling of surprise and pride.

Int1 'when I first started the second year I thought 'oh I don't know anything I just don't know anything about nursing' - and then when I am sat in the lectures and we talk about things I think 'oh I know that, I know what that is' - so I then think I actually know more than I think'

FG1 'it's funny when you talk to family - like when I talk to my mum and I'm talking to her about what I have learned and she is like 'what's that, what's that?' and I remember when I didn't know that, now I do know and it makes you realise how far you have come definitely'

There is also a growing recognition of the importance of supporting any decision making with evidence and a rationale:

Int3 'I think that is a second-year thing I never did it in the first year and I think it is definitely crept in in the second year – rationale. If there is a reason why I'm doing it I will do it'

For some this recognition of their knowledge, learning and awareness of evidence has also come with a newly recognised assertiveness:

Int3 'if you can say why and you have researched why - it makes them look bloody silly because they are thinking 'God a student knows better than me now' - and I just think knowledge is power in nursing it really is'

FG1 'you recognise you've got to be like…. for us we have to be more outspoken and say 'you know I'm a student can you look at this?' - and usually when you do they are sort of like 'oh yeah yeah of course I will' but sometimes you just have to remind them that you are there'

FG1 '… if you are decent and you push to do it I was surprised about what I was allowed to do even on a first placement. I was quite shocked with the level of responsibility they were happy for you to take'

This increasing recognition of transition and a changing self indicates the accumulation of memories, formative events, the acquiring of competencies and the forming of relationships with people and places is what forms a unique identity. The individual, unique identity of each student reflects their exclusive journey experienced *within* both individual communities and

also the transitions *across* different communities. Their view of their registered nurse colleagues and the aspiration that this represents for their own progression and career helps provide an individual image of themselves on a forward trajectory.

However, many other students found this transition quite troublesome and reflecting on their current position, far from generating assertiveness, reassurance and self-confidence still prompted disquiet and anxiety:

> *FG2* '..and I also feel in some areas I'm really progressing and I am learning a lot about things but in other areas I'm still really right at the start and I am no better off than I was when we started'

> *Int3* 'some time it is just really demoralising and you just sometimes think 'why am I doing it?' You know you just get to the point where you think I hope it's worth it at the end I hope there is a shiny special job that we are doing it for'

Some students recollect their first year experiences and it makes them hanker back to a time where, in hindsight, they felt they were better supported than maybe they recognised at the time. Some second year students feel they are in some way less favoured than students in other years. They have lost the naïve talismanic quality that they may now believe they had in the first year and nor have they yet achieved the attractiveness of the 'about to qualify' third year student.

> *FG2* 'In first year you were given lots of support and when you went to second year that was it. It almost felt as if everything was cut off and I've kind of lost all my confidence... I mean you are supposed to be able to cope with it but it doesn't change the fact that all that confidence you had in the first year and that positive feeling that you have is just all of a sudden taken away from you'

> *FG2* 'Do you think that it is maybe that in your second year you are kind of more on your own? In the first year it's like you are new and everyone is making a big deal because you are new and then when your second year starts it's kind of ... you are just there?'

Wenger's concept of trajectories of participation will always involve the alteration of a student's relationship to previous beliefs and cultures within which their previous competencies - or lack of them - had been an important component of their identity. The 'learning journey' implies the leaving behind of familiar territory (Harris & Shelswell, 2005). As Wenger (1998) points out, this can be very difficult for the student as they cross the 'boundary' from one community to another and membership of one community might imply marginalisation in another:

> *FG1 A 'it's frightening I'm just not confident, don't think I am when I'm there but I'm petrified now of qualifying - thinking I'm in this blue uniform and someone is going to ask me something and I'm not going to have a clue.*
>
> *B 'Yeah that's how I feel too'*

Students are clearly endeavouring to gain insight into (and find a role in) the history of the new communities that they are attempting to become part of. They are urgently seeking continuity rather than the lack of continuity and disconnect that challenges them as their unique identities are forged and shift. Each community of practice that the student nurse experiences, has certain 'reified milestones' (Wenger, 1998). These include recognised roles, new and established relationships, articulated responsibilities, assessments and expected competencies (Nursing & Midwifery Council, 2010), but each also has its own history, unique identity of practitioners and means of participation. Therefore each community of practice provides a model of 'paradigmatic' trajectories for individuals to negotiate their own. This may be problematic to those that do not fit that particular paradigm however it does support the task of mentors whose role is, at least in part, one of supporting the trajectories of learners' identity development as they endeavour, where appropriate, to take an increasingly central participation in the specific community of practice (Harris & Shelswell, 2005).

Gidman, McIntosh, Melling and Smith (2011) indicate that as students progress through their career their perceptions of support - not least the support that facilitates their greater participation - changes. New starters felt that the most important source of support was academic staff, with mentors a close second and families and friends a distant third. In contrast, as their careers progressed clinical mentors became far and away the main source of support. However the data from the second years indicate that the expectations of mentors and other clinical staff, and indeed of themselves as second year students, continued to challenge them and their identity formation:

> *FG2 A '... like when you don't know what you are doing - and I think that gives a knock to your confidence as well and your willingness to try things and, like, put yourself forward to have a go at things'*
>
> *E 'You do get the odd sarky comment too from some staff - 'Well I've never met a second year who can't do that before''*
>
> *C (impersonating) 'Second year? Second year? You a second year? I didn't expect that'*

5.6.2 The Registered Nurse and the HCA II

There is, however, greater recognition of their nursing identity as they articulate the difference between the role of the registered nurse and the role of the healthcare assistant. In the first year

this tended to relate exclusively to specific clinical skills and techniques; whereas second year students offer a different, more nuanced insight into what it means to be a nurse:

> *Int3 A 'When I think back then it was like I would be learning about medication - how to treat people - but now it is more holistic'*
>
> *B 'yeah totally agree with that'*
>
> *A 'it's not just medication it is not just the treatment it is, you know, the support, the social support, the emotional support it is everything isn't it?'*
>
> *C 'yeah it is bigger than I thought it was'*
>
> *FG2 '...it is the accountability and the assessment of the patient changes whereas the healthcare assistant essentially does what I suppose they are told to do - the nurse can change that and tell other people what to do.'*
>
> *FG1 'it is about making decisions I think isn't it? And taking on a lot more of that responsibility'*

Similarly

> *FG1 '..if one of the obs wasn't in the right range, what do we do? And I went to the nurse and said 'er what would we do with this?' - But now I don't just ask and then walk away I ask and then remember and the next time you have a patient and it happens again you know what you would do with that patient. It is the understanding of it'*

5.6.3 Nurses of the future II

The students in the focus groups and subsequently interviewed remain convinced of their positive role in improving healthcare in the future - echoing the opinions of the first year students:

> *Yr2 Int2 'They are trying to get us to be the nurses of the future...that is the idea that we will change practice'*
>
> *Yr2 FG2 A 'but that is the thing, we are like... they are training us up to like report everything'*
>
> *B 'it is the nurses of the future isn't it'*
>
> *Int1 'It feels like the management of the hospitals have said to the uni - 'this is what we want' and they are trying to produce it but they are not, like, exactly writing everybody else off - but they are saying 'well they are stuck in their ways now'*

There is an appreciation of the difficulties of making this view of the future a reality; and the length of time and effort that it may take. This recognition is coupled with an awareness of the negative implications of the necessary changes for the current nursing workforce:

> *FG2 'we won't ever change how people are in there... They will have to leave before the new generation. They won't ever change. You can't tell a band 6 to change her ways she won't change'*

FG2 '... Like if nobody is wearing gloves.. for something that you should wear gloves for and you are putting on gloves you are the only one putting on gloves - it makes you feel like you are being silly (yeah or that you are wasting time) and you feel like everyone is looking at you thinking 'What's she doing?' - you know you are made to feel that you are the one who is being over the top. Even though you know you are the one that is in the right. It is like being a Dudley do Right like you just said, that is what we feel like we are all of the time'

Communities of practice and their members can be reluctant to change or accept innovation if they are majorly focussed on the interests of those who are entrenched in established practices and also benefit from maintaining the status quo. The students therefore express concern that they may be negatively influenced by those individuals already established at the centre of their communities. They do however remain determined to withstand such negative changes to their attitudes and their practice:

FG2 'So give it another 10-20 years when the older ones have retired... we should reshape it. As long as we don't get influenced by the workforce culture'

Such comments hint at a recognition that it is wrong to assume that all established nurses have differing values and less of a caring attitude. Some students clearly identify that access to the history of a community as personified by some of their well-established colleagues is an integral part of participation in that community and any related identity development. As articulated although this access may be in some way second hand or vicarious, as the student often simply witnesses rather than participates, there is an appreciation that at least some form of access is necessary if it is to be made part of their identities.

Similarly despite participants generally indicating their desire for change and their view of themselves as 'new nurses' it is not necessarily true that new students are inevitably more progressive than more established colleagues. Attempts to 'fit in' may necessitate that students have an equal investment in continuity - making the necessary connection with history more likely and thereby reducing their vulnerability and making their participation easier and quicker.

However some students view retaining their principles of practice outweighs their desire and ability to fit in:

FG1 'I know some wards that name the patients after the number of the bed like 'oh I'm going to see bed 14' and I know another ward that names all the patients by their names and I like it that they call them by their names...I'm hoping that I won't become like that and I will stick to like, you know, like I have done in the first place'

FG2 A 'But then again it is different but we know we have been taught properly so we know that we will never be like them'

B 'Yeah'

C 'we have seen their bad habits but we are not actually picking up on them'

FG2 'they want us to follow their bad footsteps like leaving medication out, the keys everywhere you can't do that - we have not been taught how to... I once ended up having a row and after that they were just funny with me because I stood my ground...'

Being 'funny' with an individual following the highlighting of less than optimum practice is an example of the climate that can be identified as an influencing factor on nurses' decision to raise concerns - as this context of potential retribution can create self-doubt about whether speaking out is the 'right thing to do' (Jackson, et al., 2011; Laschinger, 2010)

Just like students in the first year, second year students still retain a view that the provision of learning opportunities whilst in practice is qualitatively different when supported by mentors and other clinical staff who have worked in those environments longer and/or who trained longer ago. Although there appears to be limited knowledge or understanding of the historical context of the previous provision of nurse education, students nevertheless feel this effects their experience for several reasons. They perceive that greater insight, understanding and empathy is shown by mentors who have had a more recent educational experience themselves:

FG1 'The ones I've worked with are slightly younger mentors so they are not really far out of education either so they understand you'

FG3 ' ... and if they are younger and qualified less time they know more about what to learn because it's about what they wanted to learn'

FG1 'I think the courses have changed, well they have to don't they? They do end up changing... like people I know who got qualified not that long ago - it was only a foundation so they are back at uni trying to get the degrees and things, doing the modules - and so those ones who are the mentors are good because they are busy doing the uni stuff so they kind of get it'

FG1 'yes I think a lot of the older nurses, not older nurses but the ones that learned on the ward - they didn't have to come to uni or anything like that they all say 'what do you need to go there for to learn about nursing you need to be here doing it''

Experienced nurses, not least those older and perhaps approaching retirement, possess practical experiences and extensive clinical skills which would be a valuable source of knowledge, acumen and insight for the students. However the current nursing work environment can often be characterised by perpetual challenge, high patient acuity, debates about safe staffing levels, inflexible shift patterns, excessive targets and reducing opportunities for professional advancement (Laschinger, 2010; O'Brien-Pallas, Tomblin-Murphy, Shamian, Li & Hayes, 2010). All these factors can result in a change in attitude and increased stress in established staff - a phenomenon that was recognised by the students (Lim, Bogossian & Ahern, 2010):

FGI *'...they have been on the ward for 30 years they are not necessarily a positive influence... and the ones that are a bit fresher into it even if they are a bit older but quite newly trained they've still got that sort of drive.'*

FGI *'I know some that have worked with have complained about their job but they have been there for like 30 years and I'm thinking well if you really don't like it why don't you do something else. I didn't say that to them obviously (laughs)'*

In a small (n17) pre and post intervention, mix method study in the USA, Bishop (2013) found that investment, in the form of a 3 day retreat, in a group of nurses, over forty-five years old who had been practicing clinically 'at the bedside' for more than five years, resulted in a 'reawakening of the spirit of nursing'. They recognised and accepted that their focus on the 'true needs' of the patient may have become lost and resulted in increased work engagement, vigour and a changed view on caring for patients and their families (Bishop, 2013). It is acknowledged that this research is limited to a small voluntary sample of older nurses from one community hospital in USA.

There is mounting evidence of an association between symptoms often described as 'burnout' and different age groups of nurses. While many studies indicate that a proportion of nurses are considering or intending to leave the profession - numbers which can vary significantly among countries: from 4 to 54% (International Council of Nurses, 2012) this phenomenon may not necessarily be most widespread in the groups that the students in this particular research appear to believe (Leiter, Price & Spence Laschinger, 2010). For example, there is also significant evidence of attrition or intention to leave of newly qualified nurses with one explanation being that new graduates, as part of a younger generational cohort, may experience dissonance between the environment in which they were educated and the professional setting that they subsequently experience (McNeese-Smith & Crook, 2003). Such groups have significantly different expectations of occupations, different expectations of social norms and career expectations and aspirations than previous generations and the pattern may suggest that younger nurses may find the current healthcare workplace less apt to fulfil their career aspirations than previously.

So although the perceptions of the students, in all years is that it is the more established staff that appear to have lost idealism and aspects of 'caring'- some of the literature may conflict with this viewpoint.

However there is also some supportive evidence that indicates that two of the primary drivers of burnout are: excessive workload and conflicts of personal values with organizational values (Leiter et al., 2010; Leiter & Shaugnessy, 2006). Examples of such conflicts in values are

represented by the students when they frequently speak of witnessing less than optimum practice on their placements. However the students provided account of several registered nurses also appear to recognise that they have changed and identify their former selves in the students' determination to care, maintain high standards and retain enthusiasm. They recognise this shift in their own identity and openly discuss those changes with the students themselves:

> FG2 *'So obviously it puts you in a difficult position because it's like these things might not be, so to speak, bad enough that you like need to ring a bell - so to speak - but they are a bit concerning and a bit disheartening especially when people say to you 'Oh I used to be like you all caring but now I'm not''*

> FG2 *''Oh I used to be like you' - but it is not a good way for a mentor to be when you are kind of learning off them and they are guiding you'*

It would be wrong to assume that no established nurses welcome the potential offered by engagement with the new generation of students or indeed disinvest themselves from the future. However the students' experience of some of the attitudes and behaviours of their established colleagues seem to still cause some confusion of what might constitute a *good* nurse; despite the students' apparent developing recognition and evolving insight into what it means to be a nurse generally:

> FG1 A *'I think as well you need to be a people person there are so many that you go - bloody hell!' (shakes head)*

> B *'Yeah no bedside manner'*

> A *'yeah they are useless, they are still good at their job but not right good with patients. There are a lot like that'*

It appears that the students are still reluctant to be too critical of their colleagues and remain keen to allow the possibility of a nurse being 'good at their job' even though their treatment and relationships with patients might be perceived as minimal or even poor.

5.6.4 Being called 'the student'

The relationships some students have with some old timers are also less than ideal and this is often evidenced by individuals being referred to simply as 'the student'; a phenomena common in all three years:

> FG3 *'I'll get the student to do it' … it just makes you think like 'Yeah you're still the student'.. it just like puts you back in your box'*

Being simply labelled as the student is perceived as a lack of appreciation, constant vulnerability to being chastised and continual evidence of the students' periphery:

> FG1 A *'And you are not always appreciated but that is the job...'*

> B 'I think really you are appreciated it's just that people sometimes forget to tell you. I think it's that if you do something bad you will get told. If you do something good they won't tell you so just appreciate them not telling you off'

However their experience evidences additional insight from year one, in that they are now more aware of who might be best placed and most willing to support their learning and development and subsequently how they might make best use of this knowledge:

> FG2 C 'Yeah – it's like Oh good she's on!'

> D 'Yeah and the people who can't be bothered with you - you just avoid' (laughs)

As ten Hoeve, Brouwer, Roodbol and Kunnen (2018) confirm support and guidance in their learning and developing is essential for effective transition into an embryo professional nurse.

5.6.5 University and Clinical Practice Dissonance II

The apparent difference in aspirations and articulation of priorities and values of the two most obvious differing communities of practice - the university and the clinical placement still challenges second year students:

> FG3 'Off you go to placement and see you again in a few months (laughs) and never the twain shall meet'

> FG2 'Personally I would say that the uni has higher expectations of you than placement does. Placement has like a realistic expectation of you and they are satisfied if the jobs get done, the patients are happy, the patients stay safe and they can eventually move out of the hospital. But I think uni they want you to be all singing all dancing flipping Mary Poppins level nurse, I've got a duck umbrella and everything, but it can be a bit like Oh my God how are you supposed to do all them five things before you can...'

However students generally recognise the rationale behind the apparently 'higher' standards and expectations espoused by the university and view this as a positive 'reminder' of the high quality expected and deserved by patients:

> FG1 A 'I think university kind of reminds you to keep trying to have high expectations of yourself when you are on placement, keep reminding yourself to keep up to that'

> B ' Yeah - most of the lecturers are nurses - and like they do do clinical jobs as well. But I don't know, they do sort of bring you back don't they? I don't know - like –'who washes patients like this?' - after placement and you kind of go 'oops that's me' - and they say 'well don't!''

Students find that some permanent clinical staff also ultimately recognise the importance of continually improving practice and identify the significance of evidence based practice but may not always indicate that in their daily practice or be committed enough to support continued change:

FGI 'uni does help you to be better than reality if you can. Like I've done stuff and gone to nurses and said 'why have you done that?' - and they will not really know why. And you will turn round and say 'would it not be better to do this?' It is nothing to do with nursing it is to do with something else that we have been taught at uni' - like different people like do different lifts and we say well at uni we been taught to do this and they say okay why not'

FGI 'sometimes they will go – 'go on then give it a go if you think it'll work but we're not gonna change'

The students have now developed an insight and awareness of why change and best practice may not always be maintained as they have understanding and recognition of some of the pressure that their mentors and others are under. They also see this pressure as inevitable and unavoidable and believe they will undoubtedly be under the same pressure following registration:

FG4 'it's not always their fault though is it? If they are really really really busy and they are under a lot of pressure and things like that - and I only know that because my mentor had said to me enjoy this while you can because it will change when you qualify'

5.6.6 Overview

The second year students participating in the research indicate a more nuanced view of nursing and clinical practice than the first year students as they speak of nursing in more complex terms and indicate a recognition of the holistic aspects of practice as opposed to a more task orientated conceptualisation of the profession. Several have generally developed a more assertive approach and resolved certain techniques and methods of achieving a more successful - or at least less traumatic - clinical experience. However many of the challenges that faced the first year students remain. These include the ongoing dissonance of the values espoused by the university and their contrary experiences in clinical practice especially when working with old timers who have been practicing for a long time and appear to have limited insight or interest into the learning needs of the student.

5.7 Third Year Student Narrative

By the time they are in the third year, students recognise a significant change in perception of them by clinical colleagues and other Trust members. They are now viewed, spoken of and engaged with as potential colleagues and future employees. However, they believe this altered identity is irrespective of their specific, individual skills, competence, attitudes or any other attributes that might be deemed evidence of a 'good nurse':

> FG1 *'I am more attractive now that I am going to qualify... I might not be any good at nursing but because they've done the training I am more important to them than in the first and second year'*

> FG1 *'You are a hot commodity in third year'*

> Int1 *'..so I'm like wow you have got that third year stamped on your head'*

In some ways the stark difference in attitude of their colleagues is viewed with pragmatism or even a hint of cynicism.

> FG1 *'It is like we are more important now as they have all these jobs ... they will do anything or say anything to get you to stay within the Trust'*

All of the students can be viewed as if they are on an *inbound trajectory* and, as Wenger (1998) highlights, they therefore need to be treated as potential members of the community of practice and granted sufficient legitimacy by those already in the community to make that happen. Legitimacy can take many forms - one of which is being *useful* to the community. This perceived usefulness is articulated clearly in the different responses of clinical colleagues to third year students compared to more junior students. This shift in the attitude of clinical staff towards them contrasts with their memory of their first and second year experience. The recognition of their newfound ability to move from the periphery and contribute further to the community is welcomed but, again, also viewed with an element of disparagement and humour:

> FG1 *'Oh we have a student, first placement (big sigh) ok – 'do you understand everything?'(*patronising*) (all laugh) ...on the fifth placement in the third year its 'Oh fantastic a third year student' – it's like a reincarnation... we know everything now'*

There is also a recognition that limitations to their actual and potential engagement remain despite their apparent change in status.

> FG1 *'In first year I was looked at as if I hadn't got a clue - we weren't trusted - Once you have got a bit more clout about ya – it tips and you become – not a part of the team – not a member but they know you are there, they know you are capable and you get given more responsibilities'*

> Int1 *'It is really difficult - especially as a student because nobody will do what you ask them to. It was only with certain mentors - one in particular I just adored.... Everybody else actually*

did what I asked them to do... because she said 'She's in charge today' and labelled it like that. Whereas I did find some nurses wouldn't label it and then did the wrong thing and ended up not doing what they were supposed to do'

Some third year students undoubtedly perceive that they are more visible to the rest of the nursing team and are therefore less peripheral in that particular community. However this is not a universal experience and others still felt overlooked and disregarded as they had done in their first and second year. This is together with a recognition of how their imminent professional registration would bring about further significant change:

> *FG4 'Yeah they sometimes talk over you – instead of waiting. But once we get our blue uniforms on we'll feel better'*

> *FG4 'You always feel like a bit underneath them still don't you - like you can't tell a nurse what to do because they'll be like 'you're just a student.'*

Their position in the community and their relationship with those established old timers, therefore, continues to cause uncertainty. As Wenger (1998) points out learning and subsequent identity formation can only be encouraged by allowing the asking of 'stupid questions' and recognising professional naiveté and lack of experience as opportunities for learning; rather than cause for patronising ill-treatment, being ignored, disregarded or marginalised. Rather than being made to feel stupid, for students of all years and experience to flourish the established community needs to engage, not reject the students and recognise and understand their inevitable lack of competent engagement.

The vague uncertainty of 'role identity' also remains - they are still 'students' ultimately and therefore their influence remains limited, their contribution and what they do remains governed by their registered nurse colleagues and their position in the community is still peripheral. Yet again the recognition of their continued marginal position is viewed with ambiguity and a little suspicion regarding the motivations of their registered colleagues:

> *Int3 '...as a third year student you are expecting to do so much more especially in that last placement - your internship placement... But, erm, it's a hard one that, erm, you are still very much kept out of the loop because you are still a student. The nurses are still in control whoever you are working with. So you are just kept out of that loop - you don't really know where you are what is your role. Are you working to be that nurse or are you there just to do what they don't want to do? I have seen that a lot'*

Despite the students' increased experience, their shift in identity and the changing views of them by their registered nurse colleagues - their enduring peripherality confirms the student experience throughout the three years - from the initial rather simple understandings of the first

year students to the more nuanced insights informed by the experiences of students in their second and third year.

The positive aspects of 'getting our blue uniforms' is tempered for some by the ongoing realisation of imminent registration:

> *FG1* *'It does come second nature but it is just the fear of actually saying 'these are my patients' – do I feel any more empowered than when I started the third year – probably not'*

> *FG4* *Q 'Do you feel ready then?' - 'NO not in the slightest! (all laugh) Still feel like I know nothing'*

> *Int2* *'I think a couple of weeks before when I was finishing my last placement I was like 'yes I am ready for this' and excited – 'bring it on!' - and then you come back after two weeks off and I had forgotten everything'*

What Wenger (1998) calls *outbound trajectories* may be experienced as a third year student, particularly, as being 'led out' of a particular community. The differing expectations and changed perceptions of those already within the community of practice lead the third year student to develop new relationships, experience and explore differing positions, and view the world and themselves differently:

> *Int1* *'I was not instantly the one who they would come to but when the nurse said 'what we doing now boss?' or whatever it was that she said to me it was like (loud laughter) it really gave me some like 'yeah I am in charge'.*

The students' clinical experience is designed to offer insight into their future roles and enable participation in the practices and experiences that will become part of their professional role on their registration as an adult nurse (Nursing & Midwifery Council, 2018). Such an outbound trajectory may best capture the experience of a third year student nurse as they approach imminent achievement of professional registration with the Nursing and Midwifery Council (Nursing & Midwifery Council, 2018). Identification with an outbound trajectory and a recognition of what participation may enable and facilitate also highlights the *aspirational* factors within an individual student's shifting identity. Meanings and identity are constantly renegotiated and new personal relationships created with participation and trajectory comprising of continual modifications of understandings for individuals.

Wenger's (1998) explanation of trajectories confirm the continuous change and movement that is necessary in the formation of an individual's identity. The students may occasionally - perhaps anecdotally in their conversations with others - view their achievement of professional registration as a *fixed* destination. However identity exists as the interaction and coming together of several different trajectories in differing social contexts. This therefore demands a

constant negotiation of the self and - without presuming time as a simple linear notion - the creation of a constancy in the present whilst incorporating the past and the future. Identity formation is therefore ongoing, just as the evolution of communities of practice. The student nurses' identity will not become final and complete 'when they have their blue uniform' - even if this may be, in some way, indicative of finally being a full member of a specific community. Inevitably new responsibilities, experiences, demands and events will cause continual renegotiation of their identity. Wenger terms this as *insider trajectories* (Wenger, 1998).

The students also reflect back on their previous expectations and aspirations and compare that to their current feelings of nervousness, vulnerability and inadequacy:

> *Grp 3* *'In first year I am going to be super nurse but now in the third year I don't feel as equipped as I thought I would in the first year'*

> *Int2* *'you are in this little bubble thinking - oh I am ok - and then you are like 'it's gone' - it's me now come on! - be sure of yourself - I know I have been sure of myself for three years it is real-time now so I don't think there is anything that could prepare you for that'*

As Wenger (1998) highlights participation in practice is a source of remembering and of forgetting and is further evidence of a shifting identity and a need to acknowledge ourselves in the past. Such unique, and inevitably partial, memories are able to be interpreted as the trajectory of a unique and individual person. Forms of participation in communities thus change with a resultant shift in perspective. This perspective is influenced by specific unique memories - and also that which has been forgotten - and generates a continual realisation of their accountability and responsibility in the student. The potential of being called to account generates a nervousness and vulnerability in the students who are now so close to registration. This echoes the comments of students earlier in their career who expressed a belief that the university used 'scare tactics' as a strategy of teaching and learning. As Wenger states 'our identities incorporate the past and the future in the very process of negotiating the present' (Wenger, 1998 p.155).

> *FG1* *'People are scared now'*

> *FG2* *'You think - God there is so much more responsibility than I thought there was'*

> *FG4* *'when you find out how much trouble you can get into it is scary'*

> *Int2* *'...we get scare mongered in the last year - if you do this you will lose your pin number if you do this you will get sacked and you think - just teach us the right way!'*

The concern about their accountability appears to be taken further as they consider their current views and perceptions of the attitude of the general public or patients towards nurses:

FG4 *'It seems like people hate nurses now doesn't it?'*

FG3 *'People don't like nurses'*

Int3 *'Yeah (laughs) sign of the times isn't it the media portrayal. Well you are the first line of fire and if owt goes wrong it is down to you..... the profession has had a rough ride hasn't it recently and it is going to take time for it to get back up....nursing doesn't do itself justice when there is poor practice going on - it's that that needs to be flushed out really people's attitudes need to change I think'*

Int1 *'I think some patients are pre-paranoid before they come into hospital that they are going to have a horrendous time and frankly some people do have but I think it is tarnishing everyone with the same brush... and they end up saying they've been looked after lovely not just by me but by the team. But then sometimes you do think gosh this person is having a right rough ride – I've just come across particular health care assistants who don't really know how to talk to people in general let alone patients. I think that outweighs some of the good sometimes because they are in such a vulnerable position once someone violates that trust it is a big thing...'*

This contrasts with the experience of first year students who felt much more supported by patients, who viewed them as Bambi-like and also with the perceptions of second year students who also recognised patients as primarily supportive to their learning and progression. It is possible that this difference is caused by the changing expectations, role and responsibilities of third year students. As the expectations of them change and they shift closer to a position as a registered nurse it appears that their connection and relationship with patients also inevitably changes:

FG4 *'I thought nurses were like the ones who proper cared for the patients - I think I was getting that confused with health care assistants weren't I really'*

FG1 *'Nurses often just have to take the word of mouth of other people about patients - but we don't want to be sat at the desk doing paperwork'*

By the third year therefore the students have gained greater insight into the lived experience of the registered nurse - good and bad - and appear to be imagining themselves in that role; with the inevitability of them replicating the behaviours and priorities of the role as they presently observe it. This is despite them viewing themselves as change agents and 'nurses of tomorrow'. This confirms a recognition and acceptance of the experience of more novice students who are advised frequently by registered nurses to 'make the most' of their present patient contact as this is likely to be temporary and significantly reduced as their career progresses. This is a further example of how the student's identity is challenged by the reality of nursing practice and how this contrasts with their original aspirations and reasons for wanting to be a nurse.

However some third year students recognise the challenges that they are confronted with and are able to retain their original values and also bring together their role as patient advocate and their flourishing recognition of their role as more than simply a skills competent practitioner:

> Int2 '*they were nice as pie with me and they said 'look there is a massive complaint coming but not about you guys' - and I said 'but hold on a second' and got them the PALS leaflet and told them that they can advise them on how best to complain and they were like – 'oh cheers' - and I was like 'nothing is going to get done if you don't complain' - like we need to have that to change things and they were okay - so if you don't go on the attack all the time people are more understanding.'*

5.7.1 University and Clinical Practice Dissonance III

Although being so close to registration, their three years experience has brought limited clarification in their understanding of a commonality between the aims of university and practice:

> Int1 '*Are university and practice heading in the same direction? – No No No definitely not - it's like they have never met – never spoken to each other*

> FG4 '*It seems to be lacking a bridge between the university and practice and it feels like it is left up to the students which can be really hard'*

> Int3 '*yeah it's like there is no continuity. Talking to older nurses now when they were doing their training they would do medicine in uni then go on a medicine placement. So everything worked - you knew what you were doing - whereas now everything is just thrown in - you don't know where you're going to get placed, what environment you are going to get placed in and you have to make do - it's like there's just no continuity with the two'*

Perhaps this is not too surprising as although problems can undoubtedly arise inside single communities of practice, other issues arise more specifically due to what Wenger, McDermott, and Snyder (2002, p.150) call the 'constellations of communities'. As communities of practice inevitably focus on their individual domains, competencies, expertise, priorities and perceptions of value and outcomes, this unavoidably forms deeper boundaries between different communities. Vocabularies and styles differ and standards of performance and experiences may well be necessitated by the diverse practices of the different communities. This can make trust and commonality more problematic for students endeavouring to achieve membership in apparently related but seemingly disparate communities such as the university and practice. Crossing these boundaries can be especially difficult when membership in one community implies marginalisation in another (Harris & Shelswell, 2005). The students' view of themselves as agents of change who have an undeniable role in improving quality and promoting evidence based practice may well suggest such a marginalisation. Students in the second and third years particularly experience clinical practice as an initial period of trauma

and stress that is often overcome and replaced by a more enjoyable and productive learning experience. A student's identity is therefore negotiated across the boundaries of several different, although linked, communities of practice. Wenger (1998) theorises this as *boundary trajectories* which link the communities and thus sustain identity across boundaries.

Wenger, McDermott, and Snyder (2002) explore the concept of *legitimation conflicts* whereby the contribution, position or 'legitimacy' of an individual is brought into question by other community members. Conflict results inevitably in an increasingly marginalised position for that individual and/or a conscious withdrawal from contact with the group where possible. As in the previous two years, the students often felt their 'legitimacy' challenged by clinical colleagues who had qualified earlier and via a different academic and practice environment:

> *FG3 'On a placement the older nurses on the ward who had a diploma kept calling her a 'paper nurse' I said 'that's bullying' and she said 'it's really upsetting me' and I said 'no you are as good as they are''*

> *FG1 'Her mentor said I don't agree with the way you lot are learning... They know things change every year but as long as it doesn't affect them they are not bothered'*

> *FG2 'ours was better because of this and yours was disadvantaged because of that – trying to get one up on you'*

> *Int2 'I agree that older nurses versus newer nurses have different opinions. Sometimes they are like traditional – and you are new and coming from university and with the evidence-based practice ...and with regards diploma and degree - no one asks - so people say they are topping up their diploma to a degree but there is never – 'oh you are just a diploma nurse and you are a degree nursing you can do more' - because you can't'*

Wenger (1998) highlights that in any community there is often little willingness from within that community to challenge any implicit assumptions in their practices. Opportunities to question can be limited and any new ideas dismissed or discouraged - this represented much of the experience of the third year students. Barriers can be created to those on the periphery or any newcomer due to the pragmatic and functional nature of the environment and the inherent reluctance for any internal critique of individuals or practices. Similarly any new ideas can be suppressed by individuals within the community who have a feeling of exclusive ownership of knowledge. They perceive they have a unique and special expertise that in some way defines their profession and that can be challenged by newcomers with new ideas confronting their perception that they already know all there is to know (Wenger, McDermott, & Snyder, 2002)**.**

The students believe that the established clinical staff are often reluctant to accept that they are bringing with them fresh ideas that might indicate best evidence and currency in practice. Their strategy therefore is to ignore the potential for change offered by the student and determine to

maintain the status quo and exclude any ideas brought by the student. As such communities are defined as much by who and what they exclude as by what they contain; at times an active exclusion may be essential as a strategy to maintain, at least a perception of, continued cohesion (Harris & Shelswell, 2005). The phrase 'community of practice' has itself been criticised for the implicitly positive connotation of *community* as a concept (Fuller, Hodkinson, Hodkinson & Unwin, 2005) and it is clear that some students found the experience less than positive. However Wenger, McDermott and Snyder (2002) highlight that any inter-relationship of people will inevitably reflect conflicts, jealousies, strengths and weaknesses. They therefore acknowledge that - as some of the students experienced - the pre-existing strength of bonds between members of the community can result in less than positive consequences; not least increased exclusivity and barriers to those attempting to gain entry to that community.

5.7.2 Old Timers vs Nurses of the future

Common to all three years is a perception that some more experienced nurses have struggled to retain their original values and commitment to high quality patient care. This inevitably challenges any positive relationship and mutuality between the students and the old timers:

> FG1 *'They don't like the way things change but we have to make sure we are up to date with these changes – for our own PIN and they don't like it'*

> FG2 *'It is a case of getting the newer nurses to keep up that new culture instead of falling into the old ways'*

> FG4 *'You do see some nurses when they are burnt out and there is no pride in their work and their standards of nursing have slipped quite a lot'*

> FG1 *'There is a lot of lazyitis I think with more seasoned nurses'*

However other students were less able to recognise this as such a stark contrast:

> Int3 *'Mmmmm I don't think you can look at that across-the-board there is definitely some lazy nurses out there but you can put that down to age because there are some very hard-working older nurses too'*

Wenger (1998) highlights the significant complexities involved in the negotiation of trajectories and the encounters between the 'different generations'. Students and more experienced colleagues in practice inevitably have significantly different perspectives on their community and thus their identities are influenced and formed by the different experiences of the history of that community. Students with their limited history of the particular community reflect both a different trajectory and also a different identity. The relationship between the students, new to the community, and more established colleagues is much more than simply an exercise in the 'transmission of a heritage' (Wenger, 1998 p.157) as it highlights the complexity

involved in mutual dependencies, conflicts, different perspectives and interconnecting identities.

However the students feel that the 'seasoned nurses' or 'old timers' do not generally advocate for this heritage - if this heritage includes valuing nursing as a profession, or nursing as an aspirational achievement:

> *FG2 'You are in your third year and people are going – stop, turn around, quit!'*

> *FG2 'You never have a person say 'I really think that what you are doing is going to be of value' most people say to you 'you'll learn nothing at Uni you will learn when you get a job' – that's the main thing you get from nurses – either that or stop now!'*

> *Int3 'I suppose this happens everywhere but again it's down to morale on the wards on your placements if they are having a bad day or if they have had a bad month or whatever they are going to say that – 'what you coming into this for? don't bother''*

> *FG2 'You do get quite a few saying why? why have you done this? It does wear you down a bit – like can you not just say good on ya!'*

5.7.3 Becoming a different person

Unlike the previous two years, there appears to be a significance and profundity to the changes that their experience and learning has brought to how they view their life and identity *beyond* their work, career and the university experience.

> *FG3 'You feel a different person as in professionally, if you are out with your friends who aren't doing a nursing course you just, I don't know, you are completely different to them now'*

The change has significant implications for the individual student and also appears to be generated from several different sources. Some recognise their behaviour change as a response to the professional responsibilities and the public expectation of registered nurses and feel they ought to behave accordingly.

> *FG2 '... I don't drink as much or go out as much or if I do go somewhere I think I... not professional but I am more wary of what I look like to other people because people might know I'm a nurse'*

> *Int1 'I can't get drunk anymore and that's more to do with something I saw while on placement - that is as well as I'm a professional - it kinda affected me because I only realised after the fact I was on a particular ward and a man had fallen hit is head - basically waiting for him to die all because he had a drink and it really resonated'*

Others see their learning as a more observant and finely tuned view of their world. The potential ramifications of behaviours are clearer, having witnessed the results of behaviours whilst in a professional capacity as a student nurse. Whilst appearing to generally consider this a positive change in identity, there is also an undercurrent of sadness or regret in some of the comments.

The implication is of a growing gravity and more mature approach, but also of a loss of innocence and fun.

> *FG1* *'I watch what's going on around me more – I am aware of what is around me and I'm a lot more observant of little things – like if they keep doing this then this might happen'*

> *FG1* *'It has not kept me like the fun, bubbly person I used to be – I am very professional now even when I'm at home and I see things in a different light. .... I read into things a lot more deeper which I wouldn't have done necessarily'*

Similarly the impact on family of this new identity is viewed with some ambivalence. This is prompted by an acknowledgement of the commitment required to achieve their career aspirations as a registered nurse and the sacrifices that this necessitates, whilst also recognising that some of the changes have been so fundamental that the way they are viewed by others will probably never be the same.

> *FG3* *'Your family definitely suffer and your friends say 'she is boring she never comes out' .... but if you do go out the conversation is different as well'*

> *Int1* *'I'm not seen as a silly niece anymore'*

Others view this change in a slightly more humorous way, whilst still recognising its significance:

> *FG3* *'In your first year all your family and friends don't expect you to know much - and now you are a neurosurgeon (laughs) They think you are a miracle worker and you can fix them'*

> *FG2* *'Yes you do change but there are only certain times you notice it - and it is normally when you are talking to people who aren't in the nursing profession - and they are sat there looking at you like 'what are you on about?' Or when you are eating and you talk about something and everyone just runs to be sick'*

> *FG1* *'stool talk over the table is not nice apparently ... I do it all the time when we are eating talking about poo, wee and sick and circumcision – and they are all like shuruuuuup!'*

> *Int2* *'Yes I go round to my boyfriends and it is what have you done today and I say well I put this catheter in and he says 'I don't want to know any more''*

These comments are further evidence of the significant shift in identity experienced by the third year students. They endeavour to understand the momentousness of the changes in their lives and although their comprehension of the changes may be occasionally less than well-defined and understandably lacking in precision; the intensity and profundity of the shift is recognised and cannot be disregarded.

5.7.4 Overview

A comprehensive and wide-ranging thematic analysis of the entire set of data from the focus groups and interviews of each of the three years highlighted both shared experiences and commonalities and yet significant variances as the students grappled with their new realities and attempted to come to terms with their shifting identities and their ever changing relationships with members of the many communities of practice that they came in contact with.

All students appear to wrestle with gaining real clarity in their role as a student - and although the attitude and behaviours of others may change towards them this does not result in clarity and consistency or characterisation of 'the student role'. However as their experiences increase they recognise more and more the specific and unique nature of nursing practice and what it means to be a nurse. Moreover there is also commonality in the idea that the current student groups are in some way a 'new breed' who represent the values and priorities required in the future and who carry with them the responsibility to improve practice not allow a repetition of the failings - apparent and real - of the previous generations of nurses. Their relationship with 'old timers' can be challenging and problematic throughout the three years for a set of complex reasons that shall be further analysed in the next chapter. A similar challenging relationship consistent throughout the data is the dissonance felt between their experiences at university and their involvement in clinical practice.

The main themes generated from the data shall now be further explored in the next chapter.

Chapter Six: Themes

6.1 Introduction

This chapter provides a further overview, discussion and analysis of the major themes generated from the data produced during the focus groups and interviews with students from each of the three years of the undergraduate BSc adult nursing programme. These three major themes were generated following an examination and analysis of the broader narratives of the participants as explored in the previous chapter.

Braun and Clarke (2013, p.201) suggest that an 'analytic sensibility' is essential to produce insights into any meanings in the data that might link to broader theoretical considerations. As discussed in the Methodology and Methods chapter this approach generated a recognition of the key overarching themes that most clearly articulated meaning for the students as they experienced their shifts in identity and progressed through the programme.

The main themes engendered by such an immersion in the data were:

4) Becoming a nurse
5) Engagement with old timers
6) The University - Practice Dissonance

The analysis and discussion of these key themes will offer the reader insight into how the students fundamentally change as a person, how their very being changes and how they literally become a different individual. It will also show how theoretically the data shows that this shift happens as a result of *participation* in the communities of practice of which they are a part. The themes highlight how the students do not simply shift in their identity by the accretion of knowledge - although this is part of their experience - they do not simply know how to dress a wound or take a temperature, for example, although these might well be examples of their increasing clinical skill set and expertise. They change fundamentally as a person; their being changes, their relationships change, they may even think they are becoming a little boring, however, they also recognise that significant people have greater respect for them. Although this may happen quite slowly, theoretically – as articulated by Lave and Wenger (1991) - this can be shown to be due to participation in communities of practice. Year one students highlight that this is not necessarily the case for them, however greater participation ensures that they become a changed individual, a person with greater expertise - a *professional nurse.*

The themes are contained, discrete and unique however they also, unsurprisingly, overlap and despite their specificity and precision also include commonalities as they explore what it means to become a nurse. All of the themes offer some insight into what nursing identity is and how that shifts, how individual nursing students acquire so much but also have to let some things go, and how this influences the power imbalance between the students and others. Any power imbalance may initially be in favour of the registered nurses or 'old timers' who are already established within communities of clinical practice - they literally have power over the students - however the students who are spending significant time in the university context come to recognise that they may have what might be defined as *intellectual power* over those existing nurses. This shift in identity highlights a potential for discontinuity in relationships between the students and the 'old timers' and more specifically, on occasions, their mentors and others with a key role in their learning. The data therefore also indicates a legitimate *problematisation* of much of the 'apprenticeship' literature, not least the seminal work of Lave and Wenger (Lave & Wenger, 1991).

Therefore by the end of this chapter the reader will have an appreciation that the depth and breadth of the data generated and the narratives recounted in the thesis not only represent the positive aspects of change for the students as they become more critical reflective practitioners and gain significant professional expertise; it also highlights the substantial challenges they face and thereby represents, faithfully and ethically, the truth of the participants.

Before moving on to the discussion of the themes I will succinctly further clarify some of the concepts used throughout the thesis and also in the literature.

6.1.1 'Old timers' - appropriate terminology?

Lave and Wenger (1991) use the terms 'old timer' or 'master' to indicate experienced individuals engaged in social practice that have attained fuller participation in the practices of their community of practice via a trajectory from legitimate peripheral participation from their original position of newcomer. Originally I was sceptical of the appropriateness of the term to capture the role, position and importance of established staff in clinical practice in the experience and shifting identity of the students/newcomers. However as the research progressed this term became more and more applicable – not due to its use on some occasions by the participants themselves but also due to the recurring theme of the impact of age, time spent, experience and established practices as explored in almost all of the focus groups and subsequent interviews.

6.1.2 Apprenticeships - clarification of the concept

As Lave and Wenger (1991) suggest there can be a lack of certainty about the term 'apprenticeship' with it occasionally being offered as a panacea for a broad spectrum of issues in 'learning-research' (Lave & Wenger, 1991 p.30). 'Apprenticeships' in nursing have quite a long history and degree apprenticeships have returned to the forefront recently as part of the strategy to meet the current shortfall in the nursing workforce, to create greater flexibility in the routes to professional registration and to attempt to engage with the current unregistered healthcare workforce in the creation of a more motivating and flexible career pathway (Department of Health & Social Care, 2016). It is claimed that the nursing degree apprenticeship route offers flexibility to the learner as they are not required to study at university full-time, although apprentices will still need to undertake academic study at degree level and meet the standards laid down by the NMC.

Presently there are also several different roles within healthcare - some new and others better established - that utilise an 'apprenticeship' model, these include nursing associate, healthcare science associate, peri-operative support worker amongst others. It is therefore even more critical to ensure clarity when utilising the nomenclature 'apprenticeship' within this research especially as the *degree* nurse apprenticeship has become such a recent high profile initiative having been finally ratified by the NMC. Previously the apprenticeship related to nursing had been offered only at intermediate, advanced or higher apprenticeship levels and, although they may have facilitated access to a professionally validated course, they did not of themselves result in professional registration with the NMC and thereby allow apprentices to take on the role of a registered nurse. The first NMC validated nurse degree apprenticeship are planned to commence in September 2018.

However the traditional nursing degree route includes characteristics common with an apprenticeship philosophy and it is these features that prompted me to utilise the terminology of 'apprenticeship' or 'apprenticeship type' education and training. Essentially apprenticeships combine work and study and mix what is often called 'on-the-job' training with 'classroom learning'. The training programmes are structured to help the learner gain the skills and knowledge needed to succeed in the chosen area and provide experience in the 'working world'. In theory this context promotes greater opportunities to learn skills and competencies appropriate to practice and helps the learner gain confidence in the specialised working environment and guarantees a greater fitness for purpose.

In this way the traditional nursing degree course mirrors several of the key principles of apprenticeships, not least, as the courses are designed to provide organised and co-ordinated learning activities largely in practice learning environments. 50% of the education and training of nursing students takes place in NMC assessed and quality assured practice placements and 'in order to gain approval with the NMC, universities and their practice placement and work based learning partners must meet all standards relevant to the programme they seek to deliver' (Nursing & Midwifery Council, 2018).

Practice is therefore an essential part of the nursing students' experience. The choice of the terminology 'apprenticeships' is also appropriate as it is supported by Lave and Wenger (1991) and their concept of situated learning which emphasises the relationship between learning and the social situation in which it occurs. As I have described throughout the thesis, social co-participation and collective engagement provide the context for learning and the development and identity formation of students occurs through participation in a social setting whereby they reflect, interpret and negotiate with other participants in a specific community. The idea of student nurses learning as *legitimate peripheral participants in the various communities of practice, as described by Lave and Wenger (1991),* was persuasive as framework to further explore their experiences and shifts in identity. It is in this context that the term 'apprenticeship' is used throughout this chapter and the thesis in general rather than the prescribed and structured as articulated in the new nursing degree apprenticeships.

6.2 Theme One: Becoming a nurse.

This theme explores the participants understanding of 'what it means to become a nurse'. It is an exploration of the process of change and an explanation of the meaning of change. It is an analysis of how the students' experience such change from their initial arrival at university as inexpert neophytes with limited understanding of nursing; up until the third year when they are ready to be recognised as a nurse who has been assessed to have the skills, knowledge and experience deemed appropriate for professional registration.

This is again presented with sub-headings to assist comprehension and readability whilst also highlighting and confirming the complexity of the main themes generated from the data.

One of the main aims of this research was exploring how participation in an undergraduate nursing degree shifted new students from knowing little or nothing about 'being a nurse' and having little identity around nursing, caring and healthcare generally, to a situation where they had become individuals who could make claim to the title 'nurse'; and who could legitimately exist and operate in the professional setting. Therefore in this chapter I examine the evidence of how the students become nurses and explore their understandings as they shift over time as a result of their participation in the various contexts of student nurses' experience.

To be deemed successful and appropriate, the educational provision designed to support the development of nursing students, unlike some other education courses offered at Universities, has a very specific aim - that *ALL* students are 'turned into nurses'. The students themselves recognise this uniqueness:

> YR3 Int1 *'...it's like we are not even in the full university. We are in the university but we are also in the School of Health ... we are nurses that is it - we cannot get involved when the university puts on things for 'normal students'. I know that because I was a 'normal student' here. So it's not only university and placements that don't match up, it is university and university, we are very much alone. I've never mixed with anybody other than School of Health students'*

> YR2 FG2 *'I don't think we are the same as other students being a student nurse, they don't have to go off on placement for example. It's pretty hard to be honest'*

Therefore, due to this unique, shared aim it is unsurprising that there is some commonalty to the students' experience and consequently associated commonality in how students change and shift their identity. There is a cohesion and unity in how the individuals view themselves as they pass through the participation of years one, two and three and how, psychologically they come to think of themselves as different people.

6.2.1 Becoming a Nurse - The First Year Students Experience

When first year student nurses talk about what they think nursing is they evidence some understanding of what it means to 'be a nurse', however this is expressed with uncertainty, lack of real clarity and a recognition that their understanding might be simple and not congruent with 'reality':

> *FG2 '...there is no proper - this is your role - as a student nurse. I remember I got asked it in my interview and I was like 'yes you are just there to be like a bit of a nurse's apprentice' - and it is like no you are not!'*

> *FG3 'If on my first day as a student nurse.... someone said 'you are doing nursing - what is that about?' - I'm not sure I really had a view of what it was all about.....'*

> *FG2 'Yeah....patient care - looking after a patient helping to get them better is what I had in my head - but what that meant, what that actually entails is too wide of a range to even pinpoint.'*

> *Int1 '...they went on a lot about holistic care and whatnot and I kind of grasp what they were saying but I didn't really understand how it would fit in...'*

Early in their experience the students are surprised and challenged by what nursing appears to be, even if they had previous caring experience and initially believed they were thereby well prepared to progress:

> *FG1 CB 'Yeah seeing what some of them do – like nurse consultants – I always think ... I won't be doing that'.*

> *FG1 DE '...the responsibility... that's a real eye opener. It is immense'*

Similarly the expectations of some of the staff they meet early in clinical practice causes confusion as there appears to be an expectation that even at this early stage in their career the students should already have a genuine and authentic insight into what 'being a nurse' means:

> *FG2 'yeah...it is hard to make a decision because they will say like 'as a nurse what would you do?' - and you are like but I'm not. I'm a first-year first placement! That is all I have said all placement 'I'm first-year first placement - I'm first-year first placement'. And I think it is not up to me to make that decision but I am supposed to act like a nurse and I **would** make that decision - so do you make it or not? I found it really hard to find my place'*

> *FG1 NB 'Expectations of ya just vary hugely like…'*

> *SW 'And some of them expect far too much of a first year student nurse.'*

6.2.2 Becoming a Nurse - The Second Year Students' Experience

By the second year the students' experience has required them to reflect and think again. Their experience has challenged their assumptions and much of their involvement has been

significantly different than their expectations. Whilst not all students are yet totally clear about their role:

> *Int1* '*You don't always know who you are do you? When you are a student nurse*'

Due to the participation, experience and challenge their understandings have, however, become deeper and more nuanced and more *real*:

> *FG1* '*when I first got to placement it was like do the obs da da da and after a few weeks it was like right okay I need to really know what these mean. I know we have the lectures but like what is the next step to take.....*'

> *FG2* '*I suppose it is the accountability and the assessment of the patient changes .....the nurse will create a care plan and the other staff will follow it through*'

> *Int2* '*it is the making decisions I think isn't it?*'

> '*Yes it is about deciding what to do with that care plan. Does it need updating et cetera or things like that*'

They are also slowly beginning to recognise their learning and how their increased knowledge was not only causing a shift in how they viewed themselves as an individual, but also how relationships with those around them were also changing:

> *FG1* '*I shock myself sometimes with what I know - you think you don't know it and then you have a conversation and you realise you are using all the terminology of these words and you think oh my God where has that come from?*'

> *Int1* '*when I am sat in the lectures and we talk about things I think.. 'I know what that is' - so I then think I actually know more than I think I know.*'

> *Int3* '*I feel that I have learnt a lot and I have really grown from the person that I was when I first started. Like confidence-wise. Like I've been able to talk to people that I wouldn't even consider, that getting along especially with the nurses who are a lot older than me, getting along with them and being part of a team*'

The theme of age in the data and its potential influence on the learning experience of students will be further discussed in other themes.

The students have had opportunity to reflect on their presumptions and previous expectations and how participation has made them able to appreciate how they and others may have misunderstood what the requirements and needs of a first year student were:

> *Int3* '*I think some people get a bit of ahead of themselves and they want to be doing things like medications on the first day and things like that and taking out drains and all this, whereas really you need to get the basics right first*'

> *Int1* '*As a second year now - when you ask about things they are not like 'oh you are only a first year you don't need to know about that' - I got a lot of that in my first year. I don't think I gave a medication in my first year and in the second year I have done them every day - I*

was always worried that I was behind everybody but looking back I shouldn't have been worried I should have just got on with it.'

Such challenges to the students' initial assumptions and the changing expectations and relationships of others also made them reflect on some more negative connotations and less positive experiences:

> *FG1 'there is an expectation isn't there when you are on placements that you can do things **just because** you are a second year'*
>
> *FG2 'I found that in my first year I had bags of confidence and er.. I suppose you are a little bit babied in the first year'*
>
> *FG3 'I also find the difference from first year and this year has been staggering I have found it really overwhelming'*

Not only were the expectations of colleagues in clinical practice changing, the students also realised that the academic expectations were also increasing due to their shifting position:

> *Int1 'well I think the step up from the first year is massive - it's like with the academic work. In the first year they give us like a structure to our essays - they would say this is your introduction, this is the background, history whatever and go through each paragraph and this year people are asking for the assignment guidance or asking what they need to write and they are like 'well just write your essay'.'*

However many students also recognised their experience had created legitimate and genuine confidence in their knowledge and abilities and capacity to cope:

> *FG1 'When you go on a new placement I know we are still always new but you kind of turn up and think I'll be all right...'*

Legitimate self-confidence also furnished them with a resilience and a willingness to stand up to others who might confront their practice:

> *Int3 'Erm I don't know... I wouldn't back down to anybody now - if I am hard faced then that's where it is. If I'm doing something and there is reason behind why am doing it I will do it. I think that is a second-year thing I never did it in the first year and I think it is definitely crept in in the second year'*
>
> *Int2 'I get that a lot. 'You need to toughen up a bit' but I don't want to, I don't think I have to do to be a good nurse – so I won't (laughs)'*

It is clear from the data therefore that although there are understandable commonalities in the experience of first and second year students - there are undeniable differences as experience and their participation in practice in particular shifts their identity.

6.2.3 Becoming a Nurse - The Third Year Students' Experience

By the time they have reached the third year, students speak of their increased knowledge, insight and recognition of role and the increased confidence that this engenders:

> *Int2 'I like the fact that from first year up to now we have a lot more knowledge to do the right thing. For a patient to say 'yes you have really helped me today' - cos you know more and your skills are more profound and better. I really enjoyed that aspect of development'*

> *FG1 '...Now you become not exactly part of the team but more of a member - not a qualified part obviously - but they know you are there and capable and you are given more responsibilities'*

> *Int1 '... I didn't even know how to bath a patient I was petrified of hurting somebody but now it is just second nature ...I feel more confident when I go to a ward that I can go and talk to anybody... that's how I feel after the 3 years... I do feel more confident...'*

> *FG4 A 'Its confidence. We have grown in ourselves haven't we? I know when I was a first year I was quite immature to how I am now and I have really grown up.' B 'Yes confident.... knowledge... the knowledge feels ingrained now, you know it'*

> *FG3 'It's like the 6 Cs how they always bang on about it that is what they say about courage I have the Courage like to say I don't know or I'm unsure or can you help me with this but in first year I felt a bit stupid and I daren't ask.'*

They are now acutely aware of the different position they hold within the various teams and communities in which they are participants. The views of others have changed towards them as individuals by the very nature of them being third year students and the expertise and knowledge that their previous and ongoing participation is assumed to bring:

> *Int1 '... the day I was taking charge of the full side she (mentor) said 'what are we doing now Boss, what are we doing now Boss' and I thought 'thank you' because she was seeing that that was what she had to do - then everybody else actually did what I asked them to do.....it was like (loud laughter).... 'Yeah I am in charge'.*

> *FG1 'I was initially looked at like I was fresh out of college and didn't have a clue about care or what care was about - I was given like - not skivvy jobs but it felt like I weren't trusted to do anything - I had to watch them make a bed. I'm like, OMG I make beds every day of my life.....but now they trust me more and give me stuff to do.'*

They often retain an empathy for the more junior students who they recognise are experiencing the same challenging and difficult issues that they themselves did:

> *Int2 'From being like a second year, third year you look to students who are first years and think like 'go on do it'. I'm very encouraging but I can imagine some people are a bit lost and lonely so I tell them just be willing.'*

> *FG2 'What I would say to somebody who was just going into nursing is - on their placements be proactive don't let 'I'm too busy'- 'we haven't got time for that we'll do it tomorrow' put them off'*

Int3 '*When you go on placement if they ask you 'do you want to do this' or 'do you want to do that' just say yes to everything - that sounds silly but whatever - just say yes to everything.... because you end up having a whale of a time*'

The realisation of difference and their change and shift in identity, whilst recognising and appreciating their position as 'third year students', can also bring nervousness, concern and apprehension. However this is invariably qualified - on personal reflection or by reassurance from other students - by their feelings of a genuine preparedness for professional registration:

Int2 '*you come back after two weeks off and...all of the staff had changed and I'm going to be in blue and it is all - my God panic – **but you get there and it is fine**.*'

FG1 A '*...when you start third year you want to get it over and done with. But now the third year is coming to an end it's like 'oh dear what have I been doing?' - In X months time I am going to be accountable and responsible and if somebody 'goes off' I have to at least recognise that someone is going off and do the necessary assessment*'

B: '*But you will be won't you? Because you know.*'

C: '*Technically you know cos it comes second nature*'

A: '*Yes it does come second nature I suppose but it's the fear of actually saying 'these are my patients*'

Int2 '*It's like you have the practical skills like doing your driving, you pass your test you think yeah I can drive. You get in the car for the first time with no one sitting beside you and you think what do I do? You go 5 mph up a road and you think I've got to stop... and it's the same principle for the nursing. Everything is there; we know we know what we are doing but actually....*'

The data again indicates that experience and participation promote a significant shift in the identity of the third year students. Whilst development is complex and nuanced and also non-linear and in some ways inconsistent, it is recognised by both the students and also those with whom they have contact. A greater confidence in their legitimate role within the communities of practice is evident by the third year - although not always constant, universal and occasionally still challenged both by themselves and by others. This confidence replaces the overriding impression of a naivety that pervades the experience of the first year students.

6.2.4 Initial Rationale for Career Choice / Reasons not to take up nursing

It has been argued that this original naivety is further emphasised and accentuated by the backgrounds, experiences and career expectations of those who choose to take up nursing as a career in the first place.

Exploration and analysis of the data and the experiences of the students *across all three years* offers significant contribution to our understanding of how and why someone chooses to become a nurse. It is clear that initially the students evidence a somewhat unsophisticated and

genuinely inexpert understanding of nursing, related in several ways to their initial rationale for wanting to be a nurse. An exploration of the literature confirms a relatively consistent but complex and somewhat varied set of reasons and motives why people choose nursing as a potential career.

Frequently expressed reasons for nursing as a career choice include altruism, a desire to help people and a belief that such a career would allow them 'to make a difference' (McKenna, Brooks & Vanderheide, 2017; Wu, Low, Tan, Lopez & Liaw, 2015). Eley, Eley, Bertello and Rogers-Clark (2012) indicate that both their qualitative and quantitative findings suggested that the prime motivation for entering nursing was the opportunity to care for others and that the two dominant themes identified from participant interviews about reasons for entering nursing were 'opportunity for caring' and 'my vocation in life'. These two main motivators are consistent with much of the literature and yet both indicate a potential for uncertainty for those that have chosen to become student nurses. For example, Price, McGillis Hall, Angus and Peter (2013) claim the decision of some to enter the nursing profession was initially contextualised by a traditional, stereotypical and 'one dimensional' understanding of nursing as a *virtuous* profession: altruistic, noble, caring and compassionate. An understanding which they claimed could be ultimately dissatisfying to current and future generations of nurses who have many career choices open to them. Interestingly some students in this research mirror similar terminology to describe their experiences:

> *Yr1 FG4* '*...on placement you rely so much on your mentor - the **virtues** that they have*'

> *Yr3 FG1* '*you say I'm training to be a nurse and people say 'oh really?' - When you think of a nurse you think stuff like that - how it's a **noble** job to do isn't it?*'

There also remains a characteristic in many students of 'always wanting to be a nurse' (Irwe & Rudman. 2012) or that nursing simply 'runs in the family' (ten Hoeve et al., 2017):

> *Yr2 Int3* '*My mum never did the degree... And if I could turn out to be half of what she is I will be happy. And she has worked in nursing for the past 30 odd years and she loves it as much today as she did when she was a student*'

As well as being a chance to help and care for others, a career in nursing can also be chosen for quite pragmatic and self-serving reasons. Nursing can be perceived, for example, as an opportunity to enter further education and also provide relative security of employment (Wilkes, Cowin & Johnson, 2015). However this must also be viewed in the context that nursing, despite its apparent job security, is still seen to be an unpopular choice among some school students; especially those who are viewed as high academic achievers. There remains a

general perception that these students could achieve something *better* than nursing; with nursing viewed as an acceptable career choice only for school students who are not high academic achievers (Neilson & Jones, 2012). Students who are high academic achievers appear not to be encouraged to enter nursing by their significant others - parents, teachers, careers advisers amongst others - who could all influence the students' career choice (Raymond, James, Jacob & Lyons, 2018; Neilson & Jones, 2012):

> Yr1 FG1 *'a lot of people say only thick people care but that's just not true you know'*

> Yr1 FG4 *'It's like when I was 18 you sort of went to be a nurse if you didn't know what to do..... It wasn't academic, you learnt how to wash a patient kind of thing and that's it. ..... Whereas really it's about professionalism as well. Same as being a lawyer - more of a credible career.'*

6.2.5 Generational differences in their view of nursing as a career?

Nurses may also be seen by some young people as having limited autonomy, being inferior to Doctors and having to contend with relatively poor working conditions (Glerean, Hupli, Talmna & Haavisto, 2017). Nursing can be associated with weakness, powerlessness, dependence and lacking in knowledge by some members of the general public (Neilson & Lauder, 2008). Moreover a mixed method systematic review of thirty-three studies by Stevanin, Palese, Bressan and Kvist (2018) indicated a difference in the characteristics often assigned to different 'nursing generations' with so-called *baby boomers* reporting lower levels of stress and burnout and workplace well-being; yet a greater intention to leave the profession than so called *Generation X and Y* nurses.

These issues are mirrored in the experiences of some of the students in this research:

> Yr1 FG4 *'There were 2 students before I got there but by the time I had come back they had had Christmas break and one had dropped out and she was 18 too and they said it was her age and I thought - no its not! But it probably is...... I must admit Sunday nights were hard thinking 'I don't want to get up in the morning' but you have got to keep going'*

> Yr1 FG3 *'the more life experience you get the more confident in being able to speak out you get to say 'it isn't working for me'. With respect H is 18... oh 19 sorry - now I wouldn't expect her to have as much confidence as say S.... to have the confidence to stand up and speak out.'*

> H: *'I'm learning it was one of my big weaknesses I don't ever speak up I just get on with it.'*

> Yr3 Int2 *'I think younger nurses get more stick... because they just think she's only bit of a kid... they think that they can overrule young nurses because they have been there that long'*

6.2.6 Developing Resilience

Therefore as the students' experience progresses there is a confirmation that not all aspects of 'being a nurse' are as they expected. Certain facets of their experience and participation sustain them whereas others challenge their desire to stay and confront their initial assumptions of their chosen career.

Even in year one many students are already very aware of the need for resilience, yet they address the stress and concerns that clinical practice can generate with openness, realism and resolve:

> *Yr1 FG3.* A '*Yeah I think the two things that you definitely need are a massive positive attitude and a really hard shell'.*
>
> B '*You do need to be thick-skinned don't you?'*
>
> *Yr1 Int3* '*You would crumble. There are some days that are just horrendous and you know everyone knows that. But you know the other day is going to be great - so if you don't have that positive outlook and that energy I don't think you would survive really'*
>
> *Yr1 FG1* '*But it's depending on the placement and how well you fit in and how well they accept you …. if you get on with them you feel like you can ask 'Oh I am just being a bit blonde here but can I just ask a question?' where if you don't fit in with the team you won't ask anything'*

This is also a source of reflection for more experienced students too:

> *Yr3 FG2* '*then you get a patient that comes in that has taken an overdose of paracetamol cos her boyfriend is in a coma after a big fight - and you are 'right this doesn't happen surely this doesn't happen.' But it does and it opens your eyes - It was a shock but now you build up a bit of resilience... I'm less in shock now compared to how I was - minor things shocked me.'*

6.2.7 The Changing Views of the Public and the Francis Report

As their career progresses they also realise that their originally naïve beliefs in the public's view of nursing and nurses can also be challenged:

> *Yr1 FG1* '*yes and it's like 'oh you nurses are a bad lot you are not getting your wage rises' - all of those social things and things that they hear in the news it's a daily impact on everybody'*

Even by year three this can still surprise:

> *Yr3 FG2.* '*When you first come you think you are going to be a nurse, squeaky clean and shiny and everybody loves nurses they all trust nurses and you get out on your first placement and everybody dislikes nurses and nobody trusts you - so what am I doing?...(laughs)'*
>
> *Yr3 Int1* '*I was doing an assignment and read something about the most trusted professions - and nurses used to be third and now they are ninth or something all because of say the hospital scandals and lack of communication. And what nurses have to do to them I suppose - you are not going to be liked if you are giving a massive enema are you (laughs)'*

During the time this research was undertaken the impact, ramifications and implications of the Francis Report (Francis, 2013) on the whole of the NHS were still being examined and deliberated. The seismic effect of the Report and the reflection, self-examination and self-analysis that it generated within the Health Service in the UK, the various health professions - not least nursing - and in the main stream media and wider society in general was occurring at the same time that the students were progressing through their academic and practice careers.

The Francis Report felt the need to explicitly reaffirm nurses' need to commit to compassionate and considerate patient care and emphasise the practical hands-on training and experience as a pre-requisite to entry into the nursing profession (Francis Report Executive Summary, 2013). Moreover the Report also confirmed that recruits to the nursing profession needed 'possession of the appropriate values, attitudes and behaviours' - and the 'ability and motivation to enable them to put the welfare of others above their own interests' (Recommendation 185). This was to be in some way assessed by an aptitude test created by the NMC and universities together.

Furthermore in The Shape of Caring review (Raising the Bar) (Health Education England, 2015) Lord Willis expressed his disappointment that the issues that he felt were most pressing in his initial Commission Report three years earlier were still widespread (Willis, 2012). The main problem areas that the Report highlighted as lacking for the future nursing workforce were the development and maintenance of high quality mentorship - as mentorship was not necessarily seen as 'badge of honour' (p.46) and the improvement of practical learning experiences. Students needed to feel that the culture and environment of the clinical placement respected and acknowledged their views and acted upon them where necessary. Willis reiterated Francis' observation that students and trainees were 'invaluable eyes and ears' in clinical settings and should therefore be encouraged to ask questions and be inspired by their colleagues to act with honesty, integrity and compassion.

These professional debates and other wider societal events inevitably impacted on the students' understanding of what it means to be a nurse. As Lave and Wenger's (1991) theory indicates, all communities of practice are inextricably part of wider communities and individual's identities are therefore inevitably reflected in that, as participation is never in isolation.

6.2.8 Negative view of nursing by nurses themselves

Students also recognise that they have to overcome the rather negative view of nursing that they frequently hear from their registered nurse colleagues:

Yr1 FG4 *'people that work there weren't particularly happy. Whenever I asked someone 'do you enjoy it?' - They say 'it's convenient - it's a job' 'I don't have to work weekends and nights' and I was surprised and saying what are you doing here then... it annoyed me - almost saying cos it's convenient ... and a lot wanted to get out of there and retire or they have young kids that was the main two types of people that worked there and it was quite bad....'*

Yr2 Int2 *'They have probably passed everything, gone to work and then that's it... so they might see it as a dead-end job because they don't want to progress or whatever'*

Yr2 Int3 *'A lot of nurses tried to talk me out of becoming a student nurse - what you doing that for? Just don't do it. They would actually sit with me on a break and try to plead with me 'don't do it, don't do it you are making a big mistake' but I never let it get to me because I've got nurses in the family ... and I just think it is sad'*

Yr3 Int2 *'you talk to your mentor and others...you never have them say 'what you are doing is of real value' - most people say to you 'you will learn nothing at Uni, you will only learn when you get a job'. You either get that ....or stop now 'just stop! Turn round and quit!''*

Yet again the students can find themselves attempting to participate and learn in an environment of limited support, challenging interactions and lack of sympathetic relationships.

6.2.9 The changing views of those around them

Despite this challenging context, by the third year there was a growing recognition that their knowledge and practical insight is deemed as valuable to those around them and as their expertise grew and they became a proficient professional. They become aware that being the person with knowledge and expertise in a community is a powerful thing and can make them feel very positive:

Yr3 Int1 *'The thing I found that has changed most is that they are more proud of me than ever .... I am more confident and seen by people as more knowledgeable ... I have changed, I am more responsible I do feel that I can be responsible for people whereas once upon a time I wouldn't be able to be'.*

Yr3 FG3 A *'.... the changing expectations of others going from first to third year. In first year all your family and friends don't expect you to know much and now they say 'oh you know what that bone is' - now they think you are a neuro surgeon'*

B *'Doctor of everything, yeah.'* (Laughs)

Yr3 FG2 *'...Er I don't have a stash of antibiotics in my cupboard! They think you are like a miracle worker and you can fix them.'*

However their reflections are nuanced as their experiences are not all positive. Professionally they are starting to adopt the manacle of the 'expert'. This shift in their understanding and the related change in themselves as a person means they also have to 'leave things behind'. Being a professional pervades their whole life and their understandings of this are often expressed in a rather mournful way:

Yr3 FG2 *'I've got some negatives as well I think. Relationships. They need building back up again. Lots of time has been taken away and I can see what's happening now to my kids. I*

need to work on them and can see the end, the light is there and there will be the time to make up'

Yr3 Int2 'My kids don't shout mum anymore they shout for their Dad!'

The recognition that it means something specific to be a professional changes their understanding. To be a nurse they must behave in certain ways and therefore cannot behave how they want or more specifically how they used to want.

> *Yr3 FG1 'Now I don't drink and I don't go in town. I watch what is going on around me like I am aware of what is around me and I think if they keep doing that then this might happen....that is because of the nursing background'.*

> *Yr3 FG3 'yeah we have always been told it is not just a job you have to be professional all the time it's the reputation of the NHS type thing. You can't go out getting drunk and post it all on Facebook.'*

6.2.10 The importance of supportive relationships

The students' experience is echoed in the qualitative research by ten Hoeve et al (2017), which confirmed that students who enter nursing with many dreams and hopes which involve being supported to care for people and the opportunity to deliver excellent care, can quickly become disappointed and despondent - which often results in a consideration to leave their studies. This is most often related to lack of support from their mentors and others in the team. Being welcomed and working in a supportive team with sympathetic relationships and supportive management sustains students in their progression far more than any other consideration - such as specific nursing specialty or specialist clinical environment for example (Wade, et al., 2008). As Perry, Lamont, Brunero, Gallagher and Duffield (2015) indicated in their systematic review, participation in a supportive and favourable clinical learning environment is influential, both in encouraging nursing students to remain in the placement organisation or Trust once their training has been completed, and also to remain in the nursing profession long term. Much of the literature confirms the importance and significance of student assimilation and engagement in enhancing the clinical practice learning experience (van der Riet, Levett-Jones & Courtney-Pratt, 2018; Grobecker, 2016; Smedley & Morey, 2009). Levett-Jones and Lathlean (2008) for example highlight how the recurring concept of 'belongingness' was so important to the students interviewees if they were to fully grasp learning opportunities in clinical practice. The importance of feelings of belongingness in the clinical area and an enthusiasm for teaching from the mentors is also confirmed by Jack et al. (2018) in a survey and interviews of student nurses at universities in the North of England. The willingness of staff to support students, collaboration and collegiality were also highlighted as vital tenets of a culture and an environment that positively impacts on the clinical experiences for student nurses by

Hegenberth, Rawe, Murray, Arnaert and Chambers-Evans (2015) in their focus group interviews with nurse managers. Whereas clinical environments characterised by inappropriate interactions or inadequate communication can be perceived as the 'tipping point' for students to decide not to continue on their nursing programme (Hamshire et al., 2013).

> *Yr1 FG3* *'so my whole idea of it just changed. I don't think I really knew what to expect - although my sister has done her nursing and she said 'you know it is really full on' so I was like 'yeah but I know I need to do it'....after being at Uni I felt 'this is great - loads of support – I'm learning everything' and then going to placement and I just thought 'I didn't think that my biggest challenge would be people' - particularly as I think I am a people person – I could have just left to be honest'*

Similar issues of the importance of supportive relationships shall be discussed further in subsequent themes.

6.2.11 Conclusion

This theme highlights how the students' understanding of nursing shifts as their participation grows. In a context of considerable change and uncertainty the students' progression and shift in identity is evidenced by their reflections, insights, appropriately increasing confidence, knowledge and abilities and the increased respect and regard of others. The growing adoption of the role of expert helps fulfil their initial aspirations and dreams but comes with challenges and occasionally sombre considerations of loss and necessary change and adaptation.

6.3 Theme Two - Engagement with 'Old Timers'

The data supported by the literature (van der Riet et al., 2018; Grobecker, 2016; Stacey et al., 2015), indicate that the relationship between the student and those who are already established within the nursing profession is crucial to their participation, learning, development and their shift in identity. Therefore the purpose of this theme is an exploration of that relationship. It would appear that much of the literature reports apprenticeship-type learning as largely unproblematic. It can be tempting to consider such approaches as a panacea as a delivery tool for relevant knowledge and skills. The assumption is that the students participation in a setting of experienced colleagues or old timers - in this case nurses - engenders the acquirement of certain knowledge and abilities through different processes over time due to the situation in which they find themselves. Within the exploration of this theme some of these assumptions will be challenged. Much of the data from the focus groups and interviews contests the norms expressed in some areas of the apprenticeship literature and indeed implied by documents such as The Francis Report (2013). Most specifically in Lave and Wenger's interpretation, for example, the learning stimulated by the apprenticeship relationship is viewed as relatively unproblematic. Although they do recognise - in their example of the apprenticeship of meat cutters - that not all cases are equally effective, especially when old timers act as 'pedagogical authoritarians' who simply view their learners as novices who should be merely 'instructed' rather than as potential partners or participants in learning (Lave & Wenger, 1991 p.76). As I shall describe, much of the data indicate that many of the students have a similar experience. Due to the well-established communities of practice and the values and behaviours of the old timers within these communities, learning appears to be viewed as essentially one dimensional rather than dynamic, continually adapting and changing with the newcomers being viewed as an invaluable source of knowledge and learning. The bi-directional aspect of learning that would welcome the novice students - as legitimate peripheral participants - and as a benefit and valuable to the community appears to be absent in the experience of many of the participants.

Therefore this theme can also be viewed as problematizing much of the apprenticeship literature.

6.3.1 Positive engagement with old timers

Undoubtedly the engagement with old timers can be positive, constructive and developmental. The context underpinning this relationship is that the student is learning from individuals who have, by definition, a certain level of experience. These are nurses, or other colleagues in the health care environment, who have 'been through it'. They have undertaken a level of training at some point in their career and have enhanced that with further clinical experience, often over many years. The students recognise this and value it both for the contribution to patient care but also to their own development and learning:

> *Yr2 FG1* *'you get to practice what you have learnt, we might have touched on something like - I don't know - how you breathe and your lungs and stuff. And then you go on placement and you might be on respiratory ward so that ends up going like 'oh yeah I actually get it now - now I can see it' - (general agreement) - and the nurses on the wards if it's a specialist ward they are amazing their knowledge is crazy good'*

> *Yr1 FG3* *'one of the best things was seeing everybody working towards the same thing - doctors and surgeons, the nurses, the domestics - they were just a great team and that's kind of reinforced my belief that I don't care really were you go you find everybody is essentially good'*

Moreover, as we shall further explore in the third theme, the importance of learning from clinical colleagues is frequently emphasised as essential to the students by their lecturers and those working within the university. This advice and insight is particularly pertinent to students in the initial stages of their experience who have yet to spend any time in clinical practice and are therefore unable to yet form their own personal opinions on the importance, priority or value of their future clinical experience.

6.3.2 Theory into Practice

The initial context for the student is that they are developing relationships with their lecturers at university, the priority being exploring and learning *theory*. They then attend their clinical placement where they need to invest in other new relationships in the context of an already established group or community of colleagues. In many ways this is a positive experience - indeed it is the fulfilment of why many students started the course in the first place:

> *Yr1 Fg4* *'All the academic side of it, I don't know how other people felt about it but being on placement secured the idea that I did want to be a student nurse'*

> *Yr1 Fg2* *'I got on placement and I thought 'yeah that's where I want to be' - the university sometimes is just book after book after book and then you get onto placement and it starts falling into place. You think 'no I can get through this' and so you want to be back at university to get those assignments done and passed because you know you want that job in the end'*

The complexity and fragility of the students' relationship with practice are clearly captured in this exchange in a focus group of year two students:

> *Yr2 FG3 A: 'the first two weeks of every placement I have absolutely hated - (general agreement 'oh I do' - 'so do I') - and yet by the end of it I love it I don't want to leave'*
>
> *B: 'Whereas I'm running out the door' (all laugh)*

The learning from experience and the uniqueness of such practical clinical experience articulates and represents the underpinning philosophy of many professions. Such relationships are at the heart of how a profession like nursing might view itself and are an integral part of the ethos of sustaining the values and principles of the profession (Nursing & Midwifery Council, 2018). It is a valid belief that a student could simply not become a nurse without these experiences and the support of those already established in the profession. Moreover it is a duty of those 'old timers' to take responsibility for the learning and development of the prospective nursing workforce and their future colleagues (Nursing & Midwifery Council, 2015). However the experience of those who are involved in endeavouring to enact this philosophy, is often less than positive and can be very problematic.

6.3.3 The students' impressions and relationship with 'role models'

One of the key challenges, according to the data, is that the students are almost universally confronted by a variable attitude to - at least what *the students* view as - support, quality care and good practice generally. The expectations of the students generated by their time in university, results in a questioning of their learning in many clinical environments. The students are forced to recognise that their advocated role models - the old timers - do not always view their responsibilities to students favourably, do not necessarily want the students with them in practice, and as described previously, have a very limited regard for nursing as a profession:

> *Yr1 Int3 'My mentor was an older person and she was like half retired and she wasn't really that interested she signed the boxes kind of thing and I think I worked about 5 shifts with her and that was it...I think maybe they get towards the end of the nursing career it is not very high on their list of priorities being a mentor.'*
>
> *Yr1 FG1 CB 'It's depending how they see students I think, if they find you an invaluable part of the team or just a hindrance to them.'*
>
> *SW 'I hate it. No matter how hard you try.... they won't accept you ... they just see you as 'the student''.*
>
> *CB... 'yeah yeah exactly...in my first placement I did try to become their friend first and I think there was a bit like whoa...with me sort of thing, so then that made me take a step back and I was a bit more quiet and withdrawn than I usually would be.'*

Similarly in year two:

> *Yr2 FG1* '*I think it alters* **some** *peoples attitude if they are a bit older and they are knackered....They are not necessarily a positive influence and it can drag you down a bit*'

> *Yr2 FG1* '*I've just had the one mentor and she was absolutely shocking but she hadn't done any education for about 20 years herself so it makes you wonder.*'

> *Yr2 FG3* '*I had two terrible mentors, absolutely terrible the first one was terrible because she was so lazy, she's in special measures now. It wasn't me somebody else told on her (laughs)... finally they did something about it. And then the second one was just the most horrific horrible person, everyone who knows her knows this, why did they make that person a mentor I don't know. But she has just been promoted to Sister which is excellent, so that's good for the patients er...*'

> *Yr2 FG3* '*Mine didn't even know my name on the second to last week she went Carol or something. I was like actually my name isn't Carol and I have been here for nearly three months (laughs)*'

Moreover even students in year three who, as we have seen, experienced colleagues sometimes view as having been 'reincarnated' as 'hot commodities' occasionally have similar experiences:

> *Yr3 FG3* '*...and you are really, really trying and maybe they just don't want you. Because sometimes they don't want students they just find students are in the way*'

> Yr3 Int3 '*So you're still on the periphery you are valued more because you can do more but you are still essentially a visitor*'

6.3.4 Students attempting to rationalise poor practice?

The students in each year recognise that they are often witness to practice that they believe does not replicate or reflect what they have been taught. They see practice that is not the highest quality, not based on current sound best evidence and therefore as they understand it, not the 'right way' to nurse. Often the students will endeavour to qualify their comments and indicate a reluctance to be too critical of their clinical colleagues:

> *Yr1 FG2* '*when the older ones have retired...that doesn't necessarily mean that they are the bad ones does it?*

> *Yr1 Int2* '*I don't think that it is their fault because if it was like that when they came in and it is not the job that they signed up to do ... why should they be expected to be doing all this when it is not the job that they signed up to?*'

> *Yr2 FG1* '*I think that the system is under quite a lot of demand - small teams working in the environment are limited to what they can do if they are short staffed, their caseloads are high with patients - but at the same time when you have got that right balance and you have got a good team where everybody is working it can and it does work - and then they have time for students and we can actually thrive in their environments*'

Yr3 FG4 '*it's not always their fault though is it?... my mentor had said to me enjoy this while you can because it will change when you qualify*'

6.3.5 'Culture of busyness'

Whilst recognising some of the challenges of the context of current health care and nursing and empathising with the pressures that their established colleagues face, occasionally the students struggle to understand and justify the priorities and behaviours of some of the old timers. In their systematic review of qualitative studies exploring work-based learning in health care organisations, Nevalainen, Lunkka and Suhonen (2018) highlight that work communities in such organisations often have a 'culture of busyness', which is demonstrated by the norms of practice of the old timers and also often learned and instilled early in a student's career. This is recognised by the students and created obstacles to their learning in the clinical workplace:

> *Yr1 FG1* '*I see all the nurses - even my mentor - running around like headless chickens and I'm like why? What are you doing? And they can't give me a proper answer.*'
>
> *Yr2 FG2* '*I think they need to take a step back and think to themselves – 'well what am I doing now' - do you know what I mean?*'
>
> *Yr3 FG2* '*a lot of nurses do say they are really busy - but a lot of them are sat playing with their phones or hanging about and I just think... I was going to say busy doing what?*'

Evidence of how this is quickly instilled in the students and how they feel the need to replicate the practices of the old timers is expressed here:

> *Yr2 FG2* '*it's like that awkwardness isn't it of having to look busy when you are not busy ('yeah standing around looking busy') - one of the nurses said to me 'take those notes and read like all of the different things that has led to this person having this procedure' - and I'm reading through it and I'm thinking I don't know what that means and what that means 'could you tell me what this means' and she had no idea (laughs)*'

This culture again challenges the students' appreciation of what nursing really is and what they thought nurses did or *should* do - according to the old timer role models:

> *Yr3 FG2* '*...it's like 'have you nothing better to do?' 'why are you talking to that patient have you no jobs today?' - you are looked on as if you are lazy - so that's not nursing then? - I often feel guilty for talking to patients for too long*'

However these considerations can also indicate reflection, insight and a growing confidence in some students:

> *Yr2 Int2* '*yeah now I can see it's a case of prioritising though isn't it - I would really like to give this patient a bit more time because she is distressed - it is difficult on a busy ward but I think that you need to see who else is in the team and work as a team and not think it is just your responsibility*'

This *attitude* to work can be perpetuated by the hierarchical structures of some health care organisations. Ortega-Parra and Sastre-Castillo (2013) claim that to be inclusive an organisation needs to be open to suggestions and innovations from ***all*** staff and help solve problems by encouraging collaboration, knowledge sharing and team learning. Most crucially is the encouragement of innovative ideas from *new staff and students* (Materne, Henderson, & Eaton, 2017). However control, cultural influence and priority are often perceived as being unilaterally directed downwards from above with the results being seen in the established nurses' working ethos. The student is therefore continually confronted by a culture that confirms a strong, occasionally unquestioning, trust and faith in authority and - most challenging for them - an associated passivity in independent seeking of knowledge and learning. The student comes from a university context that encourages them to be an active seeker of knowledge into an environment that produces passive recipients of information, rules and ways of working:

> *Yr2 FG 2 'I think as well that in the nursing profession - and the higher up the hierarchy they are - the more they appear to feel they are entitled to speak to you like (whispers) shit when you don't know what you are doing. And I think that takes a knock on your confidence as well and your willingness to try things and like put yourself forward to have a go at things'*

> *Yr1 FG4 'One of the executives from the Trust was there and I happened to make a comment about documentation... I said people are saying 'yes it has been documented and therefore it has been done' - but has it really been done just because it has been written? And she jumped-up off her feet and was really defensive and telling me you wouldn't do this or sign something to say you have done it if you hadn't!'*

A prerequisite for learning is not only to seek out and adopt new knowledge, but also to question earlier information and experience and develop the ability to critically evaluate workplace practices. This is an approach that the students were keen to maintain but found difficult dependent on the approach, attitude and culture of established colleagues and their work environment:

> *Yr1 FG2 'did you find also that depending on the person, depending on how long they had been qualified what their attitude is was dependent on what they think you should be there to do as well? (Yeah) Because some of the newer qualified staff are a lot more proactive and they are in this kind of new way of NHS thinking whereas some of the older staff really aren't and there is a big attitude difference' (definitely yeah).*

> *Yr2 FG2 'I think it is great that the NHS is training all those new staff to be this new way but I think they are going to have to retrain the staff that they have already got because the old staff, their values or the way they were learned doesn't match all these new procedures and requirements that they are bringing in'*

Yr3 FG1 '...they don't like the way things change and nursing changes every single year ... and they don't like it - a lot don't and some don't like seeing new staff and I think it is to do with their age.'

Yr3 FG2 'Quite a few people say like why are you doing it like that or we didn't do that ....a lot of older nurses didn't come to Uni they went in the hospitals ... and they say 'oh in my day it was better like this'...'ours was better cos of this' ...like trying to get one up on ya - it does wear you down a bit'

Yr3 FG1 'A lot of seasoned nurses, I've worked with like older nurses they learnt old school and keep saying 'oh no we never had any of this we lived in hospitals and we worked''.

Similarly it has been claimed that nursing staff often feel that the *workplace* is simply that – a place only for *working* (Govranos & Newton, 2014). Such a specific and narrow definition of working by implication dismisses learning, studying or seeking information to support practice as these considerations are not seen as a priority or even desirable. In the context of an increasingly highly pressured, consumer focussed health care environment such situations are increasingly likely to cause dissonance, dissatisfaction and disillusionment for students.

6.3.6 Compromised Learning

These aspects of their clinical experience, including their witnessing and participating in poor practice undoubtedly compromises any positive and progressive learning relationship between themselves and their experienced colleagues. They therefore recognise that learning in practice and apprenticeship-type models such as theirs are not unproblematic. Genuine constructive and positive learning - *and* their progression and achievement of competence and eventual registration - can only be achieved when they are participants in a conducive environment and when they have positive supportive relationships with the individuals who recognise their responsibility to teach them and facilitate their learning:

Yr1 FG 3 'it was embarrassing some people just don't wanna teach. I remember being on cardiac theatres....I thought 'oh great she will really educate me' - so she started firing questions at me. I didn't have a clue... I was like I am here to learn it is like my first year you know I'm actually about to start crying (all laugh) can you not just be nice to me and encourage me to learn because I was ready to walk'

Yr1 FG2 'some of the older people are 'Oh yeah whatever' - they are very dismissive of some of the new stuff 'Oh yeah pretend you didn't see me do that - you've got to do it like this'

Yr1 Int1 'I've faced both sides of that and I've had different experiences with the older staff. Some of the older staff are really good and they are like 'oh no you had all the training you know all the evidence behind it and whatnot' whereas others were - 'I don't know - why you're bothering with all that you really think it has any effect?''

The experiences of students in year two remain similar:

> *Yr2 FG1* '*A lot of people seem to have been pushed into mentorship and they don't have any interest in doing it and I think that shows. Whereas others are really keen and say 'I really enjoy having students because I learn a lot from them and it refreshes my own knowledge'. Others just can't be bothered you are just there and they sign a bit of paper and they really don't want anything to do with you.'*

> *Yr2 FG2* D '*I kind of quickly assess who is going to show you things and think I'll work with you, who is gonna say 'Oh come and have a go at this'. I'm like 'you can and be my friend today' (Lots of laughter)*

> *Yr2 Int2* '*...it's about going with the people that are right - you know when you are on a team I've had a fantastic mentor before - obviously there were people on that team weren't as good but you do kind of gravitate to the ones that are that way anyway don't you? And I would say always try and keep yourself in those circles really'*

And so too in year three:

> *Yr3 Int2* '*Totally true is that - from the older staff that have been in the job for a long long time. They've definitely forgotten that they have trained; that they were in that position and some nurses do like to Lord it over you no doubt about it'*

The potential for interference with learning is complex and multifaceted but significant and profound. The culture of the ward, unit, team or community constantly shapes student nurses' understanding of their role as a nurse. Therefore, if work-based learning or commitment to constant development is not confirmed, the appreciation of and motivation for learning is easily compromised. Student nurses grasp the absence of this commitment to learning via their own experience as they expect guidance, confirmation and support from their more experienced colleagues (Govranos & Newton, 2014). Although, as we have seen, students do not always have a clear understanding of the role of the nurse - they at least have a perception of what is relevant, important and meaningful work; and access to opportunities to be involved in such work is an ongoing motivator for learning and personal development, and encourages their attempts to achieve their best (Cubit & Ryan, 2011).

6.3.7 Further implications of The Francis Report II

As I have previously discussed, the wider context in which the students in this study were undertaking their initial career steps was one of no little controversy, not least the ongoing historical debate concerning the academic requirements of nurse education and the value or otherwise of university education for nurses. Their perceptions and experiences develop from and are inevitably influenced by that context.

It was impossible to ignore or disregard the findings of the Francis Report (2013) which had generated several key messages for nursing. The independent enquiry into standards of care at Mid Staffordshire Foundation Trust had highlighted failings in the most essential aspects of nursing care; not least in an apparently widespread lack of recognition of patient dignity and privacy and a pervasive lack of compassion and empathy:

> *Yr1 Int1* '*That's a personal thing again, that's an attitude thing. That's the way I've been brought up, my values I suppose which does affect the way you are as a nurse you can't deny it. I don't know - there is a question that comes up with this 'can you teach compassion?' - I don't know really*'

It was believed that the culture had been compounded by financially driven care targets in preference to genuine patient care outcomes and a discouragement, or worse, of staff expressing concerns about poor standards of care. The statutory monitoring systems of care in the NHS had been found wanting and this had generated significant discussion concerning the role of nurses in the provision and ensuring of quality care. What the priorities for nursing should be was being questioned - what *ought* nurses to be doing?

Similar questions were also being asked about the fitness for purpose generally of the current education of nurses and specifically whether individuals with the 'right values' were becoming nurses. The Francis Report did **not** advise that the education of nurses should return to an educational level below a degree however it did, by implication at least, suggest that the more recent registrants to nursing had in some way differing values than the old timers of nursing and perhaps that the 'old ways', as evidenced by these old timers, was in some way better or more appropriate to the needs of patients and service users. The Francis Report undoubtedly had a chastening message for nursing care provision, patient care, professional regulation, nurse education and particularly recruitment of students and the structure of nursing registration programmes (Hayter, 2013).

The debates generated within the profession by the Francis Report resonate with the experiences of the participants in this research. The Report prompted discussion of the alleged deficiencies related to graduate nurses. Many of the students articulated their frustration with the oft expressed argument of their colleagues - mirrored in debates by politicians and in the media - that nurses trained to degree level focus far too much on theory *at the expense* of the allegedly more important practical skills. The implication being that students educated in such a way therefore have a related lack of compassion compared with nurses trained through less academic or 'traditional' routes.

Yr1 FG2 'One of the sisters on the ward - an old timer type thing - as soon as I got there she said 'Right forget everything they told you at uni, forget it - this is real life, this is what really happens' - and it is like how do you want me to dismiss what I have just done for the last three months'

Yr1 Fg3 'I have seen a lot of grumblings on the wards by the diploma qualified nursing about us doing the degree. 'It's not going to make you any better you know just cos you are doing a degree''

Yr2 FG 1 I think also the fact that we are now doing the degree and not the more vocational qualification or the diploma I think they have this image of like a snooty person that everybody is beneath them'

Yr2 FG2 '... 'You guys learn from a text book - the real learning only starts when you have done it for 3 years' ...there's that bit of resistance when it comes like you're a student doing the degree and they have a diploma and feel threatened'

Yr2 FG 3 'yes I think a lot of the older nurses, not older nurses but the ones that learned on the ward, they didn't have to come to Uni or anything like that - they all say 'what do you need to go there for?''

B 'We are not doing any less practical work than they are. Just looking into it a bit deeper.'

C 'It doesn't matter it's what you are as a nurse. And when you need to know what you don't know, it's how you find out how to know about it and pass that information on - it's that isn't it?

A 'It doesn't matter to me.

C 'I'm sure it doesn't matter to the patients.'

There is now an established body of evidence that the greater the proportion of graduate-level educated nurses there are in a specific clinical environment then the better the patient outcomes. For example Aiken et al. (2014) found that a 10% increase in Bachelor's Degree-educated nurses in the registered nurse skill mix was associated with a significant reduction in inpatient mortality. A recent systematic review and meta-analysis by Liao, Sun, Yu & Li, (2016) supported the evidence of reduction in overall patient mortality. Much of the evidence derives from specific clinical environments, particularly surgical specialities for example. However Aiken (2018) indicated that a greater proportion of 'professional nurses' can be associated with reduction of preventable deaths, erosion of quality and patient satisfaction and increased staff morale across the whole spectrum of hospital nursing practice. It would appear to be wrong to assume that nurses or health care assistants without degrees are *per se* any less caring, compassionate, competent or committed; therefore the mechanisms of benefit are presumed to be either organisational and/or educational. The better application of research evidence by nursing staff or an organisational understanding of the importance of education and a reflection

of the organisation's broader values and ethos are just two potential explanations for these findings.

Aiken et al. (2016) also suggest that a richer skill mix generally ensures that professional nurses are less likely to experience high job-related burnout or to be dissatisfied with their jobs potentially contributing to expensive and disruptive turnover and nurse shortages. A set of circumstances that as I have discussed can only impact negatively on the learning context as experienced by student nurses.

6.3.8 Indicators of Quality and Health Care Targets - implications on the student experience

Other challenges highlighted by the Francis Report included a recommendation to move away from a culture driven by achievement of objectively measured targets - albeit set centrally by the Department of Health - that were essentially *paper-based* indicators of 'quality care' and 'success' (Hayter, 2013). The students were very quickly, and continually, challenged in their perceptions of what it meant to be deemed a *good nurse* by aspects of practice that they witnessed being undertaken by the old timers and that they were expected to replicate:

> *Yr1 FG3 'I really I expected to do the care work .... it depends on the nurse I suppose some nurses that you meet they want to do the care work because they miss the patient contact and getting to know the patients whereas others are quite happy to just do the paperwork side - both of which are equally important but you have to find that balance I think'*

> *Yr1 FG4 'all I was doing was paperwork people in people out same thing every day for 9 weeks.'*

> *Yr2 FG2 'I think in nursing now the amount of paperwork there is more and more and more and it's completely taken away from patient care ....we want to be caring for our patients – 'hands on' - that is what we came in the job for to look after people. We don't want to sit at a desk filling in paperwork - course we don't but I don't see how that is going to get any easier'*

> *Yr2 FG2 'That is it isn't it? It seems that the higher up the kind of banding system that you seem to travel the less it is about the person - the more it is about filling in bits of paper and it makes me think that I don't want to progress in the job because it takes me away from the reason I came into the job'*

Even by the third year some students remained surprised by what nurses actually did and still made them question occasionally their career choices.

> *Yr3 FG1 A 'If I knew now what I knew then I don't actually think I would enter into the career of nursing.'*

> *B 'Yes I would second that....'*

> *A 'Because it's not what I thought it was there is not as much patient care in what I wanted it to be and that was the whole point in me doing it. But then I think I'm too driven to be a HCA and just do the actual patient contact. Once you are doing the HCA job there isn't anywhere you can go there is no progression. No taking responsibility and no real helping that patient*

> *other than doing the essential care **so yes I <u>would</u> do the nursing degree knowing what I know now** but it's a very big step knowing what I know now. Very little patient contact dependant on what type of ward you are on'.*
>
> Yr3 FG4 *'I thought nurses were like the ones who proper cared for the patients - I think I was getting that confused with health care assistant weren't I really?'*

These considerations also impacted significantly on future career choices:

> Yr3 Int2 *'yes (long pause) that was part of the reason for me choosing the job that I've gone for because I want to care for people ... I don't want to just shove a drip up. I want to care for my patients... The patient contact has gone out of nursing in a lot of hospitals in a lot of wards I think'*

Again this reaction is essentially prompted by their witnessing the behaviour of established staff and the apparent priorities of nursing and their participation in practices that still surprise and disappoint them.

Their impression was that other well established professionals - or the support staff to nurses - often delivered or undertook the clinical care required by patients, which is what they had expected to do. Whereas registered nurses principally documented and wrote about the care given by others.

> Yr3 Int2 *'yeah I've been on wards before were I've said 'am I okay to help Joan have a wash' and they've said 'whose Joan?' - They've been supposedly looking after them all day and they can't even remember the patient's names. I always go out of my way to learn the names because I can't stand it when people call people 'lovey and sweetie' - I have had that experience where they only know them by their bed number'*
>
> Yr3 FG3 *'well yeah you go through a nurses notes and they have gone through the days routine of hygiene needs et cetera et cetera but they've not actually done ANY of it themselves! They have never even touched the patient'*

6.3.9 The requirement for previous caring experience

As I have previously highlighted many of the participants, typical of many student nurses, have their first experience of any caring profession only after they have commenced on the nursing course. A further result prompted by the Francis Report was an encouragement from the Department of Health of England towards requiring prospective nursing students to have completed a period of health care work experience *prior to applying* for a place on a nursing degree course. The presumption was that such experience would enhance the quality of nursing recruits and also ensure future nursing students were equipped with the compassionate caring skills necessary for nursing. Although the Francis Report did insist that there should be a clear and obvious difference between registered nurses and other workers, it also confirmed the implication, again, that certain caring skills *had been lost* in those graduating via the current

nurse education framework. Although not explicit this implies the necessity to return, in some way, to some lost golden age and system that produces more compassionate and caring nurses than the current education system.

Some of the students in this research felt some affinity with that belief:

> Yr1 Fg4 *A 'I think it was a government thing that they should make it a part... at least 12 months experience of health care. I think it is absolutely imperative... having had that experience.....to give the realism of what the job entails. Mentors have said they have heard students saying 'I'm not doing that I'm not here to do that...'*

> B *'Too posh to wash is the shorthand'*

> A *'Some people come into nursing thinking it's going to be about documentation and drugs, and it isn't. So be a health care assistant to experience things on the front line'*

> Yr1 FG3 *'it's kind of like we could make our way through early placements because we've got care experience and we've worked in hospitals before - so it was all right really'*

However there is no evidence that such a requirement of previous 'caring experience' would result in the positive benefits implied by its advocates. The data from this research indicate that students have a varied experience in their relationships with support workers or health care assistants. Just as in the case of the Mid Staffordshire Hospital, several examples of less than optimum care witnessed by the students involved HCAs.

> Yr2 Int2 *'Some health care assistants on our ward have just been disciplined for putting a sign on a staff nurses back that said 'I am lazy' - the patient had to tell them that she had a sign on her back'*

> Yr1 Int2 *'There needs to be a governing body for health care assistants especially. I'm a health care assistant I do all different kinds ... ECGs and stuff like that that I don't do as a student nurse but I'm not governed by anybody. So it's the nurses accountable for your actions if you do something wrong it's them and not you'*

> Yr1 FG3 *A 'Do you not think that the health care assistants outnumber the nurses as well? Like a big mob culture?'*

> B *'they definitely band together a lot more than the qualified do - yeah I think there are a lot closer knit definitely - I was more bothered about getting on with them than about the other staff nurses'*

> A *'you pick up the dynamics really quickly don't you (laughs) - yeah I was like 'they are running this show!'*

The influence of this group of colleagues was significant. Several students found the relationship relatively supportive - although requiring some element of negotiation and compromise to 'be allowed' to explore certain learning opportunities:

> Yr1 FG3 *'while some of them will tell you that they run the ward (laughs). If you can get in with the HCAs, if they look at you and they think you are willing to help and you kind of want to*

help - then a bit later on when you are going off to do 'nursing things' they are fine with it ....I think if you are friendly with them and create a relationship with them then your experience is a lot better...'

Yr1 Int3 'if you need to go off and - I don't know - someone says let's do the meds round but there is some stuff that needs doing in terms of personal care, if you have previously helped them and shown willing that you are happy to do that kind of stuff and you are not approaching it like you're better than that 'oh I'm not going to wipe bottoms because I'm a student nurse' then they are sort of okay with you going off and doing the other stuff that you need to learn - and they will be like 'yeah you need to learn that''

Many students undoubtedly valued the support received from some HCAs and recognised their unique and invaluable contribution to the quality of patient care and the day to day management of the clinical environment:

Yr1 FG3 'I remember advice I got before I started from qualified nurses and friends ... 'when you go onto a ward make sure you get in with the HCA's and then they are not resentful of you when you cannot always help them with certain care stuff because you are doing like qualified nursey stuff'

Yr1 Int3 'you can see who is really in charge - they do look after you (Laughs) - they do if you put the time in - and then they will be like 'you haven't even had your break, I'm going to tell them you need to have your break' They are like 'come on sweetheart I'll sort you out don't you worry''

Yr2 Int1 'In my first year I didn't really see my mentor at all - it was 'Oh you need to learn the care side so here is the HCA' - which was fine because I've never done care work before and so I really needed to learn that. Now when I go and I say 'I'm a second year' they say 'alright what we really need to learn is this then now' and so I think the nurses have at least a bit of a roundabout idea of what you need to know'

Yr3 Int2 'First year it was healthcare assistants that made me feel at ease. They took me under their wing in first year.'

However others found such relationships very problematic:

Yr1 FG1 SW 'I don't want to come across as too posh to wash because I'm not and I don't mind doing HCA duties...'
SM 'yet you're there to learn other things you're going to need as a registered nurse'
SW '...... but when you are not learning anything else'.

Yr2 FG3 'I have been fortunate in getting pleasant mentors. They've all been really good. The people that made me feel uncomfortable were mostly assistant practitioners and auxiliary staff'

Yr2 Int3 'yeah sometimes I felt like the care assistants and auxiliaries were the ones telling me what to do all the time and they were like 'oh S go and do all those observations'. 'Oh we don't need to do any observations because the student can do it' and stuff like that. And the auxiliaries would be like 'Oh could you finish all these beds while I go on my break' and you are like 'I can't, no - I'm doing the observations like I've been asked to do' and when they come back they are like 'so what exactly have you done? – Nothing!' - and you just feel sort of....'

> *Yr3 Int3* '*... when you start on a ward there is always one person who takes a dislike to you because you are a student. I think there are especially the older-type HCAs who think that you are coming to try to tell them how to do their job...*'

As all learning involves the formation of positive relationships, it is difficult to have any greater confidence in a system which mandates that all prospective students work alongside unregulated HCAs for a period of time. It is at best unexplained by its proponents how this experience would ensure the instilling of a more caring attitude in the students following their accessing a nursing degree course or indeed as their career progresses further. The problems inherent in the apprenticeship-type models are further exacerbated in these cases due to the lack of regulation of roles and the variability of experience, education, roles and responsibilities of HCAs in the current UK Health Service. If HCAs were to be a mandatorily assigned key supporting educative role model then regulation of such roles and therefore commonality in responsibilities and insight into student requirements would appear to be necessary. A commitment to support such an initiative has already been dismissed as unfeasible by the Department of Health; and has been judged prohibitive at a cost of up to £766 million per year (Council of Deans, 2013).

6.3.10 To whistle blow or not to whistle blow?

Much of the debate within the nursing profession post-Francis Report revolved around how apparently caring, compassionate and empathetic staff - including most specifically nurses - had 'allowed' this situation to come about and how and why had nurses apparently remained silent in the face of such lapses of care. The Francis Report was insistent that nurses who raise concerns about poor care - or 'whistle blow' - should be protected and supported in this endeavour. It is clear from the data that the students in this research were, at best, conflicted by some of their experiences of what they perceived as less than optimum care delivered by established colleagues or poor practice by old timers, and what actions they should take in such circumstances. Their position as novice in a relatively peripheral role in the communities profoundly challenged their values and identity as a neophyte nurse:

> *Yr1 Int1* '*because I have seen examples where people have not got on well with the sisters or whoever is in charge and it really has a knock-on effect ....you do need to be wary of the relationship you keep with that nurse. But then at the same time if they are doing something really bad and it is putting the patient in danger then I probably would just argue it and report it. I think you would have to*'.

> *Yr2 FG3* '*It may be putting the wrong type of dressing on a patient, you have put a rectangular one instead of a circular one....you would not want to admit it in case you got a telling off.*'

> *Yr3 Int1* *'if you don't speak up nothing will change. But it is really stressful thinking 'God what if I'm going to a ward that is really bad' - and you think would I speak up? Who would I speak to? Because everybody knows each other and you think 'oh God what if I said something to them and they are actually really good friends' - it's a bit difficult and I think it would be a bit upsetting and traumatising really'* (laughs)

It is clear that the anxiety and uncertainty remains throughout the three years. Much of this is undoubtedly provoked by the behaviours of the old timers and their relationships with others within and between the various communities of practice:

> *Yr1 FG4* *'It's the critical part of your learning isn't it going out on placement? But then being left to your own devices is difficult. Those people that are supposed to be neutral - they are on the same payroll as our mentors so if they had to choose a side whose side would they come down on...'*

> *Yr1 FG4* *'Even going to the PEFs ...they all know each other ...and they weren't really interested, they didn't like to hear the criticism as it was their Trust - and people that they knew and worked with and that's why I contacted someone from X (University name) and not from the Trust. They are supposed to be impartial, I get the sense they are not - that's what I said....and she (Lecturer) was really good'.*

> *Yr1 Int3* *'...everybody knows somebody else on each ward....You do worry that it will follow you because somebody always knows somebody'*

Despite this tension, as I shall explore further in the next theme, the students begin to develop a recognition of positive difference between themselves and the old timers. They begin to identify that their learning and education places them in a very progressive position to improve patient care both now and in the future:

> *Yr2 FG3* **'***they must just really dislike all (University name) students because we must just all go in and say no that's wrong, no you can't do that - But then again it is different but we know we have been taught properly so we know that we will never be like them'*

Although there remains a concern and fear in some that the negative influences will eventually and inevitably reduce their ability to discern good care from the apparent norm of less worthy practice that they witness from some of their colleagues:

> *Yr1 FG1* *'I was discussing with one of our other friends she is scared of ending up like one of the people who call patients by the bed number just because you might just naturally get into that routine'*

> *Yr1 FG1* *'....it's like you go in like all passionate and that and one day you might just turn around and say I've had enough I just can't deal with this anymore. It's really scary.'*

As they progress they become less concerned that they will replicate poor practice but are still very much aware of the potential ramifications for them:

> *Yr3 FG2* *'... it is like they just aren't bothered some of them. And then as a student you come in and think I might go and question that because I don't think that's right ... and after that they*

were just funny with me ... they try to get you to do so many different things ... it was leaving me a bit vulnerable you know being told to do things that I shouldn't'

As a strategy of coping and assimilating the experiences several students attempt to take positive learning from these apparently negative experiences:

> Yr1 FG3 *'at least you learn what you don't want to be like when you qualify' (Yeah! - all laugh)*

> Yr1 FG4 *'When you start to go in looking through a different pair of eyes, students eyes - you are mapping out the nurse you want to be which links to the person you are in the first place - but when you observe qualified nurses some perhaps haven't got the same values as others'*

> Yr3 Grp 3 *'I've met some inspirational nurses through my training but I've also met some nurses as I know I just don't want to be like.'*

Echoing Pearcey and Elliott (2004) who highlighted that whilst students can feel undervalued; this experience appeared to increase their determination to be different once they were registered nurses themselves - with a determination to avoid developing the cynicism and negative attitudes that they witnessed in other nurses and occasionally in their mentors.

6.3.11 *'Always cover your back'*

Despite this attempt at positivity, the presumption of advocacy for vulnerable patients and the assumption that a student would recognise and act should they be witness to poor practice, is also explored with some anxiety and concern. There is genuine disquiet should the student become involved in such a set of circumstances themselves:

> Yr1 FG4 *'we are coming out of the Francis report.... I think it's just they have to instil this scare tactics in students so again they set the right standards and say that these are the expectations'*

> Yr2 Int1 *'it's almost like this combative thing - cover your backs and all that stuff - protect yourself I hear that a lot. First rule of nursing protect yourself'*

> Yr3 Fg2 *'there is a lot of practice staff and you say 'do we do this?' and they say 'God no! - You don't do that. You will lose your pin.' They could just say 'no we don't do that here' - why do you have to mention your pin number? Like it is always at the back of people's minds but it shouldn't be the thing that you worry about all the time'*

Despite feeling generally supported by university teaching colleagues, several students believe that it is as much academic colleagues as clinical colleagues who engender this culture of fear and negativity. There appears to be a reluctance to view the accountability of the professional nurse in a positive, supportive and patient centred way. Rather it is seen as an opportunity to be blamed and thereby appears to generate a culture of defensive practice and scaremongering:

> Yr3 FG4 A *'there is so much of the blame culture these days everyone is out to get one over on you'*

(B 'that is quite scary isn't it? Quite shocking.')

A'... so finding out how much trouble you could get into like...'

(C 'That's my biggest worry.')

A 'When you find out all the stuff you can get in trouble with it is scary.'

Yr3 Int2 *'you get a lot of it from Uni - erm a lot of the lecturers are saying - 'if you do this you will lose your PIN you will not be a nurse' and it's like right okay - and then you go out thinking if I do that that's going to happen - it's quite weird we have just got a puppy and we are taught to use positive reinforcement rather than negative reinforcement and it's the same like if you teach us in uni the right way then that is what will happen - and the good stuff you are more likely to do that then than the negative stuff.'*

6.3.12 Problematizing apprenticeship style learning

These experiences confirm that the students' participation encourages them to be critical reflective practitioners; unfortunately in many ways the experiences are less positive and very challenging. Undoubtedly the predominant circumstances in the experiences of the students interfere negatively with their learning. In Lave and Wenger's (1991) seminal work these types of relationships are only problematized in a very limited manner. Lave (2008) admits that much of their work assumes that those who were viewed as *masters* were by necessity regarded as exemplars of what apprentices were becoming rather than as *co-participants* in a complex, constantly changing environment. Lave recognised that the conceptions of conflict, difference and change highlighted by the experiences of the students in her research were not sufficiently engaged with in her initial concept of *situated learning*. Situated learning as conceptualised by Lave and Wenger (1990) tended to view social situations and practice in a rather 'closed, harmonious and homogenous' way (Lave, 2008 p.288). Whereas in reality participation in practice is not necessarily a harmonious, consensual and adaptive process; as with any transition comes potential conflict and ambiguity. It has been argued that this uncertainty may even challenge any attempt at a consensual definition of 'practice' (Keating, 2005).

Similarly Wenger's later work (Wenger, 1998) has also been criticised for its main focus on commonalities at the expense of diversity and agency thereby offering a rather limited explanation for how communities transform themselves. The idea that newcomers learn and shift their identity and role as they move from peripheral participation in the community towards core participation offers only a limited explanation of how communities subsequently change and develop (Martin, 2005). Therefore the validity and appropriateness of concepts of 'mutual engagement' and 'joint enterprise', which are central to Wenger's proposition can be criticised as of rather limited value as a means of legitimately describing the lived experience

of the participants in this research (Eraut, 2002). Any mutuality or shared endeavours with qualified clinical colleagues is often called in question by the students:

> *Yr1 Int1* '*So we are learning all this new stuff but there is a battle really when we get out there with some staff like 'oh you don't need to bother with that come on' - whereas really we know we do need to bother with it.*'

> *Yr2 Fg2* '*and yet you see so many little bad habits all of the time that sometimes when you want to do something properly you feel almost like you are just being funny or something*'

Their perception and subsequent unease is that what they are learning via their participation is generally supporting or reinforcing existing attitudes and practices. They feel concern that, rather than supporting their progress and the development of good practice they are in fact being actively encouraged to learn poor practice.

> *Yr1 FG1* '*There was one training session we went to. Trust training before we started placement and there was an older nurse who was obviously just refreshing her training and she said something to us about hand washing she said 'yeah but you haven't really got time to do any of that on a busy ward though have you?'*

> *Yr1 Int1* '*they are always saying 'why you're bothering with all that you really think it has any effect?'*

> *Yr3 FG1* '*...and they are saying 'forget everything you've been taught' and from that day that is the attitude - and you daren't say 'well at Uni they said this ...' - because you think they are just gonna say 'well no!''*

Yet again these experiences question the value or legitimacy of *all* students being required to experience a compulsory amount of time in clinical practice in a support role prior to applying for a nursing degree. It is difficult to understand how such participation can be seen as a robust means of ensuring appropriate learning and increased empathy and compassion in the future nursing workforce, especially as the data indicates the confidence to challenge such practice only develops in year two or three at least.

6.3.13 Power Imbalance

The burgeoning confidence of the students is influenced by their perception of a power imbalance in their relationships with the old timers. The research data highlight this significant power imbalance in interesting ways. The power imbalance initially perceived is of the old timers having power over the students:

> *Yr1 FG1* '*they make you think – why did I ask that daft question?' ...yet you should ask questions, even the stupid ones and you shouldn't be looked down on as you are still learning.*'

> *Yr2 FG3* '*But as a newcomer, and a complete nobody.. you are lowest of the low if you are a student nurse - you know you are never going to be able to say anything.*'

Yr3 FG4 '*Instead of waiting to hear what you are saying about that patient that you have done all the care for all day - they would talk over you*'
B '*Yeah they sometimes speak over you. I feel a bit stupid then*'

According to Jackson et al. (2011) this can reinforce a position of the student as, in some way, 'Other'; with 'othering' being an attempt to conceptualise the dynamic complexities of how power is used within relationships (Canales, 2010). Exclusionary othering - such as talking over someone or ignoring their opinions and contributions - uses power within a relationship as a means of domination and subordination; resulting in increased marginalisation, decreased opportunities and exclusion. Inclusionary othering, on the other hand, attempts to use power within a relationship to build coalitions, engender a sense of community and encourage inclusion (Canales, 2010 p.19).

6. 3.14 'The Student'

The participants often articulate their recognition of the power imbalance by lamenting the old timers' use of the concept of 'the student'.

> *Yr1 FG3* '*The worst thing, and I know it's not done on purpose - but is when you can hear them calling you 'the student' - it kind of puts you in your place. You think you are doing well and you think you are part of the team then... 'Student' ... 'I'll get 'the student' to do it'.... it just makes you think like 'yeah they'll soon go back to Uni they're not **really** part of the team...'*

> *Yr2 FG2* '*'Where's that student nurse?'...They can't even remember your name and there is only one of you and you've remembered everybody on the ward's name*'

Whilst being disheartened by being called 'the student' and the resultant implication of their continued peripheral status - yet again there is a reluctance to be too critical and an attempt to understand and empathise with the complex milieu of their qualified colleagues.

> *Yr3 FG2* '*it does make you feel a bit put out I'm trying my best and they can't even be bothered to remember my name. But looking at it from their point of view they might have four student nurses they might have one every 10 weeks ... I don't know but it is a bit disheartening when they can't even remember your name*'

As I have noted, learning requires mutual esteem and reciprocal interaction if participation is to be maximised and this requires a culture that is inclusive and interdependent and that continually evidences a value and inherent respect in the relationships (Eraut, 2002). The frequent use of the nomenclature - 'the student' - clearly articulates a challenge to the pretence of mutual respect, equity and reciprocal power balance.

Through these experiences students are continually forced to acknowledge the existence of conflicts and ambivalences and as they attempt to enthusiastically search for meaning in their

experience, their negotiations are continually permeated by issues of power and conflicted ideology (Keating, 2005):

> *Yr1 FG2* *'I was with some nurses in my first few weeks and I'm thinking 'is this how we are supposed to be doing it? Is this right?' - I questioned myself because quite a lot of people might be doing certain things in a certain way so you just go 'Oh that must be right then'. And you carry on because they tell you to ...but then you come back into university and you think 'oh! This is how you do this' and you think I bloody knew it was wrong!'*

> *Yr2 Fg1* *A 'I also don't like it when nurses put a handle on a person - they immediately think ooh and they will stay away from them - but I think they should let you make your own decisions about that'*

> *B 'yeah they do whisper about it don't they - you hear a few and they will go 'I can't be bothered - they are doing my head in - I'm sick of them''*

> *Yr3 FG1* *'...she was told by her mentor... I don't agree with the way you lot are learning - you are all bloody thick, you don't know nothing. She was like 'I am on one of the NMC regulated degrees''*

The whole construct and philosophy of learning and positive participation is jeopardised when mutual respect is absent. As we have seen, when students are forced to recognise that any collective activity offers little opportunity for learning or improvement, then their individual motivation shifts priority and starts to focus more on simply managing and coping with the contradictions that are evident between what they perceive as their own needs and the apparent collective needs of the organisation. The students, whilst retaining their expectations of how to become a nurse, inevitably attempt various strategies to avoid too much challenge to their identity:

> *Yr1 FG1* *SW 'people take one look at you and judge you straight away.'*

> *CB 'Yeah! Definitely! I hardly ever wear make-up but on the first day of placement I always put make up on! (Laughs....)'*

> *Yr2 Grp 2* *'yeah it's like on every placement that I have been on I don't know why but my face doesn't fit at the beginning. My mentor actually said that to me on one of the wards that I ended up doing* really *well on - she was_like 'at first glance with people **like you** others don't give you the chance to get to know you''*

> *Yr3 Int1* *'I've had to learn the biggest thing is that you need to start taking responsibility for yourself...and not always think I've got this person above me to check everything'*

6.3.15 Conclusion

This theme highlights the complexities of the relationships between the participants and those in clinical practice who are designated as role models, teachers and mentors. The relationship as neophyte or newcomer and expert or old timer is central to learning; professional development and growth and shift in identity.

6.4 Theme 3 - The University and Clinical Practice Dissonance

6.4.1 Introduction

As I have described, learning in practice and the philosophy underpinning models such as apprenticeships are in essence based on *relationships.* The students recognise the crucial role of these relationships in their learning and they are sustained and inspired by some and less positively challenged by others. Much of the experience described by the students in this research relates particularly to their reflection on the relationships formed in clinical practice. This final theme explores further the other central relationships so integral to the student's progression - relationships with staff at the university. Following this theme the reader will have greater insight into the students' understanding of the university's influence on their development and shifting professional identity and how that might inform and influence their views of clinical practice. Moreover they will further appreciate the influence of the university on the students' progress in meeting their aspiration to become a nurse and also the wider, occasionally problematic, relationship between the university and clinical practice.

The data consistently show that the students are recurrently challenged by the practice that they witness on their clinical placements. A major aspect of this experience is the feeling of *dissonance* generated by the evident discrepancies between the espoused priorities and values of the university and values represented by much of the practice witnessed in the clinical environment. It is also generated by the fragility or inconsistency of the relationship between academic colleagues and those who are responsible for student learning in clinical practice – most particularly the mentor. The context of learning has certain pre-requisites that are generally evidenced in the environment of the university, and their relationships with academic staff, and yet can be found very much wanting in their experience in clinical practice and their relationships with mentors and others in that setting.

This theme therefore explores the nature of this dissonance and critically describes its ongoing development as the students' identities shift throughout the three years as they participate in the various communities. I will explore whether those significant and conflicted feelings of discord resolve as the students' experience and expertise increases, and if they become more accepting of certain practices by their third year or whether they are equally troubled in the third year as in the first.

6.4.2 'The Theory-Practice Gap' - not simply a cliché?

Many students express concern that their experience in practice appears to represent a significant difference from their understanding of the aspirations, aims and objectives that they are exposed to whilst at university. Although this may not signify genuine conflict, it undoubtedly indicates inconsistency in the central goals of the two different settings:

> Yr3 Int2 *'yeah like the old talk about the theory practice gap. Practice is going down that route - theory is going down that route. They will meet somewhere but they still haven't got the meeting point. What the uni say they do and what placement say they do at uni - I've never seen them interact'*

Examples of such expressions of dissonance is offered in each of the three years:

> YR1 FG4 SH *'I think the uni tells you like the ideal.'*
>
> NB *'Yeah. - Not necessarily the reality.'*
>
> Yr2 FG2 *'In practice it's so different. They say don't they, at university... it's about holistic care and the patient as a whole - but when you are on a ward and a patient comes in with something wrong, with say their kidneys, you look and fix their kidneys and that's all - you don't look at everything else that is wrong with them'*
>
> Yr3 Fg1 *'When you learn in uni it doesn't necessarily help you on your placement. You don't really learn that in practice because they don't know what you are learning at Uni'*

What they are taught in university and therefore what they expect to witness, participate in and experience in clinical practice do not match resulting in a strong feeling of dissonance.

6.4.3 The university experience offers a level of consistency

The students accept - sometimes a little begrudgingly - that sitting in lectures is something that they simply have to do. They recognise that this is a necessary and integral part of their progression and that it is essential to helping them become a different person - a registered nurse. The university experience is generally less problematic than clinical practice - even though they accept that it can be difficult and pressured:

> Yr1 FG1 *'See I expected theory to be theory coming into university - I haven't done a degree before so I expected theory to be assignments 2500 or 3000 words and referencing so I don't think that was as a big of a blow to me because I expected it at uni'*
>
> Yr2 FG2 *'it is really good to get your assignments and everything as well because you need to know how the body works and stuff which is really good and then that long period of time on placement is good I think because it kind of supports what you've learned'*
>
> Yr3 FG1 *'we have got to the point most of us, one assignment left we are waiting on results, most of us have jobs secured. It's just like right I need to find that motivation to get over this last essay... I really think the assignment that we just handed in was the most challenging assignment ever.'*

The completion of assignments is therefore challenging. There is also a recognition that to be successful requires significant commitment. They also recognise that occasionally their previous academic experience prior to university may not have prepared them for the greater challenges of degree level study and the changing expectations and demands of the academic curriculum:

> *Yr1 FG1* '*It's been a bit of a blow to be honest - I did the Access Course before and I was getting distinctions and doing really well and I've come here and just scraping to pass*'

However there is at least a level of consistency to their university experience, their perception of university remains constant and stays the same, at least to an extent. It is therefore relatively un-troubling compared to their experiences on clinical placements. Not surprisingly much of this consistency comes from the relationships that are established - they know their lecturers and generally feel supported by them.

> *Yr1 FG4* '*I think that is probably practice that is most disjointed - from a Uni point of view they have been consistent and the same message has come through and everything - but being on placement you rely so much on your mentor...and that is where it has been inconsistent.*'

> *Yr3 Grp 1* '*In my first year first placement my mentor told me in front of everybody that she didn't want me, and there was no support - there was nothing. I got chucked the CD keys when they went out for a fag! ... I was like.... this isn't nursing. I spoke to the course leader and said if this is what nursing is I don't want to be here anymore and she said 'you have had a bad experience and I want to instil the passion of nursing back into you' and so she gave me a lovely placement and it did, it did bring it back and I thought yes this is the kind of nurse I want to be*'

O'Brien, Graham and O'Sullivan (2017) describe how students tend to have a growing acceptance of what is required to complete their programme and a tendency to grow in confidence and pride as 'the end' becomes nearer. Moreover the students in O'Brien et al's (2017) small qualitative study confirm the value of the variety of the university support services in helping them progress and get through the programme. Similarly Hamshire, Barrett, Langan, Harris and Wibberley (2017) and Hamshire et al. (2013) in a survey of 1080 students in 2011 and 1983 students in a repeated study in 2015 highlighted recurring issues for students in nine Universities in the North of England - both in the early stage of their nursing course and also towards the end of their programme. Data from both surveys indicate a generally positive student experience, although key themes indicate similarities to my research. These similarities include: some surprise at the academic level and expectation at university - but most principally students facing poor placement experiences, particularly in relation to a perceived lack of support whilst studying at the same time as being on clinical placement. Rather disappointingly Hamshire et al. (2017) indicate that despite considerable investment in attempting to improve

students' experience across the region there appeared to be little change in their perceptions of their learning experiences. The role of the academic tutors - responsibilities for support in practice, pastoral and academic duties, for example - required greater clarity, accountability and strengthening.

Hamshire et al. (2017) suggest that due to the long term nature of these problems and the self-evident complexity of any resolution, new ways of framing and resolving the problem may need to be considered. However they concur that - as confirmed in this research and also recurrently found in the literature - the role of lecturers and other university staff remains invaluable in protecting and guiding students through their programme and their variety of placements.

> *Yr1 FG4* *'I spoke to someone from (University name) on about the 4th week - I'm not very happy, I am worried that I wasn't learning a lot - she was nice and supportive and came to see me the next day and sent someone out a few weeks later to check up on me, they were good'*

> *Yr3 FG1* *'....keeping that pride up and reminding yourself that you are doing an amazing job and here at uni so many times they remind you that you are training to be a nurse and that it's a good thing and they do make you feel really proud to be doing it.'*

However not all students had such a positive experience or felt so well supported by staff at the university:

> *Yr2 FG3* *'once you're out there you are out there aren't you?... you could have a terrible experience and nobody would do anything really to stop it'*

> *Yr3 Grp 4* *'It's just... there seems to be a serious lack of communication there and a lot of the time it is left to the students to be that link and its hard sometimes'*

Highlighting the perceived disconnect in learning between university and clinical placement staff:

> *Yr2 Int2* *'It is like the lecturers don't know what they are doing. Like I asked the question 'So when I'm on my placement and I want to do my floating DONA (*assessment*) who actually signs it?' and she said I don't know - you will have to ask your own group tutor or mentor'*

6.4.4 Clinical credibility in academic staff

Several students, however, repeatedly highlight their belief that university academics do retain significant clinical credibility and awareness of clinical practice. This appears, in some way, to assure them that the academic content and it's under pinning of practice that they find encouraging and consistent with their own, is legitimised and reassuring.

> Yr3 Int2 *'you know everyone we have worked with here at uni - they have all got a clinical background so they have all lived it at some stage and some of them still do bank shifts don't they and they see on a day-to-day what we are going into'*

> Yr1 FG2 *'some of the tutors are still in practice aren't they? They do a bit of both which I think is good - but ...I think maybe they should go and see what some students are getting up to'*

This second comment highlights, however that time spent in clinical practice by lecturers or tutors may not be the panacea to all the problems of student learning in clinical practice.

6.4.5 Lecturers and mentors - the essential supportive relationship

Therefore, as ten Hoeve et al. (2017) highlight from their semi-structured interviews with seventeen third year nursing students in the Netherlands, optimum cooperation is essential between lecturers and those who provide support for learning in clinical practice, most particularly mentors - should the students' dreams not turn to disappointment. Mutual collaboration between the individuals and groups of staff is of paramount importance both to promote learning and also thereby contribute to retention of student nurses in their training programmes. The complexity and variety of experience of neophyte student nurses particularly should not be underestimated:

> Yr1 FG3 *'Yeah I do think we are supported at uni - but I had a bit of a horrible time on placement. I remember before Christmas 'oh I can't wait for this to end I can't wait to go on placement' and then when I'm on placement and I'm thinking 'I can't wait to get back to uni' - there's no pleasing some people (laughs).*

Nor should the complexity of the relationship between staff from university and their clinical colleagues be equally underestimated:

> Yr1 Int3 *'I was about three weeks in when...I thought I've got work tomorrow I am going to start crying. So I just text X (*tutor*) it was quite late at night and she text me back and said 'right I will come and see you tomorrow' I was like 'please don't say I've said anything' she was like 'no I will just pretend that I am visiting and she (*mentor*) doesn't have to know anything' - so she came out and I told her everything that had been going on - she was like 'look you know we have got a few options.... you can either change mentor... or I can have a word with her but to be honest with you I don't think she's going to listen to me either'*

This is again indicative of the dissonance and discrepancy that threatens the students' learning. As I have contended, effective learning within any team is premised on high levels of shared intellectual content or understandings among those who are learning and working together. Shared intellect has been defined as 'feelings, perceptions, thoughts and linguistic meanings' (Zlatev, Racine, Sinha & Itkonen, 2008) and is essential if a genuine connection is to be made between the learner and those involved in their learning. The learner is not simply led by the teacher, the learner may in fact lead the teacher. In such circumstances there is a shared reality

and shared understanding which is created by the interactions of those involved, shared presuppositions and a common focus of attention - all of which are essential for construction, communication, genuine participation, problem solving and learning (Billett, 2014).

This required set of circumstances has been conceptualised as *intersubjectivity* (Murphy & Brown, 2012)*.* Intersubjectivity can be viewed as more than simply *conceptual knowledge* and can include both shared procedural capabilities and also shared values. In other words in any foundation for effective learning and working, any common understandings and awareness must be complemented by both shared procedures - that is any established ways of undertaking tasks and agreeing how to do things as a means of achieving common goals - *and* dispositions; such as values, beliefs and interests (Billett, 2014).

The very nature of the current model of training for nurses, particularly with the variety of different clinical placements, highlights the difficulties in promoting such a climate of intersubjectivity. The experience for a student is by its very nature temporary, relatively fleeting and partial. I would argue therefore that concepts such as communities of practice struggle to adequately explain such arrangements of working and learning as there is limited opportunities to form and sustain a community. Any learning must therefore be based on other premises than a progression to full-participation in a community of practice. Only when a student spends sufficient time with a mentor can they come to know the specific concerns, sensitivities, reactions and ways of working necessary to develop the essential learning relationship.

Moreover, as we have seen, many students experience a context where - due often to their relationship with 'old timers' - the processes and procedures they participate in can be quite indeterminate and the goals ambiguous and uncertain rather than common and clear:

> *Yr1 FG1* '*It's all about communication with the older trained ones… because my two mentors at X went through the degree programme. Their ethos about supporting students was completely different - they worked differently and behaved differently so to speak.'*

> *Yr1 FG1* '*because some people - and I've heard it many times that they have been in the job that long that they have lost the care that they give to patients and they are just there to do the job, get paid and go home.*

> *Yr1 Int3* '*I think it's about the way they were treated and they expect you to have to go through that as well in some sort of warped sense. Do you know what I mean - it's like well I had to go through it so should you.'*

Jack et al. (2018) highlight a related comment from their semi-structured interviews with student nurses - in this case a third year student who had recently discontinued their

programme. The student felt that the legitimisation of nursing as a career and the move from the very traditional model of nursing practice being governed and overseen by medical staff had merely been replaced by a context where nurses 'oppress themselves'. Echoing the experiences of the students highlighted above this particular student's impression was that the mentors' attitude was often *'I had a really mean mentor so I am going to be really mean to you'* (Jack et al., 2018 p.934).

The student needs to be invited to participate, granted access to and supported in their engagement and therefore learn in such a setting of social activities and interactions. For learning not to be inhibited the student needs to feel included and supported in their learning, positively engaged with their mentors and others:

> *Yr1 FG3 '...you need that support from your mentor definitely because they are the ones who you are shadowing - they are the ones that you are spending the most amount of time with and you know you are not going to learn much if you are being made to feel unwelcome'*

> *Yr2 Grp2 'the mentor was amazing and the rest of the team were amazing but for the first two or three weeks I went home like in tears most of the time thinking 'Oh my God what am I doing I don't know what I'm doing and way out of my depth' - but if it hadn't been for her and the way that she carried me through....'*

> *Yr3 Int2 'it is really good when you go to placement and the nurses say you've been a pleasure to have on the ward you've been enthusiastic and it is kind of nice to know that you actually helped'*

Intersubjectivity can, therefore offer additional help in understanding an awareness of the ongoing process of learning for students in clinical practice. Through a recognition of, and emphasis on similarities, commonalities and knowledge, learning and knowing can then be made more accessible, shared and understood. Positive relationships and evidence of mutual respect are necessary as any progression and positive development are reliant on those relationships with all parties having to recognise each other's contribution. However as I have shown this can be problematic from all parties concerned:

> *Yr1 Int3 'there is a lot of 'you can't do this anymore you can't do that anymore' - and we are not classed in the numbers whereas you would have been in the family of the ward if you will. - There is definitely a view that you are university students, you are not their student. They are almost doing the university a favour to take students'*

> *Yr1 FG3 '... especially if you come across people who qualified years ago. It was totally different then and their learning was probably a little more intensive than ours because they were having to take teams straight away in first year and learn things really quickly. And I think they may have forgotten that it's completely different now so they expect you to know a lot more and they ask you questions and you feel there is nothing worse than being asked a question that you don't know the answer to - you feel about this big'.*

> *Yr3 FG1* *'Yeah they say 'what you are learning now is all right but you really start learning when you start here - that's when the real learning starts' - and you are like in a way yeah but you need the uni stuff to get there and I think it's given me a really good background of knowledge'.*

6.4.6 Students start to feel greater 'intellectual power'

The students' university experience is crucial to them viewing and presenting themselves as a *professional nurse*. Indeed, how the students recognise and acknowledge the changes generated by their university experience influences them to, in some way, feel like even *more professional nurses* than the nurses they encounter who may not have been educated to degree level. This realisation of the potential of 'intellectual power' and authority can cause some tension - or at least reflection - in the established old timers. Established nurses can feel that their power is being reduced as *their* profession is being taken over by others:

> *Yr3 Int1* *'I think they think 'oh you are doing the degree you must think you are above us''*

> *Yr2 FG2* *'do you think some of that is like about a work ethic as well? (Yeah it is) - people who have tended to be there for longer seem to be a little bit more set in their ways and that and you come along new and they say 'Oh I used to be like you I used to care' - but it is not a good way for a mentor to be when you are kind of learning off them and they are supposed to be guiding you'*

Being students in the university and actively engaging in learning and the exploration of current and best evidence confirms that they are part of the academy and this offers them a level of professionalism that they perceive that some of the old timers do not have.

However occasionally even a number of their peers also question the legitimacy of their learning in university:

> *Yr1 FG3* *'... and from our peers even they like have that attitude – 'why is it all academic?' 'Why are we in uni doing assignments and exams?''*

> *Yr3 Int1* *'...you can get somebody that has been through university that are still crap and they still have a bad attitude and don't work the right way. Because I've come across people even now who say 'I don't think we need that' - people on the degree that believe that they don't need the degree'*

However for the most part their participation in the activities of the university is instrumental in the notion that not only are they changing as individuals but they are also responsible for fundamentally changing nursing and what nursing is:

> *Yr2 FG2* *'Yes - it is the nurses of the future isn't it?'*

> *Yr2 Int2* *'They are trying to get us to be the nurses of the future so we will change practice'*

It would appear that relatively quickly the students start to recognise that their experience in university offers them a level of security and intellectual power over many existing nurses. The recognition is consistent throughout the three years and can thereby further jeopardise and cause discontinuity in relationships:

> Yr1 FG1 A *'Cause they think we are like more qualified.'*
>
> B *'Because we **are** more qualified than the diplomas when we register'*
>
> C *'It's also because they have that, kinda like, issue that you are probably lower if you do the Diploma – it's like stereotypical'*
>
> Yr1 FG3 *'...I really don't think that some of the nurses if they were to do a degree now would pass I really don't... because some of them do lose their skills - from my experience anyway and they become quite bitter about it don't they?'*
>
> Yr1 FG2 *'I think the university is a lot more focussed - they are pumping us out as the new lot but it is going to take longer for them to change the practice cos you have a lot of older people and the nurses who have done it for 30 years - you can't change that, it's a lot harder and you can't teach an old dog new tricks.'*
>
> Yr2 FG2 *'don't you find that a lot of nurses in the blue actually don't know a lot of things as well? I mean you get nurses who know absolutely everything about everything - or at least put on the face that they do -and then you get others that can't answer your basic questions'*
>
> Yr3 Fg1 *'It will take so much longer than that to get the change into practice - It's easy to get a couple of hundred while they are sat in the same lecture theatre but it needs thousands of people to get on the same wavelength.'*

Therefore from the point of view of the student they can find themselves in a position where they are learning from - or presumed to be learning from - someone who they have limited respect for. This again makes learning problematic. Their experience in clinical practice and its lack of resemblance to what they are taught at university, quickly changes their views. They witness the behaviours, attitudes and apparent values and priorities of some clinical staff and are forced to reflect that many of the old timers who they are supposed to be learning from have limited respect either for best practice or even for them as learners:

> Yr3 FG2 *'falling into the old ways is so easy. I've done it when I've gone into placement and I say 'I will do it this way the way I have been taught at uni' - and everybody else is doing it differently and you find yourself doing it and you think hang on I'm not supposed to be doing this'*
>
> Yr1 Fg3 *'So I think uni are right in the fact that they are teaching us how things should be and ideally we would go away and do it exactly like that. But it just doesn't happen as much as you try - like you say you just get people asking you 'why you doing it like that?''.*

As I have discussed in the previous themes, some of the old timers, by their actions and their comments, indicate that they are not as committed to the nursing profession as the students

believe *they* are themselves. By their own words as relayed to the students - although they keep turning up to work - some of them are significantly less keen to be a nurse then the students are. Therefore as part of becoming a nurse, what is happening to the students psychologically is that they are having to wrestle with the differences they continually witness between the apparent reality of nursing and their own dreams and aspirations to be a nurse; and also what they are taught at university and the reality of what they witness in clinical practice:

> *Yr1 FG3* *'I think the university is quite idealistic about what they expect as a nurse - and then you go to placement and see what they actually do and, you know, they are like 'what are you doing that for?' and its 'Oh Christ here we go again' - explaining why I do it this way (deep sigh) 'we have been shown this way' – 'Well we don't do it like that here' - yeah that's why they are teaching us to get rid of that.'*

One of the critical narratives relayed to them at university is that 'to be a nurse' they will need to know what best evidence and research shows about best practice and what patients need and can rightly expect. They are therefore going to be taught this and be offered opportunity to learn what best evidence shows is currently presumed to be best practice. They then venture into the world of practice and this is challenged by much of what they witness.

Moreover they have even been warned of this potential by staff at the university prior to their initial experience in clinical practice - and also occasionally at recurring moments throughout their academic career. They are cautioned that what they might observe in clinical practice may trouble them. They are counselled that they will need to learn to manage this, they are questioned as to what their response might be - are they going to become like that person and replicate that less than optimum practice or are they going to *fight the good fight*, and maintain their standards and values:

> *Yr1 Int1* *'A relative said to me 'it's really obvious who cares and who doesn't on this Ward because - no disrespect to you and your nursing profession - but there are nurses on here who just don't care and they are really not bothered. But you give my mum really excellent care' - and that was really nice'*

> *Yr2 FG3* *'I think here (university) we are sort of pushed to advocate for patients and to stand up to people if it's not right. I think that is something that I've taken from this university - I don't know whether that is the same everywhere? But they are really pushing for us to be whistle-blowers and to speak up if something is wrong'*

> *Yr3 Int1* *'...one patient said to me 'you can tell you are a student' ....she said 'some of the older nurses they are so rough''.*

6.5 Conclusion

Within this chapter I have explored and critically discussed the major themes that were generated by an analysis of the data. The three main themes were:

1) Becoming a nurse

2) Engagement with old timers

3) The University – Practice Dissonance

A critical exploration of the data highlights the processes and experiences by which new students shift from knowing little or nothing about being a nurse to a position where they recognise their more valued position within the teams and communities in which they participate. Participation which provides confidence that they can legitimately call themselves a nurse.

The relationships with established clinical colleagues - old timers - can be very rewarding and supportive but the interactions are also continuously challenging. The challenge is persistently produced from a variety of sources, as the students are frequently confronted by practice that they view as less than optimum; witness practice that appears to refute the knowledge and learning gained from their university experience and have to come to terms with established colleagues who they feel evidence different values than theirs and standards and behaviours that are contrary to what they believe current and future health care and patients and service users need and deserve. Their experience generates a very specific type of dissonance. Being a human being is by its very nature about experiencing dissonance, however their conflict is a very *specific professional dissonance* and comes uniquely as a result of becoming a nurse. Therefore it is clear that a critical aspect in the shifting identity of the students is the need to manage this specific dissonance. The students' experience significant transformation throughout the three years, and there is substantial shift both in their view of themselves and the way others view them. However the professional dissonance remains to the end. Some of the data echo and confirm previous research that has been highlighted and critically discussed in the literature review. However this research uniquely highlights that the power imbalance often perceived in the relationships between the students and the old timers can also shift in interesting ways. The data highlight that the power imbalance is uni-directional initially, as the established nurses who are central to the communities of practice demonstrate power over the students. However as the students establish themselves, reflect and gain confidence in their

own abilities and futures - furnished by their experiences and relationships from university - they recognise that they have a level of *intellectual power* over many of the old timers. This recognition is integral to the continued professional dissonance and creates ongoing discontinuity in the key relationship between old timer and newcomer. It is essential therefore that any future curriculum development honestly and openly recognises the reality of this dissonance if it is to be overtly included in the creation of new curricula.

Chapter Seven: Conclusion

7.1 Thesis Review

In this chapter I present a holistic assessment of the research. By this I mean that I provide an overview of the process; what was done; how it was done and why - and what was discovered and why it matters. I also highlight the unique contribution to knowledge, any limitations of the study, the extent to which I met the research aims, and recommendations for potential future research.

The exploratory, qualitative research study set out to explore the shifting identities of pre-registration nursing students across a BSc adult nursing programme. The motivation for this exploration was multifaceted and was driven by long standing and ongoing considerations prompted by my significant experience in various professional roles. The complex reasoning that supported the decision-making behind the initial research choices included the personal, specific and very subjective reflection on my relationships and discussions with many students over my career and also the discussions, initiatives, changing priorities, curriculum deliberations and the ongoing challenges related to student experience at school, university and in clinical practice. A critical exploration and acknowledgement of the notion of communities of practice advanced by Lave and Wenger consistently provided a focus throughout all stages of the research, as did the inescapable pervasiveness of the wider professional, societal and political context at a time of extensive debate on the fitness of the current student nursing populace.

A significant personal history of involvement, reflection and consideration of the student nurses' experience, therefore crystallised in the ambition to further explore the understandings, perceptions and unique experiences of context of those that had chosen to take up nursing as a career; and how this context might inform their learning, and influence and shift their identities.

7.2 The aims of the study were:

- To explore the shifting identities of pre-registration nursing students across a BSc adult nursing programme
- To understand the subjective experience of students' participation in university practice
- To understand their participation in clinical practice
- To explore student understanding of nurse identity – what it means to be *'a nurse'*
- To contribute to the nursing literature surrounding student learning

7.3 The phases of the research study

The study consisted of several planned and clearly defined phases. The population of interest was student nurses on a BSc nursing course and therefore the initial stage of the research was facilitating access to sufficient numbers of students on an adult nursing programme to generate data that might be sufficiently representative of that population. Following consultation and negotiation with supportive staff at another university in the North of England, I was able to facilitate focus groups with students from across the three years of an adult undergraduate nursing BSc course. There was no further sampling criteria used - or required - that might have more accurately and *purposefully* generated participants designed to represent adult nursing's general balance and mix of age, race, gender and so on. This may be viewed as a limitation in the research - however the mix of participants across the whole of the focus groups were sufficiently representative of age, gender and cultural mix that is present in the current student nurse population in the UK to allow inferences about that population. Subsequent to the focus groups I undertook semi-structured individual interviews with students from each year to further explore the data generated from the focus groups, to confirm my understanding of the focus group data, codes, patterns and themes and to triangulate to achieve a more comprehensive understanding of the phenomena being investigated. Lambert and Loiselle (2008) claim that through its iterative nature, the integration of focus group and individual interview data can enrich the conceptualisation of the phenomena, and through a convergence of the central characteristics of the differentiated themes enhance the trustworthiness of the findings.

7.4 The main themes

The three main themes that were generated by immersion in the data and a systematic thematic analysis were:

1. Becoming a nurse
2. Engagement with old timers
3. The University – Practice dissonance

The contribution to knowledge made by this research relates to some, each or all of the research aims. I shall initially offer a succinct summary of the main contributions - *linked to the major themes* - and subsequently further discuss and develop in more detail.

7.5 Summary of the contribution to knowledge

1) Participation in clinical practice and university eventually produces a perception of intellectual power in the students that sustains them and helps to offset any negative experience in clinical practice (Themes 1, 2 & 3).

2) Their perception of intellectual power is paradoxically derived from their participation in the communities of practice of clinical practice and university and the experience of dissonance that this generates (Themes 1, 2 & 3).

3) Their experience - even when negative - also generates a belief in their unique roles as positive change agents and practitioners of the future (Themes 1 & 2).

4) The recounting of their experience highlights significant problems with the apprenticeship model and challenges the belief that apprenticeship type approaches are necessarily a guaranteed way to promote positive outcomes, quality and - in nursing specifically - any reduction in the likelihood of further failures of care in the healthcare environment (Theme 2 & 3).

5) Their experience similarly challenges the conviction that mandatory experience in a clinical or 'care' environment prior to becoming an adult nursing student is likely to reduce such failures in care in the future or promote empathy, positive values or attract the 'right type of student nurses' (Themes 1 & 2).

6) The nursing students who express agreement with the principle that all nursing students should have prior 'caring experience', do so as they appear to believe this will indicate if the prospective student is able to cope with the challenges and difficulties of current clinical

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practice; rather than a means of generating understanding and compassion. Therefore this initiative may well ensure a 'right type of student nurse' - but only to the extent that they can *survive* and not necessarily the empathetic, considerate student as hoped for (Themes 1 & 2).

7) The students perceive that the level of positive support they receive in clinical practice relates to when the mentor or other clinical colleague had last participated in a level of study themselves (Themes 2 & 3).

8) Many of the old timers poignantly recognise their former selves in the students and recognise the change in themselves and the less than positive impact that change may have on quality care - 'I used to be like you I used to care' (Theme 2).

7.6 Discussion

7.6.1 Becoming a nurse

One of the main aims in this research was exploring how participation in an undergraduate nursing degree shifted new adult students from knowing little or nothing about *being a nurse* and having little identity around nursing, caring and healthcare generally, to a situation where they had become individuals who could make claim to the title 'nurse'; and who could legitimately exist and operate in the professional setting. The main unique contribution that this research offers to the academic literature highlights that this participation in university and clinical practice produces a recognition of an intellectual power in the students. The students' perceive a greater intellectual power in themselves that sets them apart from the old timers they meet in practice, this perception sustains them and helps to counter balance any negative experiences in clinical practice.

The complexity of challenges some students experience can compromise their learning and cause significant reflection on their part - even making them question their wish to become a nurse. However interestingly - and uniquely presented in this research - what happens over time is confirmation and growing recognition of their unique role as change agents, practitioners of the future and most specifically a belief that their greater intellectual power over the old timers can positively compensate for the negativity that some established colleagues appear to believe is legitimate, appropriate and reasonable. Interestingly despite this negativity several old timers see their former selves encapsulated in the enthusiasm, caring and motivation to do good of the current students, but have to concede that that positivity is

something that has been lost at some point in their career - a loss that the current students are determined to avoid and which they perceive as being 'burnt out'.

The sustaining confidence resultant from this recognition of intellectual power appears to be derived - a little paradoxically - from their experience of dissonance between the priorities, objectives, purpose and espoused values of the university and the practices, standards and goals they witness during *some* of their time in clinical practice. There is a general, supportive consistency in their university experience that engenders their belief in themselves as the nurses of the future, despite the apparent conflict with some of their supposed clinical role models. The theory-practice gap that they perceive echoes much of the literature.

The recognition of their intellectual power, evidenced by their knowledge of best practice, adherence to evidenced based practice and determination to put in practice what they have learned in university, contributes significantly to their perception of themselves as future gatekeepers to the profession, providers of high quality care provision and advocates for patients, service users, peers and more junior students. This has implications for educationalists, clinical managers and policy makers amongst others. Previously I have questioned the coherence or benefit of assertions such as by Lord Willis (Willis, 2012) that nurses must 'stand up and be counted' - however if this type of statement is to have any meaning at all, then further support, greater validation and sustainment of those students who recognise their role in this new assertive, patient centred profession is vital. Moreover NHS and Trust colleagues - not least more senior staff - need to acknowledge and recognise the difficulties that students have in maintaining their values, should they genuinely aspire to a more assertive, caring patient-focussed future nursing workforce.

An analysis of the data also confirms some of the previous, established nursing literature. The students develop and shift in identity due to their increasing participation in the various communities of practice (Levett-Jones & Lathlean, 2009; Murphy et al., 2009; Cook, Gilmer & Bess, 2003) - evidenced in an increased confidence in their skills and knowledge, an augmented resilience and willingness to stand up to others should they believe that their role as patient advocate is necessary and required; or their own learning is being unfairly compromised. Their shift in identity is incremental from year one through to year three and is further indicated by their occupation of a more central position within the various teams that they positioned with. This echoes Lave and Wenger's (1991) contention that learning is evidenced by a newcomer moving to a more central, engaged and complex position within a

community of practice and that this greater engagement implies becoming a different kind of person.

As their student career progresses their registered nursing colleagues respond differently towards them. They become different people - not least in this changing reaction of others towards them. They are also looked at differently by their friends and loved ones - generally through a lens of maturity and professionalism - but also occasionally as a person who is less of a risk taker and less fun to be with.

Their confidence can still be quite fragile and at risk of being significantly challenged by themselves and others. Students from all three years are concerned by the apparently changing and more negative views of nursing - particularly post-Mid Staffordshire Hospitals Report and other high profile scandals that are occasionally, overtly discussed with them by patients, service users and carers and other members of the public. They are also challenged by the frequent expression of negative views of the nursing profession by the nurses who they work alongside and who they are expected to learn the inherent values of nursing from.

7.6.2 Engagement with old timers

As a student nurse their relationship with their more established colleagues continually challenges their identity as a neophyte professional, particularly with established colleagues - old timers - that they work with in clinical practice. Some students have a positive engagement with some of their mentors and other old timers and they are able to recognise and appreciate their expertise and value it both for its contribution to patient care and also to their own development and learning.

However, the students in each of the three years highlight their experience of a frequently hostile environment towards them as a student, and how they are confronted with the fact that - often despite their best efforts - they will always remain peripheral figures in many of the environments and communities of practice that are theoretically designed to be instrumental in their progression and learning. Their acceptance is inconsistent and their contribution is minimised and they are often made to feel like a *permanent visitor* at best, and an unnecessary burden at worst. Staff often refer to them as 'the student' and forget - or never learn - their name even though they may have been on placement for anything up to three months.

Therefore the evidence in this research offers significant challenge to the apprenticeship model in healthcare specifically but also beyond in the broader area of work and employment. The

students' experience and perceptions of clinical practice, relationships with colleagues and negative impact on their learning significantly problematizes the apprenticeship-type model of learning that the nursing degree - with its essential component of learning in clinical practice - is an example of. Put very simply, students perceive that they learn to do things correctly in university and learn how to do things incorrectly when in practice. The data contests the idea of apprenticeships being a panacea to the current shortfall in the professional workforce, and the belief that apprenticeships may be a unique model to ensure quality and reduce the likelihood of further examples of systemic quality breakdown in health care.

Therefore it also questions the legitimacy of the notion that patient care will inevitably be improved if all nursing students had previous clinical practice experience prior to commencing on their degree. As the data indicates, occasionally what students learn, in fact, is simply how *not* to practice - and although that in itself may, arguably, be of some value, it is difficult to maintain that it is a sufficiently robust principle to construct a major, strategic, policy upon.

The intellectual power and authority that the students believe ensures their position as high calibre nurses of the future only derives from their experience in the university and their learning and confirmation of values and principles which then impacts positively on their perceptions of their clinical practice experience. Therefore experience exclusively in clinical practice and in isolation from the ideologies and notions of evidenced based best practice, advocacy and patient centred care promoted by the university may be less likely to instil the inner strength, resilience and intellectual authority as articulated by the participants in the study and as required of the nurses of the future.

Similarly, whilst recognising that the nursing profession may benefit from an initiative that supports an aspirational career timeline that facilitates progression from the HCA role to eventual professional regulation and beyond - this research encourages, at least a reflective qualification of that unchallenged assumption - an assumption that has quite a central position in much of the current policy directives and political and media discourse.

7.6.3 The University - Practice Dissonance

Much of the discussion of the previous two themes also relates significantly to the third theme. The data consistently confirms the significant conflict that the students perceive between the two differing major communities of practice - university and clinical practice. This theme again highlights how the data is informed by Lave and Wenger's (1991 & 1998) theoretical position. Their challenged relationship with old timers and the perceived difference in values is just one

example of this discord. Not only are the students maintained on the periphery by the actions of many of their qualified colleagues they are occasionally even more directly challenged about the purpose or worthiness of their degree qualification. On many occasions the students are personally and publicly challenged as to the value and legitimacy of their academic education. They are confronted by an environment of power imbalance, that continually feels legitimatised in provoking them about their alleged lack of fitness to practice and speaks of them openly as 'paper nurses' who are the embodiment of how nursing has lost its essential values and purpose. The confrontational discourse is made further permissible and validated by similar debates in the political and professional arenas and also by anecdote and reporting in the media.

There is concern that any learning that derives from working with the old timers is likely to be contrary to what they have been taught in university and what they view as best practice. In the students' estimation their colleagues' view of what nursing is and can be is undoubtedly associated with how long the old timer has been qualified. On several occasions the students relate this specifically to the registered nurses age, however this is typically then refined as more specifically related to their time spent in practice or even more particularly to the *time that has elapsed* since that individual qualified as a registered nurse. The relationship that is deemed so crucial to the students' learning and development and shift towards becoming a nurse as articulated by the university is compromised. The potential to witness and learn from poor practice, being ignored or maintained on the periphery and even being treated unfairly and bullied are examples of this compromise. This has significant implications for nurse educators and teaching in general and needs recognising within the current and future curricula and the structures that are in place to support current and future students.

7.7 Further recommendations

Further to the implications of the unique contribution to knowledge of this research highlighted previously and the other suggestions included above additional recommendations from this research are:

> It is essential that further exploration of the needs and requirements of the old timers in clinical practice is undertaken and necessary support provided. As the data indicate, many of the staff so crucial to the maintenance of quality of patient care and support of their future colleagues recognise the loss of their previously held values and reasons for choosing nursing as a career. The students' perception is of a lack of commitment of organisations to these old timers and research indicates that support and investment in

those who have been historically loyal to the profession; and provision of space for them to reflect and re-energise may be as equally important as investment in the new starters.

The pressure on the old timers, placement capacity in general and potential negative impact on patient care - makes it imperative that there is thought and joint consideration related to the current strategy for removal of cap for student nurse numbers. Whilst the aspiration to furnish the profession with greater numbers to meet the increasing demands of modern health care may be laudable and even essential, the experience of students in this study indicates that this is likely to compromise the support for learning even further.

This highlights a related challenge to professional bodies such as the NMC - along with those universities with undergraduate nursing provision - to continue to robustly research the changing needs and expectations of registered staff and students as they review and address and their philosophies regarding the *mentorship* role and the new roles of practice supervisor and practice assessor.

7.8 Limitations of the study

The key principle in presenting limitations in a thesis is *transparency.* During the process of undertaking this research I determined to maintain an iterative reflective approach to the entire experience, an approach that enabled me to recognise real and potential limitations consistently throughout the process. I believe this was important to help recognise the progression of the research and also to assess considerations such as the focus of the original research aims, methodological sample size and data saturation, potential bias both in the scope of discussions and also in an awareness of my own prejudice or blind spots, inappropriate influence with the focus groups and so on. An honest exploration of the limitations of the research also allows me to maintain an ethical approach to the data and respect to the participants in attempting to offer an authentic representation of their voices and narratives.

Undoubtedly I began the study with certain anticipatory suppositions from my previous discussions and experiences with many students and also from my previous and concurrent exploration and analysis of the relevant literature. However the thesis has enabled me to use the participants' insights, understandings and experiences of participation and shifting identity to further develop, advance and contest what was known and analyse, derive and subsequently progress new learning and unique knowledge.

My experience as a researcher led me to question my assumptions throughout the process. I was particularly concerned that my deliberations on the potential for an exploratory research project had been generated - perhaps understandably so - from my experience supporting students who were often undergoing quite a challenging and disheartening experience as an adult student nurse. I consistently reminded myself that - like most things - positive experiences tend to be presumed and accepted and are therefore less well explored and indeed less time invested.

Whilst the strengths of this study relate to the application of robust methods that discovered and explored the subjective experiences of a specific group of first, second and third year adult student nurses - a limitation of the study is that the participants were all students at one university in the north of England.

A further limitation may be that there is no 'old timer voice' within the data - I continually reflected on the absence of the perspective of established staff, particularly as they were so central to the experience of the students.

I am confident that the methodological choices were most appropriate, valid and defendable - and the participants' commitment to the research and myself as a novice researcher was quite humbling. However like all self-reported data it is limited by the fact that it cannot be independently verified - there is no evidence of attribution or exaggeration for example.

My 'distance' from current clinical practice - the length of time I had personal experience of the type of clinical practice of which the students spoke - can therefore also be seen as a limitation of the study. It is important to acknowledge that some limitations of research are inherent within the specific researcher themselves especially as I am at a relatively early stage in my research career.

It was also imperative that I was continually reflexive regarding the potential influential power dynamic between myself as an academic - moreover a male stranger - and representative, to an extent, of 'the university'. As I have discussed in the Methodology and Methods Chapter, I was determined to create an environment that would facilitate honesty, openness and mutual respect - I am confident I was successful in this aspiration as far as is practicably possible. The participants' willingness to share their vulnerabilities and private and personal recollections in providing vivid, informative, insightful and occasionally profound insights significantly enhanced my understanding and comprehension.

Whilst openly accepting and acknowledging the limitations of the study I am confident that none of these limitations - whether individually or collectively - results in such a serious and critical flaw to negate the value and importance of the results or compromise the attainment of the research aims.

7.9 Potential for further research

Throughout the research process I was aware of the real benefits and opportunities that might be offered by replicating much of the methodology in this study - but from a more longitudinal perspective. Much of my joy and inspiration came from my time spent with first year students and I recognise that further engagement with them as they pursued their aspirations to become a registered nurse would have undoubtedly been fruitful and no doubt generated significant further insight. This would have been of particular interest regarding the growing recognition of their intellectual power and authority.

My considerable investment in this endeavour has given me even greater regard for many of my qualified colleagues and the pressure that they are under to deliver on the multitude of priorities of their role. I am certain that further research that shares the findings of this thesis with the old timers and their managers and explores their reactions would generate fascinating insight and also help inform policy, furnish Continuing Professional Development priorities and other initiatives that support the current nursing workforce.

This research challenges the assumption that previous experience of health care prior to becoming a student nurse in some way ensures greater quality of care. It would, therefore, be very interesting to further explore, exclusively the differing views of student nurses who have previous experience as a health care assistant.

7.10 Final thoughts

I believe this research has made a noteworthy contribution to the body of qualitative literature in nursing research and the final chapter demonstrates that the aims of the research have been met. A key strength of this work is that it is firmly grounded in the unique perspectives of the participants concerning their experiences as they progress on their nursing career and what is presented here represents the knowledge and insights that I derived through a robust analysis of the data.

Despite the comprehensive analysis and discussion in this thesis, I believe I have only managed to capture certain aspects of the complexity of the context of adult student nurses' shifting

identity as they progress through their nursing degree. It is impossible to represent the full richness of the data that was generated by the research process in a just a few thousand words. Accepting that in my positioning of the student and the practice and educational context that they find themselves in as problematic, I necessarily construct the data and the literature in a certain way. I analyse situations from the original perspective of challenge and dissonance and judge them accordingly. However I have made every effort to be faithful to the data as I have endeavoured to focus and prioritise on the students' narratives and concentrate the analysis on the experience of the participants which have particular relation to their changes, experiences and shifting identities.

On a personal basis I am particularly proud of the opportunity this research has offered to an impressive group of novice professionals. I was continually humbled and impressed by their caring, commitment to quality and the patient experience, insights, support of each other and myself as a novice researcher. I was continually left with a conviction that despite the difficulties and challenges facing nursing the future is ultimately safe in their hands.

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A Search Strategy

Databases searched: Summon a comprehensive search engine including the Medline, Embase, and Cinahl - library catalogue, journals and journal articles in print and online, print and e-books, multi-media and newspaper articles.

The initial search used a variety of sources *both primary and secondary also including* Google scholar

Identifying keywords and synonyms - wildcards = alternative spellings

"nursing student experience" 1335 hits limited to last 5 years 678

"adult nursing students" 224

nursing student experience" + "adult nursing students" = 13

"becoming a nurse" 3559   5 Yrs 1259 - limited to journals 317

"nursing career choice" 73 Limited to journals 67 - last 5 years 23

"fitness for registration" + nursing 4

"Communities of practice" 49,960 (Journal Articles 37,612)

PLUS   Medicine 2,476

　　　Nursing 899

Limited to last five years 1659

"Professional Identity" limited to nursing 968 (Journal Articles & Dissertation/Thesis)

Developing and emerging themes generated by the review and early data from the initial focus groups

"older nurses" 2759 Limited to 5 years 818

"poor nursing practice" 80 results limited 5 years 17

"whistleblowing" 114,111

Whistleblowing AND nursing 2658 LAST 5 Years 853

Whistleblowing AND "student nurse" 127 LAST 5 years 53

　　　Limited to "Nursing" and "education" 31

Mentor AND nursing 57,360 LAST 5 Years 17,270 Limited to Nursing 3,953

　　　Limited to last 12 months   3243

Mentor AND Nursing AND whistleblowing (Last 3 Years - Journal Articles only) 20

Identity AND nursing (Limitation 3 Years 5043)

Google Scholar

e.g student nurse poor practice (since 2017) 17,000 – snowballing by use of Cited BY

Also Used cited by function and references of full text documents found via Summon and then accessing the document via the publisher's web site.

ADDED

Truncation *

Search terms (AND, OR, NOT) and truncation (wildcard characters like *) - *Boolean Operators*

Inclusion criteria: adult only; English language, nursing

Exclusion criteria: Non English language; only as the search progressed limited by date to ensure currency and relevance – therefore was confident that seminal works were initially included

APPENDIX TWO

Focus Groups Guide

1) Tell me a little bit about your experience over your first/second/third year

Prompts: *recognise the complexity of their experience: university and clinical practice*

Explore shifting perception/identity that has resulted from their experience and participation

2) What would you say have been the most memorable aspects?

Prompts: *What made this memorable? Why?*

3) Is there anything that has particularly surprised you?

Prompts: *Why was this surprising?*

How does this relate to a shift in identity?

Is there commonality/difference both within the individual year groups but also across the three years?

Does previous caring experience/age/experience influence this consideration?

4) If you tried to explain what nursing is – what would you say?

5) Has that changed?

Prompts: *Why do you think this has changed? What are the key aspects that have changed?*

How does this change make you feel?

6) Tell me about continually being the "new kid" – what strategies do you use to become part of the new "community"?

Prompts: *explore their relationships with various established colleagues*

7) Generally would you say that there is a common purpose/aim in the teams/communities that you have worked with?

Prompts: *encourage consideration of what might make up a team/community*

APPENDIX THREE

POTENTIAL QUESTIONS FOR EACH INTERVIEW

Potential Questions Year 1 Interview

Introduction. Revisit research rationale and relevant aims. Confirm overview of plan for the interview – Reiterate link to the previous focus groups. Any questions? Confirm preparedness and consent.

Q1) Changing perceptions of nursing and nurses – what nursing is – what nurses do

Grp 1 "It has made me realise how much nurses do"

Grp 1 "The responsibility was a real eye opener"

Grp 1 "You know what I found most shocking was the huge responsibility of nurses... your accountability and the finding out how much you get paid. The responsibility is immense"

Grp 4 "What really surprised me was that you can't just stay at being a general nurse anymore ... you feel like you should know by your first placement... taking on more responsibilities, the Drs role and everything which is quite scary don't think I would like to do that myself"

Grp 1 "Jesus Oh I won't be doing that"

Q2) Perceptions of relationship with mentors – training/age/attitude to them etc. - Potential for witnessing poor practice

Grp 1 "I think the way your mentor was trained comes into play if you have an older nurse and they didn't do any university study and didn't do the theory side of it they expect you to get straight in there"

Grp 2 "some of the older people are 'Oh yeah whatever' - they are dismissive of some of the new stuff 'Oh yeah pretend you didn't see me do that you've got to do it like this'

Grp 2 "So we are learning all this new stuff but there is a battle really when we get out there with some staff like 'oh you don't need to bother with that come on'"

Grp 1 "My other two mentors at Hospital X went through the degree training programme and their attitude was totally different"

Q3) Old timers - Loss of passion – burnt out? How this might also be their potential future? Insight/Empathy?

Grp 1 It is really scary to think that it could happen to all of us – you go into the job full of passion and then you think that one day I might think I can't do this anymore – it is really scary"

Grp 1 "I have heard it many many times they have been in it so long that they have lost 'the care' and they are just there to do the job get paid and go home – Burnt out – yeah burnt out"

Grp 3 Some of them lose their skills and they become quite bitter about it don't they

Grp 2 "yes and I think I can understand sometimes why some of the NHS staff are a bit beaten down because they are trying to do things right but then the other half of the ward can be not doing things right and it is fighting the losing battle sometimes shockingly it is."

Q4) Being the perennial New Kid on the Block - their experience of the team/community

Grp 1 "Sometimes it doesn't matter how hard you try they still see you as 'the student'"

Grp 1 "People take one look at you and judge you straight away"

Grp 2 "I always stress at the beginning of a placement to think "well I hope I get on here" – then I'll ask more questions – even the stupid ones and you shouldn't be looked down on because you are still learning"

Grp 3 "They make a snap judgement and you are only there for 9 weeks you don't really have time to change that perception of ya!"

Q5) Expectations – how have you found the old timers expectations of your skills/attitude/competence?

Grp 1 Some of them expect far too much of a first year nurse

Grp 3 They do expect a lot from you and if you don't know you are made to feel this big

Grp 2 ... and you don't know how much you are supposed to take in, there is no proper "this is your role" that is one thing that I found really hard (yeah) knowing my role as a student nurse and I remember I got it asked in my interview and I was like yes you are just there to be like a bit of a nurses apprentice and it is like - you are <u>not</u>"

Q6) Reaction of established team/community to you as a student/new kid/representative of the new teaching – potential poor practice again

Grp3 "What are you doing that for? And it's like oh Christ here we go – explaining why I do it this way – well we don't do it like this here – yes that's why they are teaching us to get rid of that"

Grp 1 "Even some HCAs – "look at her student nurse – look at her trying to tell me what to do"

Grp 2 "But I think it is weird going out on placement I expected a lot of... we sort of got prepared quite a lot didn't we if you see bad practice you must report it if you see anything....and I didn't really see anything it was more just like a culture of...there is a bad attitude in the culture isn't there.. sloppy"

Q7) Positive experience – student card

Grp 2 "I think the biggest surprise for me has been were my I'm a student card gets me. (Oh it gets you everywhere) the minute I mention I am a student come in"

Grp 3 "Patients like students – they look at you as if you are Bambi – this frail fragile thing that needs nurturing"

Grp4 "The whole team were great, it's like X said, I felt like I worked there by the time I left - I was crying on my way out the door."   "Whereas I was running out the door!"

Q8) University/Practice - Common goals/values/priorities?

Grp 3 "They (the University) are there if you need them but I must admit I did feel a bit like a lamb to the slaughter"

Grp 1 "the Uni tells you the ideal and not necessarily reality"

Grp 4 "You have to take one hat off and another hat on"

> Introduction. Revisit research rationale and relevant aims. Confirm overview of plan for the interview – Reiterate link to the previous focus groups. Any questions? Confirm preparedness and consent.

Q1) Development – shift in identity – change from Year 1 – increased knowledge

Grp 1 "I also find the difference from first year and this year has been staggering I have found it really overwhelming so far"

Grp 1 "I have also found that in my first year I had bags of confidence and er I suppose you are a little bit babied in the first year"

Grp 3 "when I first started the second year I thought oh I don't know anything I just don't know anything about nursing and then when I am sat in the lectures and we talk about things I think oh I know that"

Grp 2 "it's funny when you talk to family like when I talk to me mom and I'm talking to her about what I have learned and she is like what's that what's that and I remember when I didn't know that now I do know that and it makes you realise how far you have come definitely"

Grp 3 "You don't know who you are do you when you are a student nurse"

Q2) Becoming a nurse – changing perspective – what is nursing? What do nurses do?

Grp 3 "And also how horrible.. how like gory it is to be a nurse (laughs loudly) it's not like that on telly (laughs) (oh yeah!) Whoa you have to measure people's poo and wee and fiddle with it and stuff (laughs) I don't why I didn't think of that but of course it is"

Grp 1 "And then as a student you come in and think I might go and question that because I don't think that's right and I once ended up having a row with one of the nurses"

Grp 2 "The fear of God was put into me! It made me really anxious a bit like can I do this job can I accept the responsibility"

Grp1 "yeah it is bigger than I thought it was. Like half my family are nurses when I first got into it they were like why the heck would you want to do this?"

Q3) Old timers – relationship with colleagues and mentors – "the student"

Grp1 "I think they do understand what work commitments you do...tend to be like slightly younger mentors so they are not really far out of education either so they do understand you."

Grp2 "I just had the one mentor and she was absolutely shocking but she hadn't done any education for about 20 years herself so it makes you wonder."

Grp2 "yes I think a lot of the older nurses not older nurses but the ones that learned on the ward they didn't have to come to uni or anything like that they all say what you need to go there for to learn about nursing you need to be here you need to be doing it"

Grp3 "the worst thing and I know it's not done on purpose but is when even when you can hear them calling you student it kind of puts you in your place you think you are doing well and you think you are part of the team then.. "student" .. "I'll get the student to do it"

Q4) Potential effect on care and response to poor quality care

FG1 "Oh I used to be like you all caring but now, like you know, I'm not"

FG3 "people who have tended to be there for longer seem to be a little bit more set in their ways and that and you coming new and they say Oh I used to be like you but it is not a good way for a mentor to be when you are kind of learning off them and they are guiding you"

FG1 "and yet you see so many little bad habits all of the time that sometimes when you want to do something properly you feel almost like you are being funny...you feel like everyone is looking at you thinking "What's she doing?" you know you are made to feel that you are the one who is being over the top even though you know you are the one that is in the right"

Q5) Diploma/Degree – reaction of old timers

Grp2 "I think also the fact that we are now doing the degree because they don't do the more vocational qualification was at the diploma and now we are doing the degree I think they have this image of like a snooty person that everybody is beneath them"

Grp3 "I think they think oh you are doing the degree you must be above us"

Grp 1 "you do get the odd sarky comment too from some staff "Well I've never met a second year who can't do that before"

Grp 1 "(impersonating) Second year? Second year? You a second year I didn't expect that!"

Q6) Nurses of tomorrow vs Old timers

Grp2 "they are trying to get us to be the nurses of the future so we will change practice that is the idea that we will change practice"

Grp1 "it is the nurses of the future isn't it?"

Grp 3 "so give it another 10-20 years when the older ones have retired - but that doesn't necessarily mean that they are the bad ones does it? but we should reshape it as long as we don't get influenced by the workforce culture

Q7) University and Clinical placements similarities and differences – 'being a student' dissonance

Grp2 "then you go to placement and it is completely different I think that was a big difference and I don't think we are the same as other students being a student nurse, they don't have to go off on placement. It was pretty hard to be honest"

Grp 3 "So we are on placement out there on our own in some way completely detached nothing to do with teaching for an assignment that is due after we've got another placement like in five months (laughs)"

Grp 1 "Personally I would say that the Uni has higher expectations of you than placement does placement has like a realistic expectation of you....but I think uni they want you to be all singing all dancing flipping Mary Poppins level nurse"

Grp 1 "but I think University kind of reminds you...keep trying to have high expectations of yourself when you are on placement keep reminding yourself to keep up to that"

Grp3 "yeah it is like once you're out there you are out there aren't you? Off you go to placement and see you again in a few months (laughs) and never the twain shall meet"

Introduction. Revisit research rationale and relevant aims. Confirm overview of plan for the interview – Reiterate link to the previous focus groups. Any questions?
Confirm preparedness and consent.

Q1) Third year students' shift in identity – changing attitude of others – does this resonate?
What is your perception of that shift? How does it relate to your view of the various communities?

Potential examples of focus groups quotes to generate discussion:

> *Grp1"Oh we have a student, first placement ok – 'do you understand everything?'(patronising) (laughs) ...on the fifth placement in the third year its "Oh fantastic a third year student" – its like a reincarnation... we know everything now*

> *"You are a hot commodity" (in third year)*

> *Grp1 "I am more attractive now that I am going to qualify... I might not be any good at nursing but because they've done the training I am more important to them than in the first and second year"*

Q2) If the attitude of others towards you has changed – what about your own perceptions of your shift in identity?

> *Grp3 "In first year I am going to be super nurse but now in third year I don't feel as equipped as I thought I would in the first year"*

> *Grp4 "Do you feel ready then? "NO not in the slightest! (all laugh) Still feel like I know nothing"*

> *Grp 1 "It does come second nature but it is just the fear of actually saying "these are my patients" – do I feel any more empowered than when I started the third year – probably not!"*

Q3) Can we further explore your thoughts re your and your friends/family & fellow students change/shift/development?

> *Grp3 "Your family definitely suffer and your friends say "she is boring she never comes out" .... but if you do go out the conversation is different as well.*

> *Grp3 "In your first year all your family and friends don't expect you to know much and now you are a neurosurgeon (laughs) They think you are a miracle worker and you can fix them"*

> *Grp3 "stool talk over the table is not nice apparently ... I do it all the time when we are eating talking about poo, wee and sick and circumcision – and they are all like shuruuuuup!*

Q4) Have you changed in your behaviour generally do you think?

> *Grp3 "You don't just feel different as in professionally, if you are out with your friends who aren't doing a nursing course you just, I don't know, you are completely different to them now"*

> *Grp1 It has not kept me like the fun, bubbly person I used to be – I am very professional now even when I'm at home and I see things in a different light.*

> *Grp1 "This is like a different life and I wish I had the brain at the age of thirty when I was 18"*

Q5) What do nurses do? Has you view changed of what nursing is?

> *Grp4 I thought nurses were like the ones who proper cared for the patients - I think I was getting that confused with health care assistant weren't I really*

Grp2"... you are going to be a nurse, squeaky clean and shiny and everybody loves nurses, they all trust nurses and you get on your first placement and find everybody hates nurses and nobody trusts you – so what am I doing!?"

Grp4 "when you find out how much trouble you can get into it is scary"

Grp2 "You think god there is so much more responsibility than I thought there was"

Q6) Age - Older nurses – Dip vs Degree – current community

Grp3 "On a placement the older nurses on the ward who had a diploma kept calling her a 'paper nurse'"

Grp 1"There is a lot of lazyitis I think with more seasoned nurses"

Grp4 "You do see some nurses when they are burnt out and there is no pride in their work and their standards of nursing have slipped quite a lot"

Grp2 "You never have a person say "I really think that what you are doing is going to be of value" most people say to you "you'll learn nothing at Uni you will learn when you get a job – that's the main thing you get from nurses – either that or stop now!"

Grp2 "ours was better because of this and yours was disadvantaged because of that – trying to get one up on you"

Grp1 "Someone said I don't agree with the way you lot are learning – I think you are all bloody thick, you don't know nothing....... They know things change every year but as long as it doesn't affect them they are not bothered"

Grp3 "There is this resistance when you are the nurse doing the degree and they have the diploma – they feel a bit threatened"

Q7) Difference and/or similarities between University and Placements – values/dissonance

Grp4 "It seems to be lacking a bridge between the University and practice and it feels like it is left up to the students which can be really hard"

Grp3 "Do you think the University and practice are essentially heading in the same direction   No No No definitely not - its like they have never met – never spoke to each other"

Grp2 "I knew when I signed up I wasn't going to be a 'proper student'"

Any further questions/or comments you wold like to add?

Reiterate consent and right to withdraw data at any time

Thanks

Initial Codes (Identification of emerging categories and patterns) (*Example*)

Year One

New Nurses	What is nursing?	Older nurse
they keep saying don't they at uni that we are a new breed of nurses	How much nurses do	Didn't go to University
	Underappreciated	The older trained ones
they are in this kind of new way of NHS thinking	Responsibility is a real eye opener	Method of work is so different
	Work your way up to minor surgery – I wont be doing that!	They work differently
we are learning all this new stuff but there is a battle really		What they perceive the job to be
So we are learning all this new stuff	Flabbergasted that there are so many options	**They didn't do the theory side**
because some of the newer qualified staff are a lot more proactive.	So much you haven't seen before and you are like Wow!	they are dismissive of some of the new stuff
	Responsibility is immense	Too posh to wash
training all these new staff to be this new way		**ignore uni do it this way**
	Shocking – the responsibility	**she's been a nurse for 30 years that's** clearly acceptable.
it's just a thirst for knowledge may be it is because it's new and it's fresh but they didn't want to know did they?	Its not just a job	
	It's a career a profession	**depending on how long they had been qualified what their attitude is**
working 40 hours a week minimum how do you keep on top of like new things	Nurses don't do that any more	old staff, their values all the way they were learned doesn't match all these new procedures
	all the paperwork	
this is how you have got to do it but they are not given the training to support this	Writing stuff when – when they actually haven't done anything **Like when we are qualified**	some of the older people are all "Oh yeah whatever"
	Doing meds rounds	**some of the older nurses will say I don't really know why we do this**
It is like the role really is changing	limited hands-on care	
	you don't know how much you are supposed to take in there is no proper - this is your role	that's just another thing and I'm not gonna get paid any more
I actually as a student nurse knew more about their operations than some of the nurses on that ward	taking bloods, for cannulation and everything because it is part of what a nurse does	Yeah Ive never had to do it why should I do it now?
I think though that that is an older nurse think as well (yeah) for the newer people it is just part of the job	**what that actually entails is too wide of a range to even pinpoint you cannot say that this is a nurse's role because it is so different**	**"some of the nurses that are on countdown to retirement and they are like "only 305 days to go". Really!"**
it is the way it is going so they either have to do deal with it do it or I think they should move on	yeah I think I realised how much the nurses do	that was shocking and it is basically because she should have retired sooner

	crazy I don't envy that position I don't think I want to be a ward manager (both laugh)	I don't think that is their fault because if it was like that when they came in and it is not the job that they signed up to
Poor Practice	*University/Placement*	**University**
pretend you didn't see me do that you've got to do it like this you don't need to bother with that.	***Right everything they told you at Uni forget it this is real life this is what really happens***	*Academic Side* *Scraping a pass* *Referencing* *Level 7* **Assessment** *School of health marks a lot harder*
oh just look over there a minute	***DipHE/Degree***	
she was aware that she shouldn't have been doing whereas some people are not aware and do it regardless	*Older nurses say why do you need a degree*	*Very harsh at marking*
	there is a real education difference	*Its contentious – I could learn district nurse job without a degree*
sorry but I've been told this - so I think we should do it that way the just laugh at you	***And it's like why is it us versus them?***	*On the job training*
you daren't say "Oh well at Uni they said this	*'no that's not the right way' - well okay but you should train your staff to do all the right way then and that's within the University*	*Yeah Im not seeing that university is capable of giving you those skills.*
they just gonna say "no!"	***'mine was at odds the majority of them are on the same lines but there were still a few that were odds really'***	*I think you learn them as all part of being in a profession* ***I learn by doing***
there is a bad attitude in the culture isn't there.. it s just a bit sloppy	*there is different values*	*How can you give a lecture on how to communicate?* *The University stuff sometimes it is just book after book after book*
the staff didn't know how to how to run that ward ***even between the staff there there was like a fight***	*I think they are trying to get in the right direction yes*	*I **think a lot of it is getting used to university life, Uni way of things***
some of the poor practice in placement	***you can't learn anything at uni an essay isn't going to help you look after somebody***	*so I just found it a bit frustrating really having to sit there listening to the same thing over and over again* ***the timetable was horrendous***
I am like woooooh wooooooh and I've just stood there *'sometimes it was like well hang on a minute is that right is that right'*		*I don't think we get enough skills session not at all* *I think I am doing better academically than I thought I would*
Thrown in at the deep end	**Fitting in**	**Mentors**

Going in blind
 They expect a lot of you
 New kid on the block
     I love it
     I hate it
	They won't accept you
	 If you don't fit in you won't ask anything You just won't fit in
	 Judge you straight away
	 The "student"
	 Make a snap judgement
		They hadn't done course
		
		 Couldn't do paperwork
		 How they are trained comes into play

You shouldn't be looked down because you don't know something	***Look at you and think what type of nurse is this?*** *Don't like you on day one – that's it*	*How they are trained makes a difference* *Make the most of it as a student* *They TRY to spend time with student*

I got thrown into in my first couple of weeks of placement "Oh you don't want to work there and it's really just hard work it's just grafting"	*You are not part of the team* but I was very much dismissed there I felt very much in the way **yeah don't say no even if you are a student have a go**	*they will say like as a nurse what would you do and you are like but I'm not* you need to be with your mentor to do that

Hard Work

Fast!
Literally blood sweat and tears
Hectic really hectic
Harder than I anticipated
Run myself ragged on placement
Push yourself
Can I come with you can I come with you I was cheeky with the doctors

you have got to have some balls about you (yeah yeah) because if you haven't no one is gonna come running after you to help you because they have their job to do
keep trying to keep up with things and that's all you can do isn't it
three heavy months three really heavy months
you absolutely loved it and yet the other girl had a nightmare with it

Used as HCA

I was treated as a HCA
Ended up doing all the HCA work
Its basic care and you do need to know it
When you aren't learning anything else
HCA more than the clinical stuff
I got the fundamentals of being a HCA
Look at her – tut – student nurse
it's more a job for the HCAs not the nurses

Stress

I find it stressful going to placement and I am quite a confident person
So I always stress at the beginning of a placement
first month was pretty horrendous
it is like you don't ever switch off
some of the NHS staff are a bit beaten down
Dropping Out / Quitting
They wonder why people drop out
I have to work seven days a week
Amount of times I nearly dropped – ridiculous
I nearly quit earlier this week
Bursary
Better off as single parent

Upset
That broke my heart
I felt really discouraged

Should I even be here?

My confidence was knocked

It tugs at your heart strings

Boring

My first ward was so boring
I end up bored sorry
Running around like headless chickens
They cant give me an answer –
I'm like what the hell are you doing
All the nurses were just sat there
So much writing
Its like Roman Empire – everything in triplicate
I just thought what a waste of a nurse do you know what I mean you are sat here and all you have done is sit on the phone all day

Placement

Spokes
Not doing enough then doing too many
PAD document
Cover Your Back
you've got to cover your own back and some people are quite obsessed by it
if you don't write it down it never happened
Staffing
were my I'm a student card gets me
they like you to be enthusiastic don't get me wrong some staff just don't care they just don't want you there

Expectations

Expect too much
Guinea Pig student
Daunting (laughs)

everything is, like as much as you feel prepared for it, everything is not as expected

There is a massive battle *I never thought that would be so bad*

and there is too much to learn

you have got to be open-minded

I was underprepared coming to uni

Developing Themes (Year Three) (Example)

Major themes from initially linked codes, categories and identified patterns – *developing the student narratives*

YEAR THREE

Becoming a Nurse		
Development/Change/Shift in identity		
Progression/ Growing Confidence / Increasing Responsibility	*Shifting Perspective – Themselves*	*Mentors and other colleagues*
We will all go on practice soon and all of us can think 'yeah I can easily take a patient'	*The **first year was the most hard** for me because everything was quite new*	*Like the **mentor** - I thought yes this is **the kind of nurse I want to be**... it's a deep deep passion of mine*
*you feel **confident** and feel **part of the team***	*Later it was just adult branch and it was more **focussed***	*given me that chance to sort of be in **charge** and take **charge** they are **confident** in my abilities*
*I was **petrified of hurting somebody** but now it is just second nature I feel more **confident** when I go to a ward. That I can go and talk to anybody on a ward*	*that's how I feel after the 3 years I do feel more **confident**.*	*I think the **mentors** relationship you have on the ward. I've met some really good friends*
*it takes a little while but you are only in this place for short times - when you go on to your job you are going to be doing that job so you will be more **confident***	*I think we are more important I don't know whether you feel the same but **I feel more important** now we are in third year*	*Normally it's your **mentor** and if you have a good **mentor** who really invests in you I have had **good mentors** but some people haven't Yeah if they give you more **responsibility** that really helps.*
*Technically you **know** cos it comes **second nature***	*I was really **shy** really **nervous** like afraid to say boo to a goose I think and then in your final year you have to ring your placement...my heart was going and sweating and **now I'm not so bothered**.*	***You are in charge** you can **organise** the staff what they are doing. It was really good and I enjoyed it but it **frightened me to death**.*
*You become - not a **part of the team** but a member - but not a qualified part obviously but they know you are there and **capable** and **given more responsibilities** from other years*	*It was a shock but now you build up a bit of **resilience** type thing*	*I am learning to realise now that you can't do it all as much as you want to you can't so you have got to **delegate***
I felt like I had been there for years and I had only been there a week	*you do look like an idiot running around really trying the keen puppy who doesn't want to drop his ball sort of thing but you have to Over 3 years I have got more **organised** and everything and its **come together a lot more**.*	*I knew at work they treat me as an **equal** and they let me be on my own*
*I am going to be **accountable** and **responsible** and if somebody goes off I have to at least recognise that someone is going off and do the necessary assessment,*		*It is nice when you get that one that gives you that **bit of trust***
***It opens your eyes** ...before that I thought everyone is like me, they are going to care they are going to be nice and then you go out and think no*	*I was a **HCA** a long time ago I was very young but knowing what I know now I look back and I think I wish **I would have done things differently**.*	*Some parts of nursing are the same as **health care assistants** but we have the extra **responsibility** for medications for dressings that sort of thing to be aware of*
		*we have big **responsibility** health care responsibilities have pressures and have other **responsibility***

nobody is like you everybody is different

*I like the fact that first year up to now we have a lot **more knowledge** to do the right thing for a patient*

***Confident.... knowledge the knowledge** feels engrained now, you know it,*

*It's like the 6 Cs ...I have the **courage** like to say I don't know...but in first year I felt a bit stupid and I daren't ask*

*When I first started I only knew the basics of **what a nurse did***

*You are **assessing** it and acting upon it whereas maybe before you wash them and think that looks a bit red. Did you do anything?*

*Its **confidence**. We have grown in ourselves haven't we?*

*It's **growing** into your role.*

*You are **confident** with your own **knowledge** now and piece everything together and does feel like over the last 6 months everything has been glued together*

This year has definitely been a good overall splodge it all together and mould it into a ball rather than having our little bits to piece.

*You think, wait a minute something is not right with that patient **I wasn't scared** to say come here and look at this*

*As we get our uniforms on I feel better then like **an actual nurse** instead of just a student nurse*

*I thought there was **more patient contact** than what there actually is*

I never do what I do now when I was 17. I didn't dream of it.

*I can't imagine myself doing it at that **age**... going out partying and stuff it took till I was 20 and I wanted to do a really **responsible** job.*
*You shouldn't have the **responsibility** of other people's lives when you can't cope with the **responsibility** of your own. You don't take your own life seriously at that age*

*I know when I was a first year I was quite **immature** to how I am now*

***I haven't been on a night out for over 18 months** most students getting our every other night getting blathered and you don't have chance and you can't turn up to work with a cracking hangover.*

Shifting Perspective of Others

'I'm a student this is my first placement.' "Oh a student a first year... oh ok" do you understand everything?"
*You are a **hot commodity**,*

*I'm more **attractive now** as I'm going to qualify*

***Yes you do change** but there are only certain times you notice it when you talk to people not in the nursing profession they are sat looking at you saying 'what are you on about?' and eating and you talk about something and everyone runs to be sick!*

I'm not their silly little niece anymore

A night out for us is grabbing a coffee or something or lunch

***It is a nice job to have though** like you say I'm training to be a nurse and people say oh really? they do make you feel really **proud** to be doing it.*

*I've met some **inspirational nurses** through my training but I've also met some nurses as I know I don't want to be like.*

*It's weird... **you feel underneath** them you can't tell a nurse what to do as they are still over your student.*

*They sometimes speak over you. I feel a bit **stupid sometimes***

*Do you not find as a student you tell your **mentor** how to fill in your PAD document and they say tell me what you want to write? I say I am amazing..... (laughs)*

Mine said what do you want me to write in it?

*It depends what ward and who your **mentor** is*

*Certainly **HCA** on your first placement taught you the basics of care...and then it was nurses who stuck with the meds and procedures and stuff*

*Sometimes we do the **HCA** job for them*

*We do more work than the **HCA** and **probably equ**al and in some cases more than the staff nurses.*

*Obviously when you erm a **HCA** the difference between you and the staff nurse is the staff nurse has got a **degree***

They are not regulated by the NMC

*"**Im too posh to wash**" and it's like no that's the most important thing you can do*

*I have not really thought about **being ward manager I want patient contact** and from what you say the higher you up the less patient contact you get*

Engagement with Old Timers	You do get a few saying why have you done nursing it does wear you down a bit can you not say good on ya.,	Becoming a Different Person
*In my first year first placement my mentor told me in front of everybody **that she didn't want me** and there is **no support** there was nothing I got chucked I got the cd keys when out for a fag*	*you never have that person say ... **what you are doing is of value to you** ..the most people say to you is you will learn nothing at Uni you will learn when you get a job, that's the main thing you get from like nurses either that ....or stop now!*	*You feel a **different person** as in professionally, if you are out with your friends who aren't doing nursing course you just I don't know, you completely different to them now.*
They do things a certain way don't they	*we didn't do that like I did that on the **diploma** and I know you are all getting **degrees** and never discussing the nitty gritty of the content and the overall going to uni to do the training,*	*I would be a lot more **confident**, If I'm out in the street or I'm catching a train I would talk to people I don't know now., If I want something I will ask for it now*
*A lot of **seasoned nurses** I've worked with like **older nurses** they learnt **old school** and oh no we never had any of this you lived in hospitals and you worked*		*i feel I've aged loads over the 3 years.*
I don't agree with the way lot are learning you are all bloody thick, you don't know nothing	*A lot of people like a lot of **older nurses** didn't come to uni they went in the hospitals*	*Yes I a good way mainly **confidence** and feeling more **confident** in myself as a person.*
*I think a lot would be blank today they know things change every year but as **long as it doesn't affect them they don't bother***	***they say oh in my day it was better** ... you do get the well ours was better cos of this and yours is disadvantaged cos of this like trying to get one up on ya.*	*You can **question things** rather than putting up with it; I won't put up with all the rubbish any more.*
think in nursing it's all politics and protocols and drives	*I think the university's is a lot more focussed they are pumping us out as the **new lot** ..it is going to take longer for them to change practice cos you have a lot of older people and the nurses who have done it for 30 years it's a lot harder and you can't teach an old dog new tricks*	*Now I don't drink and I don't go in town I watch what is going on around me like I am aware of what is around me*
A lot of blame		*You are **more alert** to everything that happens. You not in your own world you are more aware of your surroundings.*
*Sometimes I'm scared to do things cos people can send you straight away send you to the garden... **people are scared now***	*it comes like your student doing the **degree** and they have a **diploma** and **feel threatened***	*I've got some **negatives** as well I think. Relationships. They need building back up again.*
***Poor Practice** taking pride in your work and stuff that's a massive thing in nursing cos you do see the odd nurse when they are **burnt out** and there is no pride in the work*	*On her first placement, my friend, the older people on the ward kept **calling her a paper nurse** you are in your 3rd year and **saying just stop turn round and quit,** I think I've come this far and not quitting*	*When we are eating talk about poor wee and sick. It's like oh shuruuuuupppp*
*they find that their **standards of nursing slip** quite a lot there is so much of the **blame culture** these days everyone is out to get one over on you. if you are **not caring and compassionat**e you should not be in the job,. You guys **learn from a text book** and the learning starts when you have done it 3 years*		***In first year** all your family and friends they don't expect you to know much and they say oh you know what that bone is and now they **think you are a neuro surgeon***
		***Doctor of everything**, yeah. Laughs*

The University/Practice Dissonance		
Academic	**Support**	
*It's just the **academic** side can be a bit of a drag sometimes I need to get this over and go on **placement** and not think.*	***University*** *School of health is fabulous and the team as a **university** team there is a lot of **support** for students*	*Then actually the **University** work it really well in the first year easing you into it and even though it's a **shock** every year*
*What I don't like about **studying** I took all this 3 years away from my family really*	*just because you have had a baby **your life is not over** and I thought oh my god that is really good and that is why I threw myself into education and I thought my life isn't over*	*On a **ward**, a lot of the staff **don't even know that you are coming.***
*I can't fully focus on my **placement** and practical whilst I have the **essay** over me*	*It's **something we won't get back** but we all know it's for the right reasons.* *made me think **I'm going to quit** is just those really weak...omg I cant do this., then you realise why you are doing it and you remember oh yeah its **because its the patients***	*Your mentor might but the rest might not and they are like who are you and what are you doing here? It would make like so much easier on our behalf and their behalf and if everybody knew they were expecting a new couple of students.*
*out on **practice** they are brilliant and they are caring compassionate person what makes you a nurse isn't a grade not a **piece of paper***		
*What you learn in **Uni** it doesn't necessarily help you on your **placement**.* ***You don't learn on practice**. They don't know what you are learning at Uni.*	*They say one day on **placement**, one patient on **placement** can make you carry on.* ***It's such a good feeling** yeah I am doing the right thing*	***There's a big gap**. Even though they do have training I remember one of them saying I've been on training for this*
*I have seen a lot of grumblings on the wards on the **diploma qualified** nursing to us doing the **degree**.*	*Yes I say I have the **nurse curse***	
*But doing the **degree** I think gives you better **critical skills**. Look a bit further into it.* *There are **differences** but you have to think in your mind they have told me that where am I going to meet in the middle and its like finding that safe **compromise***	*I think it's always a **shock** to the system every time you move up a year. You move into the second year and you feel a bit like you have been **thrown into the deep end**. You are expecting to know what all the words mean and you still kind of don't. In the **third year** you have obviously drawn out a little bit more and it has to be like that I get that but it is good the way they build on it and I think they... **there's a lot of support out** there as well.*	
***We are taught properly** aren't we but when we go out there...*		
*I don't know like sometimes you get **lecturers** and you think don't you remember your training*		
*It's like there is **something missing in the middle I think**.*		

University of HUDDERSFIELD

The shifting identities of student nurses
Participation Information Sheet

What is the purpose of the Study?

The aim of this research is to explore the experiences of student nurses on the BSc Nursing Studies degree. It will explore the student's participation in both clinical practice and also in University and will help highlight students understanding of nursing identity and discover what student nurses think about what it means to be a nurse. As learning takes place and experience develops so individual identities shift and therefore the experiences will be sought from adult field student nurses on each year of the degree programme.

The findings from this work will be published subsequently and therefore contribute to the nursing literature. Attrition rates among current nursing students within the United Kingdom continue to be problematic and evidence continues to indicate that decisions to leave the nursing course can be related to difficulty in coping with the complex pressures of modern health care. It is hoped the research will contribute to knowledge in this area and help promote a more stable and sustainable future as this depends on the ability to recruit the next generation of candidates to the nursing profession.

Who is the researcher for the study?

The study is being undertaken by Graham Ormrod, a nurse and researcher. This study is being undertaken as part of doctoral studies and is supported by Supervisors at the University of Huddersfield

What will happen to the information?

Why am I being asked to take part?

You are being invited to take part as you are a student nurse on the BSc Nursing Studies course and your experience and opinion is valuable to the specific research.

What happens if I agree to take part?

You will be contacted by e-mail by the researcher and invited to take part *in an initial focus group of four or five other student nurses at a similar stage in their University career*. Any further questions you may have about the study can be answered at this point. Only then if you agree to take part will I arrange a suitable date and time for the focus group.

What happens at the focus group?

The study will be explained to you before the focus group starts and you will be asked to sign a consent form if you are still happy to take part. The focus group will be initially supported by a couple of vignettes written to attempt to encapsulate the experience of student nurses at your stage of training and experience and used as a means to instigate discussion around your experiences and changing perspectives. The focus groups should last for between 45-60 minutes depending upon how much you and the rest of the group may wish to say.

It is proposed that a few students will be subsequently invited for further one to one interviews to further explore their experiences

What happens if I change my mind and do not want to carry on in the study?

You may withdraw from the focus group at any time. If you choose to withdraw you will be asked if data collected up to that point can be included in the study, you can refuse without giving a reason and all information will be deleted where

The focus group will be audio recorded and notes may also be taken is to help the researcher record your thoughts and opinions accurately. Direct quotations are expected to form part of the thesis, publications and presentations. However your identity will be protected by use of an alias if necessary so no one will be recognisable from these quotes. In the unlikely event that disclosures made highlight significant patient harm or risk to your own personal safety such considerations of anonymity may be overridden and subsequent referral may be required to appropriate University or professional personnel.

All information collected will be stored securely and any identifying material such as names will be removed in order to ensure anonymity. Subsequently all data collected will be kept securely for 5 years and then destroyed in line with University of Huddersfield guidelines.

What are the benefits or risks of taking part in the study?

Taking part gives you the opportunity to share your experiences of being a student nurse and also learn from the experiences and insights of others who are likely to have had similar experiences to you. It is also hoped that the results of the study will help influence the decision making of policy makers in the future to assist in the recruitment and subsequent support of the future nursing workforce.

There is a very small possibility that you may find discussing your experiences upsetting, although, in fact many find it very positive to talk though their experiences with other students. It is therefore unlikely that there will be on-going distress caused by the focus group; however, should any issues remain you will be offered referral to relevant support services within your Student Union.

possible. The right to have information deleted remains up until commencement of data analysis whereby information collected will remain within the study and will form part of the final analysis. Any comments included however will be assured of anonymity.

How long will the study last?

I aim to undertake 9 focus groups in total; 3 groups each with students from year one, two and three. This will require recruiting up to 45 students to the study. Some students will then be invited back for more detailed one to one interviews to further explore their subjective experiences.

What will happen with the results of the study?

These will form part of a thesis. These results will also be published via conference presentation and research papers. If you would like a copy of the results, please let me know.

Contact Details

Should you have any further questions regarding the study please contact:
Researcher: Graham Ormrod
Email: G.Ormrod@hud.ac.uk Telephone: 01484 473461

If you have any concerns about the study please contact: Project Supervisor: Dr Warren
Gillibrand
Email: w.p.gillibrand@hud.ac.uk
Telephone: 01484 473689

Proposed Vignettes

Title of study: The Shifting Identities of Student Nurses

Name of applicant: Graham Ormrod

Year One

I

Susan believed she had always wanted to be a nurse for as long as she could remember. She had listened to the stories of her mum and aunty when they spoke about their experiences caring for patients and felt sure that this was the career she wanted. When her granddad was poorly, watching the nurses care for him confirmed her ambition and although she could see that the nurses were often very busy she was convinced that "being a nurse" was what she wanted to be. She listened to her mum and aunty continually say how nursing had changed and how it wasn't what it used to be however this only made her more determined to apply to University and fulfil her destiny to be a nurse

II

John was feeling very down hearted. He believed that the mark and feedback he had just received for his first University assignment had confirmed his worst fears that he might not be able to cope with the academic requirements that you apparently must meet to be a nurse these days. He had been so pleased with comments he had received from his practice mentor who had been impressed with how "caring" he was and yet how he was prepared to "get stuck in" to help when staff were busy. "Not like some of the new nurses" she had said with a smile. He was beginning to wonder if he agreed with what some of the staff on the ward had said that nursing should "get back to the bedside how it used to be". Why did he need a Degree to be a nurse anyway?

Year Two

I

What an interesting comment to make thought Melody as she reflected on the shift that she had just left. One of the district nurses who she didn't really know well but had worked with her today in the absence of her mentor had said "What do you want to come in to nursing for and spend the rest of your career writing?" She had had to admit she had been surprised by the need to document everything so thoroughly but viewed this as just a small, but important, part of her chosen profession. Not for the first time she found herself wondering what nursing was really about.

II

Sunita felt very pleased that she had been able to help and support the Foundation Course student who had been working on the shift this morning. She could see as soon as she walked on to the Unit that the poor woman looked petrified, she looked like she was going to burst into tears! How quickly time had flown. Was she really in her second year already? She knew that everyone expected more from her now and this could be a little intimidating especially when such vulnerable patients and frightened relatives looked to her for help and to make things better. She often thought back to her

induction week at the University and reflected on how much she and her friends on the course had changed. She wondered if her family and her old "pre-Uni" friends thought the same?

Year Three

I

Maria felt on top of the world the careers advice session that she had just left had come at absolutely the right time. Registration and becoming a "real nurse" was in touching distance now and all the hard work, commitment, prioritising her studies and having to "go without" was going to be all worthwhile. The comments she had received from her mentor on the Stroke Rehabilitation Unit had really boosted her confidence and she hoped the Sister was being genuine when she said she would welcome her back after she qualified. If she could just get over 70% in the Policy Module then she would get the First that her personal tutor had always said that she was capable of. She'd been asked to represent other students at next weeks Open Day at the University and she felt ready to inspire the next group of prospective students just as she had been inspired by so many people in the last two and half years.

II

Is it because my face just doesn't fit Amy wondered? The patients were lovely and some of the staff were nice – in fact all of them were "ok" but for the second placement running she had some nagging doubts about whether nursing was really for her. She believed her personal tutor when she said that everyone has doubts when they get so close to qualifying and all those lectures on accountability start to seem really real! Even if she never practiced would it really have been a waste of time? A Degree is a degree isn't it and a 2:2 at that and she had learned so much that would be transferrable to other prospective employers. Or, she thought, was she just kidding herself?

University of
HUDDERSFIELD
Inspiring tomorrow's professionals

Permission for Researcher Contact

CONSENT FORM 1

Study Consent

Title of Project: **The Shifting Identities of Student Nurses**

Name of Researcher: **Graham Ormrod**	Please initial all boxes
I confirm that I have read and understand the purpose of the interviews. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	☐
I understand that if I withdraw I will be asked if data collected up to that point can be included in the study, I can refuse without giving a reason and all information will be deleted where possible. I understand that my right to have information deleted remains up until commencement of data analysis	☐
I have been informed that the interview will be recorded and I give my consent for this recording to be made	☐
I give permission for my words to be quoted (by use of pseudonym)	☐
I understand that the information collected will be kept in secure conditions for a period of no longer than five years	☐
I understand that no person other than the researcher will have access to personal information and all responses will be made anonymous	☐
I understand that my identity will be protected by the use of a pseudonym in the report and that no written information that could lead to my being identified will be included in any report	☐
I agree to take part in the above study	☐

_____   _____   _____

Name of Participant   Date   Signature

_____   _____   _____

Name of Person taking consent   Date   Signature