The Professional Socialisation of Project 2000 Student Nurses:

A longitudinal qualitative investigation into the effect(s) of supernumerary status and mentorship on student nurses

by

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DECLARATION

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or institute of learning.

Signed

ABSTRACT

The aim of this three year longitudinal qualitative study was to explore the effect(s) of supernumerary status and mentorship on students undertaking a Higher Education Diploma in Nursing course.

A purposive sample of seventeen students was used. Ten students volunteered to be interviewed throughout their course and to keep a diary to record their experiences of mentorship during their practice placements. Each of the ten students agreed to a tape-recorded in-depth interview on five occasions during their course. Students brought their diary to their interviews to act as an aide memoir. A further seven students volunteered to participate by diary-only. These students kept written accounts of their experiences of being supernumerary and having a mentor whilst on their practice placements.

Data were analysed with the aid of NUD.IST and subjected to the constant comparative method of grounded theory until themes and categories emerged. Literature was used to support or refute emerging themes and categories, which were subsequently interwoven into the findings to support, illuminate or contradict findings where appropriate.

The categories of anticipation of the first practice placement; reality dawns; becoming a branch student; total surrender of supernumerary status; and the end is nigh were used to present a unique account of the process of professional socialisation from the perspective of students undergoing the HE Diploma in Nursing course. Apart from professional socialisation of HE Diploma in Nursing students, a number of other areas have been highlighted in this study that have not been reported elsewhere. These were the development of intuition in third year HE Diploma in Nursing students, and what constitutes good mentoring from the students' perspective with the incorporation of a time dimension. Findings were submitted to member and outside validation and credibility of the findings was established.

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Abbreviations

In this thesis, the following abbreviations are used:

Common Foundation Programme	CFP
Department of Health	DoH
English National Board	ENB
General Nursing Council	GNC
Glasgow Royal Infirmary	GRI
Higher Education	HE
National Board for Nursing, Midwifery and Health Visiting for Scotland	NBS
National Health Service	NHS
National Health Service Management Executive	NHSME
Royal College of Nursing	RCN
Registered General Nurse	RGN
Rostered Service Contribution	RSC
Royal Infirmary of Edinburgh	RIE
Scottish Higher Education Funding Council	SHEFC
Standing Nursing and Midwifery Committee	SNMC
Statistical Package for the Social Sciences	SPSS
United Kingdom	UK
United Kingdom Central Council	UKCC

The terms Project 2000 and HE Diploma in Nursing are used interchangeably as this reflects their current usage in the literature and practice.

It has been argued that the term mentor is used inappropriately in relation to student nurses on short practice placements. However the term 'mentor' has been used consistently throughout this study as it was the term used by the institution from which the sample was drawn and consequently by the students who participated in the study.

CHAPTER I

INTRODUCTION

1.0 Introduction to the study

The stimulus for this research was the introduction of Project 2000 in Scotland in 1992 with its notion of the 'knowledgeable doer.' I had always been deeply interested in the support of student nurses as they learn, particularly in the practice areas. The new educational course meant that students were supernumerary for the first two years of their education and had a mentor to support them whilst in the practice area. This additional support especially interested me as I was intrigued as to how it would affect their learning. I was also interested in whether supernumerary status and mentorship would affect the way students learned to nurse in the practice areas. Prior to commencing this research, I did not have any firm preconceived opinion of the conclusions which I would reach.

I decided that a qualitative approach to the research was necessary since very little was known about the phenomenon. Since only Project 2000 students themselves could convey what it was like to be supernumerary and to have a mentor, grounded theory was ultimately chosen as the research method. Grounded theory has been established since 1967 when first described by Glaser and Strauss. As a research method it seeks to describe, explore and explain the experience of individuals from their particular point of view.

Qualitative research permits greater flexibility in reporting a study's findings (Miles and Huberman 1994). Increasingly, qualitative research is reported using the first person. In this work, the author has elected to follow a more traditional thesis presentation whilst at the same time acknowledging and supporting the flexible and first person format (Wolcott 1990; Webb 1992).

The decision to present this thesis along more traditional lines was taken on the following grounds: ease of writing in that the author was more familiar with traditional presentation; the lack of uniformity in presentation of other qualitative PhDs and dissertations (Melia 1981; Bradby 1989; Seed 1991; Macaskill 1994; MacKenzie 1994; Watson and Kiger 1994); advice from the supervisor; and compliance with the expected University of Glasgow's Medical Faculty format.

1.1 Aims of the study

1. To explore the effects of supernumerary status on student nurses undertaking a three year higher education diploma course in adult nursing.

2. To explore the effects of mentorship on student nurses undertaking a three year higher education diploma course in adult nursing.

3. To generate either substantive or formal theory in relation to the above two aims.

CHAPTER II
LITERATURE REVIEW

2.0 An overview of the literature

2.1 Introduction

In qualitative reports, the literature is presented in two ways. First, main studies pertinent to the area of the research are presented to place the study in context. Second, unlike quantitative doctoral theses, new literature may and is presented in the findings' section. As categories emerge through the use of the constant comparative method of analysis, appropriate data from previous research is interwoven with the findings (Holloway and Wheeler 1996).

Elkan and Robinson (1995) argue that previous research on Project 2000 courses has usually been related to the first cohort of students going through the course. They therefore allege that many of the problems identified may relate to the "teething problems" connected with any new programme of study. There has been little investigation into supernumerary status as a discreet entity, which is surprising since it is the linch-pin of Project 2000 (UKCC 1986). Project 2000 courses have been associated with the development of the mentor or preceptor role. It is argued in this study that the majority of work connected with the roles of mentor or preceptor is flawed, relying on limited samples and false premises and therefore presenting methodological problems.

2.2 Historical background to student status

The conflict between learning to be a nurse and working as an apprentice was first noted in 1905 (Alexander 1990) and has been an enduring theme over the past 50 years (Ministry of Health Board of Education 1939; RCN 1943; Ministry of Health 1947; RCN 1964; HMSO 1972; Commission on Nursing Education 1985; UKCC 1986). Many of the recommendations made failed either to be implemented or were implemented piecemeal owing to political or economic considerations (Table 1).

Table 1 A review of reports making recommendations for the education and training of nurses.

1939	Ministry of Health Board for Education (1939) as cited by (Naish 1993) supported the idea of student status in a limited form when it agreed with the GNC that student nurses be allowed to study and sit preliminary examinations before entering nursing school. In this way, it was thought new recruits would be protected from the dual strain of being a student and a worker and thus wastage would fall. *Result: preliminary training schools formed* (Martin 1989)
1943	The Nursing Reconstruction Committee (1943) established with Lord Horder as chair (RCN 1943). The committee considered ways of implementing the (Education 1939) **Horder report** and recommended that there should be a separation of the educational needs of student nurses from the needs of the nursing service. They believed that the workload on student nurses should be tailored with their need to be seen as students of nursing (Dolan 1993; Naish 1993). *Result: recommendations fell on stony ground* (Dolan 1993).
1947	In 1947, with a view to the manpower implications (wastage was 54% at the time (Balogh 1992)) and needs of the proposed NHS, the Ministry of Health set up a working party to examine the recruitment and training of nurses. The working party chaired by Professor Wood (Ministry of Health 1947) recommended that students should have full student status and be supernumerary during their practical training. *Result: According to (Dolan 1993) the Wood report was not only disregarded but was actively resisted by the GNC and the RCN. The* ***Wood Report*** *also proposed a two year training which was pursued in the Glasgow Experiment of 1956 (Auld 1992).*
1955	The SNMC of the Scottish Health Service issued a proposal to set up this two year experimental course in Glasgow Royal Infirmary. *Result: the Glasgow experimental training commenced in 1956.*
1964	In 1964, the RCN commissioned what became the **Platt Report** on Nurse Education (RCN 1964). Their recommendations included a need to reconstruct the existing training system and indicated that student nurses should have student status for the first two years of their training before becoming full members of the ward team in their third year (that is, adoption of the Glasgow experimental scheme). *Result: The GNC for England and Wales remained opposed to this because according to (Jolley 1987) the Platt recommendations were seen as being too drastic and unrealistic.*
1972	**Briggs Report** in 1972 (Briggs 1972). Briggs recommended that clinical placements of students should be controlled by the training institution and that specific learning outcomes for each placement be consistent with the theoretical input preceding the placement and that students should practise in a firmly controlled environment. In this way it was felt that the disadvantages of the present system would be conquered (UKCC 1985) The report failed to recommend any radical changes to the apprenticeship style of nurse education because of financial considerations and that student status should be viewed as a long term goal (Naish 1993).*Result: modular scheme of training implemented with students continuing to be apprentices.*
1976 1979	Between these years, both the GNC and the RCN submitted evidence to the Royal Commission on the National Health Service. The GNC preferred that the nurse trainee remain an employee of the NHS whilst the RCN argued for student status for nurse trainees (Jacka and Lewin 1987).
1985	The **Judge Report** on Nurse Education commissioned by the RCN was adamant that student nurses should have supernumerary status (Education 1985). *Result: According to (Naish 1993) it was only then that there was a true impetus for student status.*
1986	UKCC launched **Project 2000 - A New Preparation for Practice** (UKCC 1986) and amongst the recommendations was complete separation of education from service and that student nurses had supernumerary status. Supernumerary status was also seen as a means of enhancing the educational standard (UKCC 1986). *Result: student nurses would be supernumerary to NHS staffing establishments.*

It was not until 1986 that both government and the statutory bodies governing nursing agreed that student nurses should have student status (UKCC 1986). Initially it was argued that students should be supernumerary for the full three years of their nursing course but after detailed costing and consideration of human resource implications, the proposal was amended. Students would be supernumerary for the first two years with 1000 hours in the third year dedicated to education-led, rostered service (UKCC 1987).

It should be noted undergraduate nursing courses had been in existence for sometime (Luker, 1984). When Project 2000 courses were introduced, undergraduate nursing students continued to be supernumerary, learning within a Project 2000 curriculum framework. Undergraduate nursing students were funded by SHEFC as opposed to receiving a non-means tested bursary from the NHSME.

Two reports from Table 1 are considered in depth as they are pertinent to this study: the Glasgow Experiment and Project 2000.

2.2.1 The Glasgow Experimental Training

Supernumerary status was first introduced into the UK in an experiment set up by the SNMC in 1956 (Auld 1992) in response to the 1947 Wood Report (DoH 1961; SHHD 1963). The study consisted of an experimental group of 75 student nurses based at the Glasgow Royal Infirmary and two control groups. The first control group comprised 355 student nurses at the GRI and Royal Infirmary of Edinburgh who were eligible to sit their final nursing examination at the same time as the experimental group. The second control group consisted of 2000 student nurses from 52 Scottish hospitals for the general, sick children's and fever parts of the register.

The students (n=75) in the experimental group had student status, were supernumerary during the first two years of the course and were allocated only to wards where the necessary clinical experience could be obtained. Interestingly, although supernumerary, they were salaried during their entire three year training.

In their third year, these students were called 'Staff Nurse designate' and completed their training as a member of the workforce.

During the experiment, student status was defined as: "required to do practical work in the wards of the hospital only to the extent required for their training. These students will not be used as the basic staff of the wards in order to allow the maximum flexibility in organisation" (DoH 1961, p4). Supernumerary was defined as being "in addition to the ordinary staff in the wards and departments to which they (students) were assigned" (SHHD 1961, p33).

Data collection for the experimental and the first control group consisted of a questionnaire covering personal, educational and work history; IQ tests; a specifically designed multiple choice examination paper; and the GNC preliminary and final examinations. Following the final examination in the third year, a specially organised practical assessment was conducted by internal and external assessors on both groups. The response rate for the experimental group was 100%. The DoH (1961) reported the first control group's response rate as high but did not specify figures.

The second control group was involved solely in the completion of the same IQ test as other students. The overall response rate was 98.5% (Macguire 1969). From the analysis of the IQ tests, it was discovered that the experimental group had higher IQ's and higher educational attainment levels than the control groups. This was attributed to local selection and recruitment policies (Macguire 1969).

According to Macguire (1969, p209), both the experimental and students in the first control group performed identically in the practical assessment but the experimental students "...would have liked to have belonged more effectively to the ward team. They felt they were denied responsibility and in this respect had achieved only partial student status." In addition, the experimental group performed better in examinations, and had less wastage and less sickness compared with first control group (Macguire 1969).

Following the Scottish results, the GNC in England introduced a small number of similar supernumerary nurse schemes and like Scotland found that student nurse wastage dropped and examination success rose (Martin 1989). However Jolley (1987) points out that the journals of the day reported that the courses were considered to be more expensive than traditional training. Another major drawback related to experimental training was that students were seen to lack the gradual increase in responsibility afforded the traditionally trained student nurse (UKCC 1985). In combination with the economic climate of the period, further extensions of existing courses and implementation elsewhere ceased. Project 2000 students are also said to lack the gradual increase in responsibility afforded the traditionally trained student nurse (Shead 1991; National Audit Office 1992; Castledine 1994; Ramprogus 1995).

In considering the value of the Glasgow Experimental Training study it is accepted that randomised control trials were a relatively new phenomenon in 1950's and that its lack of use in the Glasgow study was typical of its time (Treece and Treece 1977). Nevertheless the size and distribution of the control groups allow one to argue that it is unlikely that any systematic bias was introduced.

2.2.2 Project 2000

In 1986, the UKCC established a project group with the remit "to determine the education and training required in preparation for the professional practice of nursing, midwifery and health visiting in relation to the projected health care needs in the 1990s and beyond, and to make recommendations" (p2). Six project papers were issued and circulated widely to members of the profession. Comments received assisted the group in producing the document 'Project 2000: A New Preparation for Practice' (UKCC 1986). The new 'knowledgeable doer' nurse was to be educated to allow them, on registration, to work in the hospital or community setting.

The document recommended that all students follow a Common Foundation Programme (CFP) of 18 months, followed by another 18 months in the student's choice of branch (care of adults, care of children, care of people with a learning disability or care of people with a mental health problem). Students were to have student status and to be supernumerary to manpower requirements for all but 1000 hours of education-led, unpaid, rostered service in the third year (UKCC 1986). Students would receive a non-means tested bursary (Rogers 1993).

The UKCC (1986, p54) stated that "supernumerary status for students is the linchpin of our recommendations .... We see it as the single most important move in achieving the requisite level of educational control and in transferring a situation where at present neither the learner is free to learn nor the teacher is free to teach."

2.3 Research into 'Project 2000'

Since 1993, there have been 12 research studies conducted specifically into Project 2000. Since Project 2000 was a new venture, it is not surprising that seven out of the 12 were qualitative studies. Three studies were quantitative and two were triangulated. The focus and length of all 12 studies varies and includes the implementation of 'Project 2000' and its effects on academic and professional standards; service contribution of students; analysis of concepts of teacher, supervisor, mentor and supporter; and perceptions of staff and students.

Only nine of the studies are presented in this literature review. The remaining studies involve unrepresentative samples (Parker and Carlisle 1996), invalidated tools (Hickey 1996), or omit methodological detail (Hamill 1995).

2.3.1 Studies focusing on the implementation of Project 2000

Bradby and Soothill (1993) investigated the status transition of students from the CFP into the branch programme by studying the first two cohorts of students in one college of nursing and midwifery in England. In the first cohort, there were 53 adult branch students, 23 from mental health and five from mental handicap branches. The second cohort comprised 42 adult branch students, eight from mental health and 10 from mental handicap branches. Data were collected by a self-complete questionnaire three months after the transition from the CFP to branch programme. The response rate was 67% for cohort one and 78% for cohort two.

Bradby and Soothill report that a number of students felt more of a nurse once they were in the branch programme, a finding supported by Mangan (1992) and Clark et al (1996b). While students in Bradby and Soothill's study regarded being a team member as important, they felt unprepared for the accompanying increase in responsibility. It is noteworthy that some 30 years earlier, the desire to be part of the team was a feature of supernumerary students in the Glasgow Experiment. Some students in Bradby and Soothill's study described the transition to the branch as overwhelming and it was noticeable that students did not perform adequately if they felt unwelcome in the practice area. Bradby and Soothill also state that students were very much aware of their lack of technical skills especially as they realised they were due to register in 15 months.

Despite the overwhelming and difficult transition described by students in the study, Bradby and Soothill report that there was a growth in the students' confidence and competence. This may seem rather contradictory until it is noted that the questionnaire was distributed three months after the event. The increased confidence and competence may therefore have developed as a result of moving through the transition.

Since sampling strategies were not reported by Bradby and Soothill their sample may be biased and lack external validity (Polgar and Thomas 1995). Bradby and Soothill also omit details regarding how data were analysed so false inferences may have been drawn (Polgar and Thomas 1995).

In their interim report, Bradby and Soothill (1993, p368) refer to previous studies on status transition in first year general students (Bradby 1989; 1990). They indicate that "there is something different about this status transition which needs to be recognised." Although there is missing methodological detail in this interim report, the findings seem promising in terms of identifying the status transition of Project 2000 students.

Jowett et al (1994) conducted a triangulated, four and a half year longitudinal study using six of the 13 Project 2000 demonstration sites in England that started their 'Project 2000' courses in late 1989/early 1990. Their aim was to examine the implementation process of Project 2000. Students (n=420) were sent questionnaires and a 72% response rate (n=317) was achieved. From this, a systematic sample was drawn to produce a representative group of students (n=77) to interview. A random sample of 29 sisters or charge nurses, four teacher practitioners, 35 student supervisors and 22 community nursing personnel was also interviewed.

Students were interviewed three times during their course and once afterwards. Managers and practice based staff were interviewed once in the early stages of the study and again in the third year of the course. Education-based staff were interviewed on three occasions during the course. The variation in the number of interviews per group occurred because of either the (in)availability of senior staff or changes in areas of responsibilities within Colleges' structure.

Thematic analysis was used to analyse interview data. 'Post-verification validation' by disseminating a draft report to all study sites was undertaken. Although not explicitly stated, from the statements given in the report, verification was achieved and consequently credibility and confirmability.

Findings particularly relevant to this study are reported by Jowett et al (1994). Initially practice placement staff express concern regarding the Project 2000 course. They are apprehensive regarding their role as supervising the 'new' students. They feel there is an increased burden placed upon them and many resent the time necessary to supervise these students. On the other hand, students feel that personal and academic growth occurs as a result of the course. They are eager to utilise their skills in the practice setting, and value their rostered service contribution as a means of easing the transition from student to employee. Bradby and Soothill's (1993) and Jowett et al's studies reveal similar findings. Students highly value being a member of the team and many feel unprepared for and experienced stress during the transition from CFP to the Branch. Jowett et al's report gives sufficient detail to allow replication.

To gain an understanding of the participants' experience of the implementation of Project 2000, Ramprogus (1995) used a qualitative approach based on Hermeneutic inquiry. The study involved the use of documentary analysis, informal individual interviews and focus group interviews in four demonstration site Colleges. One College was used as a pilot site. The sample in the main study consisted of teachers (n=18), students (n=25) and clinical staff (n=22).

Students in Ramprogus's study were exceptionally keen to be a member of the team which replicates other studies (Glasgow Experiment 1961; Bradby and Soothill 1993; Jowett et al 1994). Ramprogus believes that students feel so marginalised in practice settings, that there is an emphasis on 'fitting-in.' Students believe that they lack practical skills and therefore they lack a nursing identity and consequently are terrified of being staff nurses. Supervisors consider the students' level of performance at the end of the course as being equivalent to enrolled nurses. May et al's (1997) study conducted some two years later in Scotland disputes much of Ramprogus's work.

May et al's (1997) longitudinal study examined the teaching and learning processes of the Diploma in HE in Nursing and Midwifery courses and their relationship to the educational outcomes for individual students. They adopted an illuminative evaluation approach to their research and used six out of 12 Colleges in Scotland.

The sample consisted of College Principals or Directors, course leaders and staff (n=41), teachers (n=62), students (n=278), and mentors (n=113). Data collection methods included group or individual semi-structured interviews, non-participant observation and documentary analysis. Data from interviews and non-participant observation were transcribed and the software package Hyperqual was used in the analysis. Inter-researcher rating in establishing categories was cross-checked by a third experienced researcher.

As May et al's (1997) study is an evaluation of Nurse and Midwife Education in Scotland, findings are related to a broad range of aspects. Only the findings specifically related to the context of this study are presented. Mentors acknowledge the lack of available time leading to difficulty in balancing service pressures with fulfilling their mentoring role. The lack of time as a barrier to successfully implementing mentorship is well reported in previous studies (Wilson 1989; Jowett et al 1991;1994, Marshall 1993; Ormerod and Murphy 1994; Eraut 1995; Neary et al 1996). Despite this, mentors express their pleasure at the students' holistic approach to care as well as their patient education skills. May et al state that the majority of mentors are content that students are safe and competent practitioners by the end of the course. This contrasts with Jowett et al (1994, p101) who report that two-thirds of students "unreservedly said that they felt prepared (to take on a staff nurse post)." The remaining one-third either felt unprepared or were unsure whether they felt prepared for a staff nurse role. The contrasting findings may due to collecting data related to preparedness for adopting the staff nurse role from two differing perspectives; mentors and students.

Students in May et al's study report that they are commonly used to plug gaps in service provision to the detriment of their educational needs. This is an area of agreement with Ramprogus who asserts that since students are so desperate to become team members they are open to exploitation. According to May et al, a positive placement experience is characterised by the student being allowed to retain their supernumerary status whilst being a full and active team member. Students' individual learning needs are identified and met by allowing students to progress at their own pace. May et al state that students develop confidence in their knowledge base and practice by the end of the course but nevertheless are nervous regarding practising as a qualified nurse.

Summary

Studies focusing on the implementation of 'Project 2000' have all involved students in the first cohorts of students (Bradby, 1993; Jowett et al, 1994; Ramprogus, 1995; May et al 1997). As mentioned earlier, many of the problems identified in such studies may relate to the "teething problems" connected with any new programme of study (Elkan and Robinson 1995). Jowett et al (1994) assert that their study is the most comprehensive in coverage but acknowledge that further studies are required. In addition the studies reported have been limited in addressing the students' perspective of Project 2000 (Cahill, 1996). To add to the body of knowledge, this study deliberately focused on the students' perspective of being a supernumerary student nurse who has a mentor whilst on practice placement.

2.3.2 Studies focusing on the analysis of concepts of teacher, supporter, mentor and supervisor

White et al (1993) aimed to analyse the concepts of teacher, supporter, mentor and supervisor and explore perceptions and interpretations of the value of these roles by those involved in adult and mental health branches of Project 2000 courses. A two stage qualitative approach was used. The first stage involved a purposive sample of students (n=30), practitioners (n=17), and teachers (n=17) from three of the Project 2000 demonstration sites. All participants participated in semi-structured interviews lasting 30 to 90 minutes.

White et al found that saturation of categories was quickly reached during the analysis of interviews. A decision was made to limit transcription to approximately one third of the tapes that were chosen purposively. Tapes not transcribed had 'telling fragments' summarised by hand. The question of researcher bias arises in the methodology and the researchers acknowledge that inevitably some was introduced.

The second stage involved a case study design with six cases being investigated, three of which were adult branch focused. Case studies involved the use of non-participant observation, debriefing interviews, extended interviews and the use of documentary evidence. Students were observed in their placement on two separate occasions to ensure that observational data gained were typical.

During observation, verbal interactions between mentor and student were tape-recorded and fragments of the tapes were selectively transcribed as noted above. Following observation, students participated in a debriefing interview with the member of staff designated as their mentor. Questions related to events that they felt had helped or hindered learning. Extended interviews were essentially group interviews involving the student, their mentor, the ward manager, the link teacher and other members of the ward team and were related to issues that emerged from debriefing interviews.

Data were analysed using content analysis. White et al report that the nature of the student-mentor relationship is fundamental to the quality of the learning experience. Students are able to differentiate between good and bad practice and able to choose appropriate role models. The student-mentor relationship is hampered by competing demands made upon the mentor and the lack of time for teaching and supervising students. Students feel that occasionally supernumerary status prevented them from being a team member. Practitioners report concern regarding the students' abilities on qualification. Ramprogus's (1995) findings replicate this concern whereas May et al (1997) dispute it. Whilst White (1993) and Ramprogus (1995) ascertain this finding from the perspective of trained staff, May et al's finding reflects the students' perspective. This adds weight to the argument that the conflicting evidence is due to the differing perspectives used.

Davies et al (1994) conducted a study to explore how educationalists, managers and clinicians defined and understood the role of the practitioner - teacher. They also wished to investigate the implementation and impact of the introduction of mentors in the CFP. Eleven sites and four Colleges across Wales were used. Davies et al (1994) used qualitative and quantitative techniques both simultaneously and sequentially. Data collection methods included the acquisition of documentation, focus group interviews, semi-structured interviews, student and mentor diaries, questionnaires and non-participant observation of student experiences in the clinical areas.

Some 360 interviews were conducted with teachers (n=46), practitioners (n=287), senior education managers and professional advisors (n=7), education managers, college directors and practitioners of limited technical quality (n=9). The latter category was not operationally defined. Interviews not conforming to the agreed interview schedule or of poor technical quality were discarded, leaving 333 interviews to be analysed using SPSS, a coding frame and thematic analysis.

From 1,332 questionnaires distributed to all practice based staff involved in mentoring students, teachers involved in teaching Project 2000 students and managers throughout Wales, there was a response rate of 72%. The sample was deemed to be representative.

Students kept a diary over a 10 day period in the clinical area and asked their mentor to keep a diary too, over the same 10 day period. Six hundred and twenty-two sets of diaries were distributed but the response rate was poor (n= 138 students; n= 133 mentors). The poor response rate was attributed to a lack of communication between researchers and subjects. It could also have been due to other factors such as the lack of guidance in completing the dairy; students recruiting mentors instead of the researchers; and the need to pay for posting diaries back to researchers who then refunded the postage. Davies et al (1994) acknowledge that the poor response rate from diaries means that the data could only be used to illustrate findings derived from other means. These methodological problems are pertinent to the present study since diaries were also used in data collection.

Davies et al (1994) report that differing names are used throughout Wales to label the staff nurses responsible for teaching and supervising students. The term mentor however is recognised by all participants but the meaning attributed to the term equated with that of a preceptor. A good mentor is described as someone who possesses appropriate professional attributes, knowledge, good communication skills and the motivation to teach and support students. The fundamental functions of the role are teaching, support and assessment of the students' performance in the practice area. As in studies previously described, Davies et al found, as did White et al (1993), that mentors experience conflict between the competing demands of providing patient care and fulfilling their mentor role. The presence of a mentor in the practice area influences how a student perceives their learning experience. Having a mentor means that learning is more likely to be planned and meaningful. This too reflects findings from White et al (1993).

Students in Davies et al's (1994) study, who do not have a mentor experience 'hanging about' or 'tagging along' with little purpose to their learning.

2.3.3 Studies focusing on the perceptions of students and/or staff regarding Project 2000

Watson and Kiger (1994) used grounded theory to investigate the feelings and perceptions of staff who were about to encounter Project 2000 students. Fourteen staff nurses who worked within different areas of a large teaching hospital were interviewed. Only half of the staff nurses had completed a mentorship course.

Watson and Kiger (1994) report that three conceptual themes emerged from the constant comparison of data; individual reaction to Project 2000; practical and implied changes; and influences affecting the student environment. Individual reactions tend to reflect an understanding of Project 2000 and the changes it brings. Some interviewees express concern regarding a perceived lack of skill development in Project 2000 students, particularly when comparing their own training with the HE Diploma in Nursing course. White et al (1993) and Ramprogus (1995) also ascertained this finding from the perspective of trained staff. Watson & Kiger also report confusion regarding the implementation of supernumerary status.

There is no mention of researcher reflexivity but the authors note that the scrutiny of the research supervisor (Kiger) was used to gain additional distance from potential preconceptions. The report is written in the third person which according to Webb (1992) places distance between the researcher and the study.

Whilst Watson and Kiger's study focused on staff perceptions of students, Macaskill's (1994) grounded theory study investigated Scottish Project 2000 student nurses' perceptions of their placement learning experience. The study was limited to the first 12 months of the CFP.

Tape-recorded informal interviews were conducted with 13 students on their return to College after their placement experience. Data were analysed using the constant comparative method.

Macaskill reports that students feel stigmatised because their uniform is noticeably different. The perceived stigma is heightened by the students' negative emotions, which are particularly evident in placements labelled as 'poor'. Students expressed a need to belong and to become part of the ward team. This finding confirms earlier research (Glasgow Experiment 1961) and is supported by more recent research (Bradby and Soothill 1993; White et al 1993; Jowett et al 1994; Ramprogus 1995; and May et al 1997).

Staff attitudes characterised good and poor placements. Where students feel accepted and able to approach staff and participate in care, placements are perceived as good. Poor placements are characterised by feelings of isolation and rejection. The overall value attributed to a placement crucially depends on the availability of learning opportunities and the guidance and support offered. Macaskill concludes that the mentor creates the students' learning environment. It is unfortunate that Macaskill's study only followed students during their first year. The present study has the advantage of gaining the students' perspective over the entire three years of the course.

Clark et al (1996b) explored the perceptions of the philosophy and practice of nursing within the context of Project 2000 reforms to identify any issues arising for consideration in the continuing development of nurse education and training. A case study design using two case study centres was employed. Data were collected by self-completion questionnaires, focus group interviews, in-depth unstructured interviews, attendance at meetings, informal discussions and review of course documentation. Clark et al's sample included students, teachers, practitioners and managers. The total sample size in centre one was 355 and 565 in centre two.

The overall questionnaire response rate was 82% (n=498). Data from the other participants in the study were collected using focus group interviews.

Clark et al (1996b) found that students enter the course with lay perceptions of nursing but these change as the course progresses. Certainly by the end of CFP, students are only just beginning to see themselves as nurses. Once in practice, students value basic care. As students progress through their course, they develop a more holistic approach to patient care. Students' views regarding the advantages and disadvantages of supernumerary status are markedly consistent over time. The facilitation of learning is seen as an advantage which also increases their self-confidence. Among the disadvantages stated is the lack of practical skills and feeling stigmatised. Students welcome rostered service because it enables them to be full team members. However, it reduces their learning opportunities. Clark et al (1996b, p198) identify an important difference between traditional students and Project 2000 students. "The depth and breadth of theoretical knowledge together with the assertiveness training from the course, appeared to allow diplomates to feel comfortable in saying when they did not know how to do something rather than forging ahead on a trial and error basis, as had been the practice in the past."

Clark et al suggest that by the end of the course, students are socialised into the more traditional approaches to nursing. Students express a great desire to 'fit in' and be a team member. This finding is supported by evidence from previously discussed studies (Glasgow Experiment 1961; Bradby and Soothill 1993; White et al 1993; Jowett et al 1994; Ramprogus 1995; May et al 1997). Fitting-in and being a team member appear linked to gaining good ward assessments. The lack of skills is identified by newly qualified nurses as an initial deficit only (Jowett et al 1994; May et al 1997). This adds another dimension to the finding by White et al (1993), Watson & Kiger (1994) and Ramprogus (1995) as Clark et al (1996b) seek to gain trained staff's impressions of the students' skills level post-qualification.

No students, in Clark et al's study were followed throughout the course as there were only 18 months for data collection. Clark et al therefore recommend further research to determine the full extent to which nursing principles gained from the course were internalised. This longitudinal study explores the internalisation of nursing principles in more depth.

2.3.4 Summary

Research has focused either on demonstration sites or a few different sites in Wales and Scotland. Elkan and Robinson (1995, p387) argue that "there has been disproportionate emphasis not only on the earlier Project 2000 schemes to be implemented but also on the earlier cohorts of students to enter their respective Project 2000 programmes." Perhaps it is unfair to expect anything else since much of the research was funded by national bodies eager to evaluate the new programmes. Research published from 1996 have used later cohorts of students (Clark et al 1996b; Parker and Carlisle 1996). May et al (1997) is an exception as they used students from the first cohorts but unavoidable because Project 2000 only commenced in Scotland shortly before their study began.

A number of issues arise from the studies reported. Macaskill (1994) and Clark et al (1996b) report that students feel stigmatised by the attitudes and responses from staff. By the end of the CFP, students are beginning to feel like nurses (Bradby and Soothill 1993; Clark et al 1996b). Being a team member is important to students (Bradby and Soothill 1993; White et al 1993; Jowett et al 1994; Ramprogus 1995; Clark et al 1996b; May et al 1997) and although rostered service facilitates this, students are unprepared for the accompanying responsibility (Bradby and Soothill 1993, Jowett et al 1994) and the reduction in learning opportunities (Clark et al 1996b). A lack of time to combine mentoring and service provision is mentioned by White et al (1993), Davies et al (1994), Jowett et al (1994), and May et al (1997). Bradby and Soothill (1993) note that students lack technical skills but that their confidence and competence increases over time, a finding replicated by Jowett et al (1994) and Clark et al (1996b).

There are however differing opinions regarding the competence of students near to or on qualification (White et al 1993; Watson and Kiger 1994; Ramprogus 1995; Clark et al 1996b; May et al 1997). Some feel that students lack the necessary skills (White et al 1993; Watson and Kiger 1994; Ramprogus 1995) whilst Clark et al (1996b) and May et al (1997) believe that students are appropriately prepared and that any skills deficit is short-lived.

2.4 SUPERNUMERARY STATUS

2.4.1 Research into supernumerary status

Although other studies have explored supernumerary status in conjunction with related Project 2000 issues, only one study has exclusively investigated supernumerary status (Parahoo 1992a;b;c).

Parahoo (1992a;b;c) conducted a triangulated study with three aims: to compare the perceptions of students, preceptors and lecturers regarding the term supernumerary status; to discover from two successive cohorts of third year BSc (Hons) students whether they considered themselves to be supernumerary whilst on medical and surgical placements, and to identify obstacles, if any, to the implementation of supernumerary status.

The first cohort of 19 third year students kept a diary over nine weeks and recorded, within 24 hours, whether they felt supernumerary or not; and their thoughts and feelings regarding supernumerary status. The response rate was 68.4% (n=13) with non-responders stating that they were either too tired or had forgotten to complete the diary. Five of the students were then randomly selected and interviewed about their perceptions of supernumerary status. Five lecturers and ten preceptors involved in the students' learning were also interviewed. It is unknown whether the interviews were tape recorded and there are no details given regarding analysis of data. This flaw threatens the validity of the study (Burns and Grove 1993).

The second cohort of 19 third year students, 19 preceptors and five lecturers were asked to complete a seven item questionnaire "to shed some light on some of the issues under consideration" (Parahoo 1992a, p40). No specific detail is given regarding how the questionnaire was constructed or to the reliability and validity of the questionnaire. Therefore the findings may reflect measurement errors (Polgar and Thomas 1991). Supernumerary status was often seen as a privilege rather than a right. Parahoo reports that students relinquish their supernumerary status and give care to dissipate the conflict they feel between patients' needs and their own learning needs.

Students mention trained staff's confusion regarding supernumerary status which results in a variety of interpretations. This is supported by Watson and Kiger (1994). Most of the students in Parahoo's study believe that staff shortage is the main reason for not being fully supernumerary. This is confirmed by the work of White et al (1993), Davies et al (1994), Jowett et al (1994), and May et al (1997).

Results from other studies reveal that students feel positively about supernumerary status as it facilitates their learning (Jowett et al 1992; 1994; Bradby and Soothill 1993; Orton et al 1993).

Summary

A number of studies have investigated supernumerary status. However these have either been small (Omerod and Murphy 1994) or involved supernumerary degree students (Wilmott 1990; Parahoo 1992 a;b;c; Spouse 1996). There is a lack of research related to the Project 2000 students' experience of being supernumerary. The present study deliberately focuses on supernumerary status of Project 2000 students from their perspective as an aspect not explored previously.

2.4.2 Definition of supernumerary status

Despite the paucity of research into supernumerary status, the profession has adopted definitions and cites advantages and disadvantages based upon anecdotal evidence. This seems absurd when a researched definition was available. In the Glasgow experimental training (1956-1961) student status was defined as the students being "required to do practical work in the wards of the hospital only to the extent required for their training...." (DoH 1961, p4). However this definition was ignored by the statutory bodies when planning Project 2000.

In 1987, the ENB commented that student status in nursing could not equate with student status in academia. No definition of student status was given. Instead of the UKCC (1987) defining student status, they decided it should be replaced by the term supernumerary status. The rationale for the replacement was that supernumerary status was a more precise term. However, the UKCC failed to clearly define it and this only served to cause further confusion within the profession. In the Glasgow experiment, supernumerary status was defined as being "in addition to the ordinary staff in the wards and departments to which they (students) were assigned" (DoH 1961 p33). Yet again, the statutory bodies neglected to use this previously conducted research.

In 1987, the ENB defined supernumerary status as not being included in the manpower figures of the workforce (ENB 1987). Nevertheless, a lack of clarity and understanding regarding supernumerary status remained. This led to confusion, disillusionment, scepticism about its achievement, especially in times of staff shortages (Leonard and Jowett 1990; Bradley et al 1991; Parahoo 1992a;b; May and Domokos 1993; White et al (1993); Davies et al (1994); Jowett et al 1994; May et al 1997).

The resulting misunderstanding of what was meant by supernumerary status caused students to feel like 'spare parts' (Robinson 1992) and experience stress as they endeavoured to establish their role within the practice setting (May and Domokos 1993).

White et al (1993, p4) comment on the confusion prevailing at ward level, and acknowledge that "student supernumerary status should be further operationalised, with further guidance being made available on its interpretation and use". However, a definition that is clear to the profession remains unoperationalised. For the purposes of the present study, the definition presented in the Glasgow Experimental Training has been adopted.

2.4.3 Aim of supernumerary status

The aim of supernumerary status is to reduce the theory-practice gap by allowing student nurses to meet their own educational needs in the practice setting as opposed to the needs of service (Beckett 1984; Storey 1987; Beck 1990; Rafferty 1992; Robinson 1993). McCaugherty (1991) and Parahoo (1992c) caution against assuming that the introduction of Project 2000 will resolve the theory-practice gap.

Benefits of supernumerary status have been reported by Martin (1989) from the first five years of an integrated degree course. Martin states that the relief from pressure of providing care as part of the workforce and the gradual introduction of the student into the practice areas are the benefits of supernumerary status. Jowett et al (1992) researching the implementation of Project 2000, list: a qualitatively better training; less stressful or traumatic episodes; not being used as a pair of hands; and proper supervision, as the top four benefits of supernumerary status from the students' perspective.

Disadvantages of supernumerary status have been found. Trenchard and Pembrey (1985) identify the potential for supernumerary student nurses to feel that they are not part of the team. In 1989, the NBS believed that one of the challenges in the implementation of the 1992 HE Diploma in Nursing course would be integrating students into the ward team whilst acknowledging their supernumerary status (NBS 1989).

Students in (Parahoo's 1992 a;b;c) study complained of not being part of the ward team. They felt they were left standing about, particularly if their mentor was not on duty with them. It has been reported that not being part of the ward team leads to a feeling of alienation, exclusion and of feeling useless (Elkan and Robinson 1991; Robinson 1991a; Parahoo 1992a;b;c; Robinson 1993; Jowett et al 1994). Jowett et al (1992), using a much larger sample of students (n=420) than other studies, list the disadvantages of supernumerary status as being: the attitudes of others; not being part of the team; lack of practical skills; and it being unachievable. (Parahoo 1992b) offers the lack of staff, the organisation of care and the attitudes of clinical staff as the reasons for problems in the implementation of supernumerary status.

2.5 Mentorship in Nursing

The first appearance of preceptor in the International Nursing Indices was in 1975 (Shamian & Inhaber 1985, Clayton et al 1989). By 1975, according to Myrick (1988a) there were 58 preceptorships reported being used for student nurses. She continues to state that by 1985 there were 109 preceptorship programmes in generic courses and an increase in usage in diploma and degree programmes. Mentorship and preceptorship have therefore been reported in nursing usage for the last 20 years.

Darling (1984) is commonly quoted as the most notable nurse who brought the value of mentorship to the profession's notice. Like many nursing initiatives, the drive to use mentorship came from North America. Morton-Cooper & Palmer (1993, p69) in discussing the stimulus for mentorship in the Great Britain, state that "it is well documented that the terms 'mentor' and 'preceptor' were brought to the consciousness of most British nurses via the educational language and curriculum development of the last decade." Morle (1990) notes that the first mention of mentor was by the English National Board in 1987.

The diffusion of the concept of mentorship from North America to Great Britain is noted by Burnard (1990b, p352) when he states "it seems to have slipped into the folklore of nurse education almost unnoticed and quickly become part of the educational language of the Eighties and Nineties." It could be argued that this really led to the misuse and abuse of the terms mentor and preceptor. There seemed to be a decided lack of academic rigor when applying the terms, with Colleges of Nursing almost arbitrarily choosing between mentor or preceptor as a label to describe the person supervising the student nurse whilst on practice placement.

2.5.1 Research into mentorship

The early research on mentors and mentorship was carried out in America. British studies into mentorship began in the late eighties. Merriam (1983) conducted a critical literature review of mentorship. She notes that the definition of mentor and the process of mentorship is not always clearly defined and appeared to be defined according to the researcher's own perspective. Research designs used were relatively unsophisticated with testimonials and opinions being sought and the principal data collection method was by surveys. Researchers conducting interviews achieved a higher incidence of mentoring in their findings. This led Merriam (1983, p170) to ponder "how much prompting was needed in order for subjects to recall a mentoring relationship". It is argued that researchers working from different definitions of mentoring may also be a reason. Merriam notes the reporting of positive aspects of mentorship far outweigh the negative and concludes that more research is required to evaluate the value of mentorship.

Hagerty (1986) in her second look at mentors makes similar conclusions to Merriam (1983). She notes that the research design and methodology of mentoring studies are suspect and samples unrepresentative. Hagerty also identifies questionnaires as the most popular data collection method and laments the fact that they are self-designed and any psychometric properties included therein are not documented nor investigated.

2.5.2 Studies focusing on the need for mentorship

Early research focused on persuading others that mentorship should be adopted. Roche (1979), an eminent businessman of the time, caused an upsurge in interest in mentorship by suggesting that having a mentor meant improved career progression and earlier attainment of high salaries. Roche surveyed 3,976 male and 28 female top executives who had been mentioned in the Who's News column of the Wall Street Journal. The response rate was a poor 31% (n=1,250). Women taking part in the study made up less than 1% of the sample. Yet despite this, Roche made various assumptions regarding mentoring and women executives. Publication details regarding the questionnaire, the pilot study, its validity or reliability or indeed how the data had been analysed were omitted. The study failed to establish whether the respondents success was due solely to having a mentor as other variables were not investigated or reported and thus cause and effect was assumed. Nevertheless the findings were so popular that little attention was given to the seriously flawed research.

In the same year, Atwood (1979) published details of an equally flawed piece of research. The quasi-experimental study involved two newly qualified baccalaureate graduates. One of the newly qualified nurses was allocated to a mentor in an oncology unit, while the other was allocated to a unit (nature of which was unspecified) without a mentor system in place. The latter nurse therefore acted as control. The nurse allocated to the mentor nurse received a planned introduction to the unit and was counselled on a 1:1 basis. She was asked to keep a daily log of her feelings and interactions with patients and staff. The length of the diary keeping was not specified. She was given a Benner Scale skills test to determine her competency level. It is not known if the control nurse received the same test or was asked to keep a diary. These omissions threaten the study's validity (Sajiwandami 1996).

For a period of four weeks, the nurse and her mentor worked together with the mentor giving guidance, assurance and counselling as appropriate. After this period, a second nurse joined the oncology unit and was allocated to the same mentor nurse. The first nurse expressed feelings of abandonment, the nature of which is omitted in the report.

The age, gender, and qualifications of the second nurse were not given. Atwood (1979, p716) states that "...within three months, the mentor nurse has introduced two nurses into the system in what *appears* (my italics) to be a most productive and smooth manner, and all involved express great enthusiasm". There is no mention of how this information was gathered or analysed. Perhaps it was through the nurses' log but Atwood only mentions the first nurse keeping a log.

The control nurse became very discouraged after six weeks. Atwood refers to this nurse as he, therefore one questions whether Atwood was comparing like with like. The sample size of three is extremely small and there is no mention of how the sample were selected. There is also no reference to informed consent, or whether the participants were aware of participating in a research study. Atwood's interpretation is subjective and extremely biased in favour of the mentor programme.

To discover the frequency and nature of mentoring amongst nurses Fagan and Fagan (1983) conducted a retrospective quantitative study using the Kentucky Mentoring Survey. The questions on mentoring were largely stimulated by Levinson's work (Levinson 1978). Postal questionnaires were sent to all 212 registered nurses in one hospital. Eighty-seven questionnaires were returned, with all but four from women (61 staff nurses, 25 supervisors and one high level administrator).

It is unlikely that Fagan and Fagan had an operational definition of mentoring as they used the terms mentoring and preceptoring interchangeably. The nurses expressed that having a mentor improves their self-confidence, facilitates their learning of technical aspects of care and how to work with people, encourages creativity and understanding of the administration of the hospital.

Fagan and Fagan also mention that nurses adopt their mentor's positive traits (honesty, discipline, hardworking, dedication, independence, sensitivity and tactfulness) whilst any negative traits were ignored by most of the sample.

Fagan and Fagan (1983) omit to give details about the reliability and validity of the Kentucky Mentoring Survey which raises questions regarding the adequacy of the findings (Polgar and Thomas 1995; Sajiwandami 1996). Additionally, memory decay of respondents can be a source of unreliability in retrospective designs (Avis 1994) which Fagan and Fagan do not address. Despite these limitations, the study has been included as it was the first attempt to gauge the usefulness or otherwise or mentorship.

As noted previously, Darling is the nurse who is most often associated with mentoring. Over a two year period, Darling (1984) interviewed 50 nurses, 20 physicians and about 80 health care executives about their experiences with mentors. Darling reports that a mentor has three vital ingredients, has three basic mentoring roles and nine action roles (Table 2).

TABLE 2 Darling's (1984) Action Roles of a Mentor

Standard Prodder	Mentor drives the student to achieve high standards
Teacher-Coach	Mentor spends time in the education and guidance of the student.
Feedback Giver	This a natural follow on from the teacher-coach role whereby the mentor gives the student positive or negative feedback.
Eye Opener	Here the mentor broadens the student's horizons and introduces the student to new ways of looking at things.
Door Opener	Mentor facilitates and makes opportunities available to the student that would not otherwise be so.
Idea Bouncer	The mentor acts a sound board and makes the student feel safe in brain storming ideas.
Problem-solver	This describes the mentor's ability to examine and solve problems.
Career Counsellor	Mentor aids the student in examining their career path and long term plans.
Challenger	Mentor encourages the student to develop the capacity of critical thought and analysis.

Darling does not cite an aim for her research. She does not account for sample selection, nor the status of the nurses. Description of how the interview data were analysed is absent and she fails to justify her findings. These omissions seriously flaw the reliability and validity the research and consequently the findings must be viewed cautiously (Polit and Hungler 1991; Polgar and Thomas 1995; Sajiwandami 1996).

Despite the lack of methodological detail, Darling's work has been heavily referenced in the literature. Darling's attraction, action and affect are commonly cited as the three vital ingredients of a mentor. The three basic mentoring roles: inspirer, investor and supporter along with the nine action roles are also frequently referred to in the literature (Foy and Waltho 1989; Donovan 1990; Morton-Cooper and Palmer 1993; Cameron-Jones and O'Hara 1995; Cameron-Jones and O'Hara 1996). Some researchers have used Darling's work in their own research (Foy & Waltho 1989; Cameron-Jones and O'Hara 1995; Earnshaw 1995). It is for these reasons that Darling's findings are presented in this chapter.

Cameron-Jones and O'Hara (1995) conducted a three staged study into mentorship. The first part involved an investigation into mentors' conceptions of their role. School teachers who were mentors (n=127) and nurse mentors (n=87) completed an adapted version of Darling's (1984) instrument by indicating which aspects of their mentor role they would place the highest and lowest emphasis on. From the findings Cameron-Jones and O'Hara (1995) give a general picture of professional mentoring and compare and contrast differences between mentoring student teachers and student nurses.

The second stage of the study was to conduct a content analysis on a publication about nurse mentoring (Nurse Mentor Guide published in 1991 by the Open College Health and Care Sector). Three categories emerge from their analysis: professional gatekeeping; student support; and other. Cameron-Jones and O'Hara (1995) consider the text to be reasonably representative of the literature available to nurses in the U.K. The text is theoretically light and its coverage of mentorship is superficial.

It is agreed that it is widely available but it is argued that it not widely recommended and it cannot be assumed that nurse mentors would have read it.

The third stage was to consider whether the present-day conception of the mentor role was likely to prevail in the future. The adapted version of Darling's (1984) instrument was used again with 39 final year Bachelor of Nursing students. They were asked which aspects would be important for mentors in the future. The future was defined for students in the following question: 'What will the nurse mentors of the future need to do to make sure that students are well equipped for their role in the century ahead?' Essentially students were being asked for their opinion rather than make any considered judgement. Students were asked to identify which aspects of the mentor role they would place the highest and lowest emphasis on. The top seven aspects are supporter; feedback-giver; problem-solver; assessor; model; energiser and friend. From this, Cameron-Jones and O'Hara (1995) assert that the future role of the nurse mentor is likely to emphasise the 'harder' aspects of the role. Only time and further research will demonstrate whether this will be so.

The limitations of Cameron-Jones and O'Hara's (1995) study is that they used an adapted format of Darling's (1984) instrument. This was a fundamental flaw since Darling's research was poorly reported and the validity and reliability of the instrument she produced was not established. There is no evidence that Cameron-Jones and O'Hara (1995;1996) were able to gain more details from other sources. The adapted instrument was piloted but no details are given regarding testing reliability and validity. Cameron-Jones and O'Hara's (1995) findings must be viewed cautiously until empirical evidence of the validity and reliability of Darling's (1984) work is available.

2.5.3 Studies focusing on the perceptions of students and/or staff regarding mentorship

There have been two studies conducted focusing on the perceptions of students and/or staff regarding mentorship (Foy and Waltho 1989 and Baker 1990). Foy and Waltho (1989) conducted an evaluative survey of a mentorship system. Despite the study being poorly designed and unrepresentative, Foy and Waltho were biased in favour of the mentoring system. Baker (1990) conducted a qualitative study that aimed to determine the consumer's satisfaction with the service of mentorship. It too is poorly designed and like Foy and Waltho, Baker makes biased assertions in favour of mentorship. These studies reflected the increasing popularity of mentorship despite the lack of empirical findings.

2.5.4 Studies focusing on the effects of mentorship on student or pupil nurses

Littlejohn's (1992) research on mentorship was the first reported in the UK. Using a quasi-experimental design Littlejohn studied the effects of mentorship on learners. No random sampling occurred because of the small numbers of new learners undertaking pupil nurse training (second level). The mentors were two enrolled nurses and their ward sisters. Four students involved in the study were blind to the nature of the study, being asked only to participate by completing four questionnaires during their 13 week placement. It is likely that this decision was made in an attempt to prevent the Hawthorne effect. It is unclear whether trained staff were aware also blind to the nature of the research therefore the validity of the research may be threatened through bias and expectation (Sajiwandami 1996).

Two of the students were assigned to Maple ward that had a mentorship scheme introduced whilst the other two were assigned to Apple ward that functioned as the control. Students completed a questionnaire at the end of weeks one, three, eight and 13. Both mentors and learners kept diaries during the study although the frequency of writing is not specified. The analysis of the diaries is not explained.

Results indicate that enrolled nurses perform most of the teaching regardless of whether they are mentors or not. Mentors on Maple ward were helpful to students and kept students informed of their progress more so than on Apple ward. This finding could have been due to researcher failing to control for the Hawthorne effect in the mentors. There seems to have been no consideration given to the effect of the learning environment on the students. Notwithstanding the expressed limitations of the study, mentorship was implemented in the unit for first level nurses despite the target population of the study had been second level nurses. This is an example of mentorship being implemented because it seems like a good idea rather than on the basis of objective findings derived from a well-conducted research study. This reflects similar biases in studies previously discussed (Atwood 1979; Foy and Waltho 1989).

MacKenzie (1994) used grounded theory methodology to explore feelings and perceptions of student nurses towards their mental health practice placement. She also explored the expectations of the students' practice supervisors and practice supervisors' feelings and perceptions of their role. MacKenzie notes that in Aberdeen, the term practice supervisor is used in preference to mentor. The appropriate operational definition is used by MacKenzie.

MacKenzie used a convenience sample of eight female students who were in CFP. During interviews, students were asked to identify good practice supervisors. Seven of the eight supervisors identified agreed to be interviewed. Data were analysed using constant comparative methods and four categories emerged: being supernumerary on practice placement; knowing what to learn; being a practice supervisor; and helping students learn. Relevant findings from this study are woven into the analysis of this study (see Chapters IV, V, VII and IX).

The introduction of mentoring in the CFP of Project 2000 in Wales is reported by Davies et al (1994) and Phillips et al (1996a;b). Their study has been discussed earlier in this chapter. Amongst their findings is that a good mentor is someone who is knowledgeable, a good communicator and is both able and motivated to teach and support students. They identified three key elements of the mentor's role: teaching, assessing and supporting the student whilst on practice placement.

The aim of Spouse's (1996) study was to "describe the lived experience of becoming a nurse and to determine the processes that influenced that experience" (Spouse 1996, p120). Her study involved a four year longitudinal study using a phenomenological approach. Informal unstructured tape-recorded interviews focusing on placement experiences, written accounts of critical incidents and non-participant observation in placement setting were used to collect data. In accordance to the methodological approach, a purposive sample of seven females and one male first year supernumerary degree students was used. From content analysis of the verbatim interview transcripts, five categories were identified; befriending, planning, collaborating, coaching and sense-making.

According to Spouse befriending is the key to all practical learning activities and involves the development of a trusting and open relationship between student and mentor. Planning entails design of a teaching programme to meet individual student's needs. Collaborating means that the mentor permits the student some independence by delegating specific aspects of care. Spouse reports that students have little experience of coaching, they usually work independently with minimal supervision. The focus of independent activity is practising technical skills. Sense-making involves the mentor explaining aspects of care which students fail to understand.

Spouse concludes that the most important element of the 'micro learning environment' is the quality of the student-mentor relationship. This supports the findings of White et al (1993) who note that the nature of the student-mentor relationship is fundamental to the quality of the learning experiences for Project 2000 students.

From the literature, a definition, the components, purpose and functions of the mentors' role, and the benefits and limitations of mentoring are described in detail and often expressed as though they are fact. A discussion of these areas follows and the reader is asked to bear in mind that the foundations of the claims made have been derived from often flawed research studies, anecdotal evidence or opinion. However it is considered appropriate to include them in this chapter to provide an overall view of the literature.

2.5.5 Definition of mentor and mentorship

The term mentor originates from Homer's Odyssey. The detail of accounts varies from author to author but essentially the story is as follows: Odysseus was the King of a small Greek island called Ithaca. He was married to Penelope and when their only son Telemachus was still an infant, the Trojan War began. Odysseus set off to fight in the Trojan war which legend states lasted 10 years. Before departing to the war, Odysseus appointed Mentor, who was an old and trusted friend, to be a tutor advisor to Telemachus and guardian to his estate (Butcher & Lang 1883).

Confusion over the language used in association with mentorship in nursing has been identified for some time. Hagerty (1986) is the author most cited for noting the 'definition quagmire' (Burnard 1990; Morle 1990; Armitage and Burnard 1991; Anforth 1992). However although the meaning is implied, the words definition quagmire are missing, thus reflecting the danger of using secondary sources. It is almost twenty years since Shapiro et al (1978) called for a clarification of concepts and despite repeated requests from others over the years there has been no clear move forward (Merriam 1983; Megel 1985; Hagerty 1986; Watts 1986; Burnard 1990; Donovan 1990; Armitage and Burnard 1991; Maggs 1994; Woodrow 1994).

Authors have offered many different definitions but there is some consistency in the terms used to describe the mentor. The mentor is older (Merriam 1983; Burnard 1988; Arnoldussen and White 1990; Stachura and Hoff 1990); more skilled and experienced than the person they mentor (Fagan and Fagan 1983; Merriam 1983; Davis 1984; Darling 1985a; Burnard 1988; Hyde 1988; Foy and Waltho 1989; Arnoldussen and White 1990; Prestholdt 1990; Brennan and Williams 1993; DeMarco 1993; Marshall 1993); and wise and faithful (May et al 1982; Megel 1985; Hyde 1988; Arnoldussen and White 1990; Nyatanga and Bamford 1990; Fields 1991; Kelly 1991)

A precise definition to which all can agree seems impossible. As Merriam (1983, p162) states "its meaning (mentor) appears to be defined by the scope of a research investigation or by a particular setting where it occurs". Hagerty (1986) concurs with Merriam's observation.

Morton-Cooper and Palmer (1993) state that the ENB advocated that practitioners should have someone who would act as a "wise, reliable counsellor, to act as supervisor, assessor, and, if possible, mentor"(ENB 1988, pvii). An incompatibility resulted by including the role of assessor with that of the wise reliable counsellor. It was argued that one could not offer counsel if one also had to make judgements on that person's performance.

In 1991 the ENB revised its definition of a mentor to be "a person selected by the student to assist, befriend, guide, advise and counsel (but who will not normally be involved in the formal supervision or assessment of the student)" cited by Morton-Cooper (1993 pvii).

Prestholdt (1990, p26) offers a definition which reflects the majority of opinion and research findings. "Mentoring is viewed as a *long term* (my italics) adult developmental process with active involvement in a close personal relationship. Mentors serve as counselors, teachers, sponsors, and guides for neophytes learning about their professions and how to cope with dynamic workplace realities".

2.5.6 The mentoring role

Morton-Cooper and Palmer (1993) break the mentoring role down into three component parts, namely, personal, functional and relational factors. These can be seen in Table 3.

Table 3 Personal, functional and relational factors present in the mentoring role (Morton-Cooper and Palmer 1993, p64).

Personal	**Functional**	**Relational**
Promoting	***Providing***	***Facilitating***
Self-development	Teaching	Interpersonal relations
Confidence building	Coaching	Social relations
Creativity	Role modelling	Networking
Fulfilment of potential	Counselling	Sharing
Risk-taking	Support	Trust
	Advice	
	Sponsorship	
	Guidance	
	Resources	

Further essential components have been identified by other authors. They involve a description of the criteria which the mentor should meet. These can be seen in Table 4.

Table 4 Essential components of a mentor as cited by authors

COMPONENT	CITED BY
The mentor should usually be older than the student and more experienced	(Roche 1979; Burnard 1988; Barlow 1991)
be higher up the ladder than the student	(Roche 1979; Megel 1985; Barlow 1991)
be an authority in their field	(Megel 1985; Barlow 1991; Fox 1991)
be influential	(Megel 1985; Barlow 1991; Fox 1991)
be interested in the growth and development of the student	(Megel 1985; Fox 1991; Morton-Cooper and Palmer 1993)
be willing to commit time, effort and emotion into the relationship	(Roche 1979; Megel 1985; Fox 1991)
possess good interpersonal skills	(Barlow 1991)
be unselfish in the relationship	(Burnard 1991; Shea 1992)
possess competence, personal confidence, flexibility, patience and perseverance and a sense of humour. Be self-aware, approachable, politically astute, proactive and responsive.	(Morton-Cooper and Palmer 1993)
be honest and open	(Daloz 1986)
have respect	(Barlow 1991; Allen 1992)

2.5.7 Purpose of Mentorship

Mentors are said to promote professional and personal development (Kelly 1978; May et al 1982; Merriam 1983; Davis 1984; Daloz 1986; Burnard 1988; Davidhizar 1988; Cahill and Kelly 1989; Lee 1989; Arnoldussen and White 1990; Prestholdt 1990; Jackson 1991; Williams and McLean 1992; DeMarco 1993; Morton-Cooper and Palmer 1993).

2.5.8 Role of mentor

The role of the mentor is said to be multifaceted. The components of the role as described in the literature can be seen in Table 5. It should be noted that the mentor's role does not include supervision, socialisation or assessment.

Table 5 Role components of a mentor as described in the literature.

ROLE	CITED BY
teacher	(Kelly 1978; Merriam 1983; Darling 1984; Darling 1985a; Davidhizar 1988; Bracken and Davis 1989; Northcott 1989; Baker 1990; Prestholdt 1990; Wright 1990; Fields 1991; Fox 1991)
sponsor	(Levinson 1978) cited in May et al 1982; Merriam 1983; Watts 1986; Cahill and Kelly 1989; Prestholdt 1990; Fields 1991; Kelly 1991)
supporter	(Levinson 1978 cited in May et al 1982; Merriam 1983; Darling 1984; Burnard 1988; Davidhizar 1988; Cahill and Kelly 1989)
encourager	(Davis 1984; Burnard 1988)
an exemplar or role model	(Levinson 1978 cited in May et al 1982; Watts 1986; Burnard 1988; Cahill and Kelly 1989; Baker 1990; Wright 1990; Kelly 1991)
counselor	(Levinson 1978; cited in May et al 1982; Davis 1984; Watts 1986; Davidhizar 1988; Cahill and Kelly 1989; Northcott 1989; Baker 1990; Prestholdt 1990; Fields 1991; Kelly 1991; Anforth 1992)
guide	(Levinson 1978 cited in May et al 1982; Merriam 1983; Darling 1985a; Daloz 1986; Watts 1986; Cahill and Kelly 1989; Foy and Waltho 1989; Arnoldussen and White 1990; Prestholdt 1990; Wright 1990; Fields 1991; Kelly 1991; Anforth 1992; Butterworth and Faugier 1992; Williams and McLean 1992; DeMarco 1993; Marshall 1993; Morton-Cooper and Palmer 1993)
advisor	(Merriam 1983; Darling 1985a; Burnard 1988; Laurent 1988; Foy and Waltho 1989; Northcott 1989; Fields 1991; Anforth 1992)
inspirer	(Darling 1984; Burnard 1988)
investor	(Darling 1984)
trusted friend	(Fagan and Fagan 1983; Davidhizar 1988; Fields 1991; Anforth 1992)

2.5.9 Benefits of Mentorship

As Megel (1985) notes, the literature abounds with benefits related to mentorship, most it unsubstantiated by research. Fagan and Fagan (1983) note the benefit of professional development whilst Cahill and Kelly (1989) add personal development. Jackson (1991, p38) claims that "without mentorship, potential may be wasted, never achieved or achieved too late." As referred to earlier, there has been a great deal of bias towards the positive aspects of mentoring.

2.5.10 Limitations of mentorship

Davidhizar (1988) observes that problems associated with mentorship parallel those occurring in parenting. The problems which can arise are attributed to a well-meaning but excessive altruism or from a more malignant egocentricity. Excessive altruism leads the mentor to over-protect the student for fear that they may fail or be upset at criticism (Merriam 1983; Megel 1985; Davidhizar 1988; Jackson 1991). The student is smothered and in this oppressive environment the student's growth is stunted (Merriam 1983). This leads to emotional and cognitive dependence (May et al 1982; Jackson 1991), the avoidance of risk (May et al 1982), the stifling of original thought, creativity and innovation with the danger of the student becoming a clone of the mentor (May et al 1982; Davidhizar 1988; Kelly 1991; Morton-Cooper and Palmer 1993). A concern of Burnard (1990, p46) is that this scenario could lead to the 'sitting by nellie' syndrome with the "blind adoption of skills demonstrated by the mentee".

Egocentricity results from the mentor being self-opinionated and envious of the student. In this scenario, the mentor exploits the student (May et al 1982; Merriam 1983; Davidhizar 1988; Jackson 1991), taking credit for the student's success, manipulating the student to work hard to achieve goals with the aim of furthering the career of the mentor (Morton-Cooper and Palmer 1993). With this excessive control and direction, the student becomes disabled and unable to function independently resulting in the student conforming to the directions of the mentor (Morton-Cooper and Palmer 1993).

It can develop to the stage where the student is effectively cut off from other relationships. The type of mentor who inflicts this kind of behaviour is aptly called by Darling (1985b) a Toxic Mentor.

Summary

Mentorship in America is associated with qualified nurses, whilst in the UK it is associated with student nurses. Most of the research conducted in the area has been poorly designed (Foy and Waltho 1989; Baker 1990), used unrepresentative samples (Fagan and Fagan 1983; Foy and Waltho 1989; Baker 1990; Littlejohn 1992; Cahill 1996) or lacked detail regarding research design and analysis (Darling 1984). This study investigates the effect of mentorship from the students' perspective since the term mentor continued to be associated with students.

There is no universally agreed definition but most authors agree that the mentor is older, more skilled and experienced than their mentee and that the relationship is long term. Mentorship promotes professional and personal growth.

2.6 Preceptorship in Nursing

As indicated earlier, the term preceptorship is often used interchangeably with mentorship. Myrick (1988) outlines the history of preceptorship in North America. In the 1970's nurse education moved from apprenticeship training to two year Diploma programmes or a four year degree programmes in Colleges and Universities. However, the newer education programmes left newly qualified nurses experiencing considerable stress because they were unprepared to make the transition from student to qualified nurse. Kramer (1974) coined the phrase reality shock to describe the phenomenon. The problem was serious as newly qualified nurses experiencing reality shock resigned. It was considered that the implementation of preceptorship would lead to a better prepared clinical nurse.

2.6.1 Research into Preceptorship

Most studies have used a quasi-experimental design to investigate preceptorship (Myrick and Awrey 1988; Scheetz 1989; Jairath et al 1991; Yonge and Trojan 1992; Ouellet 1993). The length of the preceptorship courses investigated range from three weeks to 17 weeks with the median being eight weeks. Samples of final year Baccalaureate degree students (Myrick and Awrey 1988; Scheetz 1989; Ouellet 1993); third year Baccalaureate degree students (Yong and Trojan 1992); or final year Diploma RN students (Jairiath et al 1991) are used. Data are collected using validated tools such as the Slater Nursing Competencies Rating Scale (Slater Scale) (Myrick and Awrey 1988), Schwirian's Six Dimension Scale of Nursing Performance (6D Scale) (Myrick and Awrey 1988; Jairath et al 1991; Yonge and Trojan 1992), and the Valiga Concept of Nursing Scale (Ouellet 1993). Scheetz (1989) used self developed instruments and omitted details regarding establishing validity and reliability.

Findings from these studies are mixed. Myrick and Awrey (1989) and Ouellet (1993) conclude that there is no conclusive evidence that preceptorships are beneficial. Studies incorporating preceptored students' views, reveal that they perceive improvement in their own performance (Yonge and Trojan 1992). Preceptors or researchers measuring changes in the preceptored groups found changes such as increase in problem-solving ability (Scheetz 1989, Jairath et al 1991), an increase in application of theory to practice (Scheetz 1989), an improvement in psychomotor skills (Scheetz 1989) and an increase in professional development (Jairath et al 1991).

All the studies cited lacked randomisation of subjects to experimental and control groups. Sample sizes varied but all were considered small. Instruments were used inappropriately. For example, Ouellet (1993) admits that the Valiga Concept of Nursing Scale was not designed to note changes over time yet Ouellet used it for this purpose. The 6D Scale was designed for trained nurses, not student nurses yet was used with student nurses (Myrick and Awrey 1988; Jairath et al 1991; Yonge and Trojan 1992).

Bias was introduced into studies either through sampling methods (Yonge and Trojan 1992) or not controlling for the Hawthorne effect (Myrick and Awrey 1988; Scheetz 1989; Jairath et al 1991). Ouellet (1993, p22) states that there is a "need to explore systematically, using a qualitative approach, the nature of the preceptor-student relationship including the variables that influence the relationship." The present qualitative longitudinal study addressed Ouellet's suggestion.

Research into preceptorship has similarities with that conducted into mentorship. From the literature, the components, purpose and functions of the preceptors' role, and the benefits and limitations of preceptorship are described in detail and all expressed as though they are empirically based. The material is presented to provide the reader with the background surrounding preceptorship.

2.6.2 Definition of preceptor and preceptorship

The word preceptor is derived from the Latin praeceptor which means a teacher, tutor or instructor (Morton-Cooper and Palmer 1993) and originated in fifteenth century England where it signified a tutor or instructor (Shamian and Inhaber 1985; Peirce 1991; Ashton and Richardson 1992; Goldenberg and Iwasiw 1993).

The definition of preceptor poses less of a problem than the attempts made in defining mentor. According to Brennan and Williams (1993, p34) preceptorship "...is a more definitive concept and thus affords for less scope for loose interpretation". However, Morton-Cooper and Palmer (1993) disagree stating that due to the myths and misunderstandings surrounding both mentorship and preceptorship, the usage of these terms are virtually interchangeable.

There is general agreement that a preceptorship is a time limited relationship (Chickerella and Lutz 1981; Peirce 1991; Butterworth and Faugier 1992; Yonge and Trojan 1992; Cerinus and Ferguson 1994) which exists between an experienced clinically based registered nurse and a student nurse (Chickerella and Lutz 1981; Shamian and Inhaber 1985; Perry 1988; Viar et al 1988; Davis and Barham 1989; Hawkins 1990; Armitage and Burnard 1991; Peirce 1991; Yonge and Trojan 1992; Allen 1993; Goldenberg and Iwasiw 1993; Ouellet 1993), or newly qualified (or returning) nurse (Shamian and Inhaber 1985; Morton-Cooper and Palmer 1993).

2.6.3 Purpose of preceptorship

Preceptorship is viewed as a means of facilitating cognitive learning and enhancing students' clinical skills within the realities of the world of work (Itano et al 1987; Perry 1988; Viar et al 1988; Hawkins 1990; Ouellet 1993). In the process, the student develops self-confidence, clinical competence (Chickerella and Lutz 1981; Spears 1986; Scheetz 1989) and a realistic perception of what is required of a qualified nurse (Spears 1986; Goldenberg and Iwasiw 1993).

Preceptorship should reduce the stress and trauma which can occur in the transition from student to staff nurse (McGrath and Princeton 1987; Ashton and Richardson 1992; Brennan and Williams 1993). Most authors agree that preceptorship facilitates the socialisation of a senior student or newly qualified nurse into the role of registered nurse (Hawkins 1990; Butterworth and Faugier 1992; Allen 1993; Morton-Cooper and Palmer 1993; Ouellet 1993).

There is a discrepancy between the North American use of a preceptor and its use in the UK. North Americans view preceptorship as facilitating a senior student into the role of a newly qualified nurse whilst in the UK the UKCC (1993) has defined a preceptor as a first level nurse, midwife or health visitor who will guide and support a newly registered practitioner.

It could be argued that this definition arose proactively from the concern that students completing Project 2000 courses would not be as clinically competent as their more traditionally trained predecessors and therefore would require more assistance and guidance in their first staff nurse post.

2.6.4 Role of the Preceptor

As far back as 1974, Kramer (p32) defined the role of the preceptor as "a nurse who has the ability to integrate education and work values so that realistic strategies for resolving conflict may be developed. Such a relationship allows for the trainee to work and identify with a competent role model. This involves not only observation by the trainee, but also planned two-way exchange of approaches and evaluation."

It is not surprising that many authors follow Kramer in listing socialisation of the student or newly qualified nurse into the realities of the work place as part of the role of the preceptor (Shamian and Inhaber 1985; Allanach 1988; Scheetz 1989; Hovey et al 1990; Jairath et al 1991; Laschinger and MacMaster 1992; Morton-Cooper and Palmer 1993; Burke 1994; Cerinus and Ferguson 1994; Myrick and Barrett 1994).

According to the literature, role modelling is central to the role of a preceptor (Shamian and Inhaber 1985; Esson 1986; Itano et al 1987; Perry 1988; Armitage and Burnard 1991; Jairath et al 1991; Lee 1991; Peirce 1991; Laschinger and MacMaster 1992; Burke 1994). Most human behaviour is learned by observing a role model, forming an idea of how something should be done and then coding this information as a guide for future learning experiences (Watts 1986; Perry 1988).

Another role is teaching and feedback on performance, where the preceptor facilitates the application of knowledge to practice (Chickerella and Lutz 1981; Shamian and Inhaber 1985; Esson 1986; Perry 1988; Davis and Barham 1989; Scheetz 1989; Armitage and Burnard 1991; Jairath et al 1991; Lee 1991; Morton-Cooper and Palmer 1993; Burke 1994; Cerinus and Ferguson 1994).

Myrick and Barrett (1994, p195) state "theoretically, the preceptor is in the ideal position to provide one-to-one teaching: answer directly and immediately questions related to the clinical assignments; adjust the teaching process in accordance with the learning needs of the neophyte, and intercept errors before they transform into habits."

Supervision and assessment form the final roles of the preceptor (Shamian and Inhaber 1985; Itano et al 1987; Perry 1988; Davis and Barham 1989; Morton-Cooper and Palmer 1993; Burke 1994). Related to supervision is assessment or evaluation of performance and this is the focus of some disagreement amongst authors. Whilst the majority of authors see assessment as part of the role (Shamian and Inhaber 1985; Esson 1986; Perry 1988; Bracken and Davis 1989; Scheetz 1989; Hawkins 1990; Jairath et al 1991; Lee 1991; Morton-Cooper and Palmer 1993; Cerinus and Ferguson 1994) there are those who believe that either learning contracts and peer or self assessment should be used (Burke 1994).

2.6.5 Vital qualities of a preceptor

There is some consensus regarding the essential qualities of a preceptor. Most authors agree that preceptors should be clinically based and practising registered nurses with a minimum of twelve months experience (Shamian and Inhaber 1985; Lewis 1986; Itano et al 1987; Boyes 1989; Hovey et al 1990; Morton-Cooper and Palmer 1993; Burke 1994; Myrick and Barrett 1994). Shamian and Inhaber (1985), Lewis (1986), Itano et al (1987), Boyes (1989), Hovey et al (1990), Morton-Cooper and Palmer (1993), Burke (1994), Myrick and Barrett (1994) conclude that the number of years experience is not usually a factor as long as the preceptor possesses clinical competence. In regard to academic qualifications there is less consensus. Perry (1988) is of the opinion that preceptors should possess at least one academic degree beyond that which the student is studying for. In ideal circumstances, Myrick and Barrett (1994) advocate a Masters degree in Nursing or at the very least a Baccalaureate degree in nursing education. In reality they acknowledge that most preceptors have been prepared at diploma level.

Perry refers to preceptors in Australia, whilst Myrick and Barrett discuss preceptors in Canada. In the UK, neither the U.K.C.C. or National Boards have given any indication of the preferred academic standing of the preceptor.

The skills of teaching, communication, decision making, leadership, and counselling are listed as essential qualities of a preceptor (Shamian and Inhaber 1985; Esson 1986; Lewis 1986; Spears 1986; Perry 1988; Boyes 1989; Davis and Barham 1989; Morton-Cooper and Palmer 1993; Burke 1994; Myrick and Barrett 1994). Teaching ability is seen by Cerinus and Ferguson (1994, p37) as vitally important. They state that "experienced nurses are usually thrust into teaching situations, but being clinically competent does not necessarily make a nurse a competent teacher." They continue by stating that the preceptor also has to be able to create an environment conducive to learning.

A number of authors cite Piemme et al's (1987) list of personal characteristics an effective preceptor should possess; patience, enthusiasm, positive non-threatening and non-judgmental attitudes, open mindedness, flexibility, sense of humour, self confidence, self awareness and the ability to demonstrate respect for peers (Armitage and Burnard 1991; Ashton and Richardson 1992; Morton-Cooper and Palmer 1993). Over the years the list has been expanded to include; honesty in relationship and feedback (Lewis 1986), the ability to demonstrate caring (Lewis 1986), organising ability, advocate of learner, assertiveness, professional and self confidence (Armitage and Burnard 1991), objective, maturity, and respected by peers (Morton-Cooper and Palmer 1993), sincerity, warmth, commitment, and understanding (Burke 1994). Morton-Cooper and Palmer (1993) refer to the atmosphere of trust in the preceptorship relationship which fosters the development of knowledge and skills.

2.6.6 Advantages of preceptorship

There have been many advantages cited in the literature and these can be seen in Table 6.

Table 6 The advantages attributed to preceptorship in the literature

Advantage	Cited by
Increase in staff satisfaction and morale	(Shamian and Inhaber 1985; Davis and Barham 1989; Morton-Cooper and Palmer 1993)
increase recruitment and retention	(Shamian and Inhaber 1985; Davis and Barham 1989; Peirce 1991; Morton-Cooper and Palmer 1993)
increase in clinical competence, confidence and quality of patient care	(Chickerella and Lutz 1981; Shamian and Inhaber 1985; Esson 1986; Itano et al 1987; McGrath and Princeton 1987; Davis and Barham 1989; Yonge and Trojan 1992; Andrusyszyn and Maltby 1993; Morton-Cooper and Palmer 1993; Reider and Riley-Giomariso 1993)
reduction in the service - education gap	(Perry 1988; Andrusyszyn and Maltby 1993; Morton-Cooper and Palmer 1993; Reider and Riley-Giomariso 1993)
reduction in reality shock by socialisation into role	(Shamian and Inhaber 1985; Itano, Warren et al 1987; McGrath and Princeton 1987; Perry 1988; Davis and Barham 1989; Peirce 1991; Yonge and Trojan 1992; Reider and Riley-Giomariso 1993)
professional nurturance	(Chickerella and Lutz 1981)
increase in self-directed learning opportunities for the preceptee	(Yonge and Trojan 1992; Morton-Cooper and Palmer 1993).

Shamian and Inhaber (1985, p87) acknowledge that documented strengths of preceptorship are mostly assumptions and state that "the time has come to evaluate these assumptions in an impartial manner, to prove the value of preceptors and to select those methods for training preceptors that are the most effective. We must pose research questions and evaluate the model." Almost 10 years later, Myrick and Barrett (1994, p194) state that "...there remains a dearth of research to substantiate many of those benefits vis-à-vis preceptor, preceptee and ultimately the health care consumer."

2.6.7 Limitations of preceptorship

Chickerella and Lutz (1981) report that preceptorship requires extra time of and adds responsibility to the preceptor. Brennan and Williams (1993, p36) also highlighted lack of time as a limitation and warn that if the problem is not addressed, there is the "danger of preceptorship becoming a paper exercise with only the statutory assessment function being performed in the proper manner". This has parallels with mentorship and the lack of time to implement the mentoring role (Wilson 1989; Jowett et al 1991;1994, Marshall 1993; White et al 1993; Davis et al 1994; Ormerod and Murphy 1994; Eraut 1995; Neary et al 1996).

Brennan and Williams (1993) also identify conflict as being a potential problem. Conflict may be due to age or gender differences or either party having unrealistic expectations. The final documented limitation is the necessity of weaning the preceptee away from the preceptor (McGrath and Princeton 1987). As stated previously there is minimal research to substantiate these claims.

2.7 Professional Socialisation

The literature reviewed thus far suggests that student nurses require support whilst on the practice placements. The aim of such support is to ease the transition from lay person to nurse, to facilitate the application of theory to practice and to prepare students for the reality of the workplace and their future role as staff nurses. It is appropriate therefore to investigate the literature further in relation to professional socialisation to complete the aim of this literature review, that is to place this study in context.

Professional socialisation has been defined as the process by which the individual learns the culture of the nursing profession (White and Ewan 1991). By learning the culture, students acquire the values, attitudes and practices that make the profession distinct (Smith 1976; White and Ewan 1991; Ouellet 1993).

The process is an active one that requires students to be motivated and self-directed (Deane and Campbell 1985; Ouellet 1993). White and Ewan (1991, p190) stress the active nature of the process by commenting that students "are not blank pages waiting to be imprinted with a professional persona."

2.7.1 The process of professional socialisation

There are three perspectives offered regarding the process of professional socialisation.

2.7.2 Simpson et al's (1979) model of professional socialisation

Simpson et al (1979) state that although their research began in 1958, 10 years passed between the collection of data and its analysis. Simpson et al (1979) conducted a six year longitudinal research study involving eight cohorts of nursing students from the Duke School of Nursing (n= 95 from 1959 to 1965). They maintain that the professional socialisation process has three sequential phases. Simpson et al (1979) do not claim that their research is suitable for generalisation but suggest that it should be viewed in terms of a general hypothesis.

Phase 1 The transition to task orientation

Phase one involves the student replacing their lay views of the profession by achieving mastery in specific work tasks and acquiring knowledge pertinent to a professional nurse.

Phase 2 Attachment to significant others in work milieu

During phase two, 'attachment to significant others in work milieu,' the students develop a reference group incorporating significant others within the profession such as teachers and other students. The students continue to be concerned with technical tasks but now attempt to apply them and integrate them into practice.

Phase 3 Internalisation of professional values

The third phase, 'internalisation of professional values,' is the culmination of the student internalising the values of his/her chosen profession and adopting the prescribed behaviour of the role (Skevington 1984).

Simpson et al (1979) argue that the first phase of socialisation of nurses involves the transition from lay perspectives to the technical orientation of insiders. They argue that the professional school encourages the first phase in the professional socialisation of nurses by emphasising the need to master skills and knowledge as a pre-requisite for professional status. Simpson et al (1979, p48) state that as the student "concentrates on acquiring skills, the student's self-identification becomes more congruent with the newly discovered cultural content of the role."

Whilst the 'researcher' was actively involved in analysing the data to produce a core category she continued to be reflexive by using memos to monitor changing thoughts and avenues for further exploration. One question that arose was whether students were socialised into becoming task-centred or was this development due to physical tasks being relatively easy to learn since there were set procedures to follow? To explore this further Goddard's work in 1953 was considered.

According to Macleod (1996), Goddard's work stems from the working party on the recruitment and training of nurses (Wood Report) in 1947. Goddard used work study methods to determine what is the proper role of the nurse. Again according to Macleod (1996), Goddard categorised nursing duties into five areas for the purposes of analysis: basic nursing; technical nursing; administration and organisation; domestic; and miscellaneous.

Elkan and Robinson (1993a) contend that Goddard (1953) believed basic care to be vital because not only was it essential, but it was also universal. They point out that it is only historically that basic care has gained negative connotations. Melia (1981) argues that basic care is synonymous with physical care.

Melia (1979) cites McFarlane (1976) as commenting that, basic nursing care is seen as easy and therefore the province of junior nurses, whilst technical nursing is the province of senior learners and qualified staff. Melia (1979) observes that Goddard (1953) defines technical nursing as the care given pertaining to a specific disease process. This definition is not surprising since at that time, nursing followed a medical model of care. Medical students in Becker et al's (1961) study valued technical skills to the extent that they felt they should not waste time practising skills they already knew how to do. In Fretwell's (1982) study students viewed basic nursing as work and technical tasks as education. She reasons that this was because students do not need a staff nurse to teach them how to perform basic tasks but they need a staff nurse to help them learn technical tasks. Fretwell (1982), Melia (1982), and Greenwood (1993) describe students talking of technical tasks as 'real' nursing. Clark et al (1996b) report that Project 2000 students appear to equate practical and clinical work with nursing.

The 'researcher' was then prompted to ask herself why has basic nursing care come to be seen as a low level task and seen by some with disdain? Koh (1996) claims that technical care forms a significant and integral part of a patient's care and it is this care that the patient associates with the quality of care received. It could therefore be argued from a socialisation perspective, that since students come into nursing with lay views, they too would believe this. Melia (1981) and Lawler (1991) believe that the hierarchy of skills approach is responsible for basic nursing being classed as having low status and technical nursing having high status.

Fretwell (1982) argues that technical nursing achieved prestige with its increasing use in areas such as intensive care units. Since Fretwell's assertion, there has been an expansion in the use of technical equipment in nursing which has necessitated learning more technical skills. The expanding role of the nurse has also seen the need for trained nurses to acquire proficiency in skills that were once the sole province of medical staff. This therefore underlines Koh's (1996) viewpoint about patients' perspectives on technical nursing.

Davies et al (1994) suggest that for CFP students, who have limited exposure and experience, basic nursing care is seen as important because it was something they can do unaided. However they also mention that the same students are even more excited at the prospect of 'real' nursing.

White et al (1993) are of the impression that routine tasks such as the performance of basic nursing skills incite little curiosity in the student so that once gained, they hold little interest in terms of learning. It is noteworthy that Simpson et al (1979, p49) state that students soon observed that basic nursing tasks "were commonly performed by aides, not nurses...(they) grew increasingly aware that a nurse is distinguished by the skill level of tasks she performs rather than by how close a relationship she has with patients."

More recently, Andersson (1993) asserts that students in her study viewed auxiliary caring activities and those performed by nurses as two different jobs. Clark et al (1996b) believe that since students measure their own progress, they do so by mastering basic skills first and then set out to become more proficient at the more complicated skills. As will become obvious in the theory proposed in this study, an alternative view is expressed.

2.7.3 Davis' (1975) model of professional socialisation

Davis (1975) describes a model of socialisation that has six sequential stages. His model was the result of a five year study of professional socialisation of collegiate nursing students at a university school of nursing. There is mention of using five succeeding classes of students but no total number of participants is given. Davis used a variety of methods to gather his data; observation, longitudinal survey and panel depth interviews. Davis coined the phrase doctrinal conversion to describe the process of professional socialisation. Unfortunately, despite searching the literature, there was little information available regarding the actual methodology of Davis' study.

This perhaps reflects the norm of the day, where dissemination of the findings was possibly considered more important than describing how the research was conducted (Treece and Treece 1977).

Phase 1 - Initial Innocence

As with Simpson et al (1979), Davis (1975) notes that students retain their lay conceptions of nursing in the initial phase. He calls this the initial innocence phase. Students are eager to practise technical skills rather than observing and communicating. Becker et al (1961) in their seminal work 'Boys in White' also note this behaviour in the socialisation of medical students. Davis however adds a psychosocial dimension to his research, by describing how students commonly experiencing feelings of worry, disappointment and frustration at this time.

Phase 2 - Labelled Recognition of Incongruity

During this phase, students begin to share their concerns with one another and realise although others feel similarly, their view of nursing is not accurate (Kelly 1991; Bassett 1993). The realisation that their lay image does not match reality leaves students with what Davis (1975) describes as a feeling of dissonance. Dissonance can be defined as a lack of harmony between their expectations and reality that produces tension and frustration and a desire to find a way to reduce the dissonance (Day et al 1995). To cope with these feelings, Davis notes that students will either leave or continue on into the next phase.

Phase 3 - Psyching Out

Davis (1975) believes that during this crucial phase in the subjective process of becoming a nurse that students attempt to identify exactly what is expected of them and the best way of achieving it. He notes that the majority of students use a direct approach by asking questions to ascertain this and select and carefully observe role models (Hinshaw 1976; Chitty 1993). Students feel uneasy during this phase because although they are beginning to accept the new and serious reality (Bassett 1993). Davis (1963; 1975) describes students frequently joking about by saying that they were 'putting on a front.'

Phase 4 - Role Simulation

During this phase the students try out the new reality (Bassett 1993). Davis (1963; 1975) states that students are highly conscious of their behaviour at this time with the aim of achieving successful and valued performances of particular tasks and roles. The more practice and positive feedback the students' receive, the more the students believe that their performances are authentic and become part of their repertoire of how to act (Davis 1975; Kelly 1991; Day et al 1995).

Phase 5 - Provisional Internalisation

During this phase, the students fluctuate between a desire to cling to their long cherished lay image of nursing and to adopt and internalise reality-based images (Davis 1975; Hinshaw 1976 cited in Chitty 1993; Bassett 1993). Davis (1975) and Kelly (1991) both note that during this phase, students increasingly identify with role models. However, the feeling engendered by this fluctuation may cause some students to question their suitability for nursing (Davis 1975).

Phase 6 - Stable Internalisation

According to Hinshaw (1976) cited by Chitty (1993) stable internalisation occurs when there is a stable and reliable use of the internalised professional model. Students' self-image is firmly that of a professional nurse (Davis 1975) and they have accepted the change from lay person to socialised nurse (Bassett 1993).

Davis (1975) believes that by the end of the first year of training, students will have worked their way through the first four phases and experience phase five and six during the second and third years.

Davis' research was carried out using nursing degree students and although the findings were applicable to the traditional programme of students, the same case may not be true of the HE Diploma in Nursing students (Bassett 1993). Simpson et al (1979) and Davis (1975) perspectives of professional socialisation are both of American origin. It should be noted that their research was conducted on students receiving a different education to those in the UK and therefore there may be cultural differences too.

2.7.4 Bradby's (1989) model of professional socialisation

One British study by Bradby (1990a) used Glaser's (1971) status passage as an underlying theoretical framework. Bradby used four cohorts of female first year student nurses (actual number not disclosed) in two schools of nursing. Although her research was conducted in 1983, it was not published until 1990. Therefore students in her sample were trained under the more traditional style of apprenticeship training. Bradby used a multi-method of data collection; interviews, essay, diary, writing a letter to a potential new recruit, self report questionnaire, and psychometric tests for self-esteem and anxiety. Bradby analysed the data using the constant comparative method of grounded theory. Bradby (1990a) states that during a major status passage a number of subpassages can be identified.

Bradby identified four subpassages in her study in relation to socialisation of student nurses: serial, disjunctive, divestiture and collective or group passage.

Serial Passage

It is during this phase that specific skills are passed on from one generation to another which Bradby (1990a) compares with 'sitting by Nellie' which characterises apprenticeship type training. She believes that this phase is exemplified through the use of mentors.

Disjunctive Passage

In this phase, Bradby (1990a, p1222) refers to situations where the student is abandoned to progress without help or guidance which not surprisingly leads to the development of potentially unsafe practices. She asserts that "much of the essential care for patients was undertaken in this manner." Not surprisingly, an obvious feeling of anxiety is often experienced by students.

Divestiture and personal identity

"Divestiture is the attempt of the organization to strip the individual of his or her identity in order that conformity with the institution's needs will occur" (Bradby, 1990a, p1222). Bradby refers to students feeling that they are there to 'get on with the job' or 'just a uniform' thus losing their identity. Smith (1976) names this as the process of role stripping where symbols associated with their previous role are replaced by a uniform and a title. Bradby (1990a) emphasises that feeling part of the ward team is very important to students, much more so than the quality of care delivered to patients. Students commented on their need for staff to like them and regard them as individuals. Bradby (1990a) notes that the majority of students regain their personal identity after about six months since they begin to report that they felt more like an adult and more independent.

Collective or Group Passage

Bradby (1990a , p1223) refers to a cohort of students as a collective and claims that such a group can derive support from one another. However in her study she was surprised to find that there was "a lack of group affinity except in adversity."

Sense Making

Bradby (1990a) believes that the overall process of integrating and socialising into the nursing profession can be referred to as sense making and claims it takes six to ten months to occur. She notes that students feel surprise and reality shock on entering the wards for the first time but once they had fitted into the ward routine they found it easier. The majority of students in Bradby's study felt fairly settled within two to four weeks within their first ward and within two weeks of their second ward. It should be emphasised here that such placements were undoubtedly lengthier than those in the HE Diploma in Nursing course. Within six months, Bradby (1990a) claims that students felt more comfortable within the practice areas, had grasped theoretical concepts and feel more adult and independent. She also notes that the transition was easier if there was someone to show them the ropes.

2.7.5 Socialising Factors

Davis (1990) is of the opinion that, regardless of the profession, there are common socialising factors. These are the presence of reference groups and significant others, and special socialisation techniques such as 'homogenising' and 'hazing.' The issue of uniform as a method to reduce individuality is an example of homogenising. This removes some of the student's individuality since they are all dressed the same. Hazing involves the allocation of what Davis calls submissive and degrading work and accuracy pressures with concomitant harsh punishments for failure. Students commonly refer to this as 'dirty work' which Wilson and Startup (1991) confirms is demoralising.

Kramer (1974) states that the learning of jargon is another feature of professional socialisation that can be used in two ways. If the student does not learn it properly, then she can be excluded from obtaining professional identity. However once learnt properly, it helps to confirm identity with the profession.

Bradby (1990a) adds shift work as another socialising factor that has implications in the development of a theory in this study with students participating in shift work for only 1000 hours during their course. Since Bradby's study was British and involved the use of grounded theory methodology, it is tempting to apply the findings from this study to Bradby's four subpassages involved in the socialisation of students. However, on reflection, since her study focused only on the first year of training it was felt inappropriate to use this model as the sole focus of comparison. Simpson et al's (1979) model lacks the detail of Davis' (1975) and Bradby's (1990a) studies. On closer inspection of the models offered by Davis (1975) and Bradby (1990a) similarities were noted and could in fact be combined (see Table 7).

Table 7 Davis's (1975) and Bradby's (1990) models of professional socialisation - a comparison

Davis (1975)	Time	Bradby (1990a)	Time
Initial Innocence: Lay conception; eager to practice skills; worry, frustration, disappointment - all feelings kept private		***Serial Passage:*** specific skills passed on and learnt	
Labelled Recognition of Incongruity: Feelings shared -> lay conception not accurate; often afraid of being asked to take on more responsibility than they feel capable of; feeling of dissonance	12 MONTHS	***Disjunctive Passage:*** abandoned without help or guidance -> can lead to unsafe practices. Feeling of anxiety predominates ***Divestiture and personal identity:*** loss of identity as a means of attaining conformity with institutions needs. Need to be part of the team ***Collective or Group Passage:*** Feelings shared in adversity	6 to 10 MONTHS
Psyching Out: Establish what is expected of them and how to achieve it; select role models; unease felt -> putting on a front ***Role Simulation:*** Highly conscious go being able to perform tasks successfully and feel more comfortable in role. The more practice and positive feedback the more student begins to internalises role rather than feeling they are putting on a front.		***Sense Making:*** Achieved through getting to know ward routine; becoming more comfortable within practice areas; grasped theoretical concepts; felt more adult and independent.	
Provisional Internalisation: Fluctuation between lay conception and internalised image of role occur; increasing identification with role model.	1 to 2 YEARS		
Stable Internalisation: Self image is now of a professional nurse.			

2.8 Research into professional socialisation of student nurses

2.8.1 Studies investigating links between preceptorship and professional socialisation

The majority of research studies conducted in this area have been quantitative. Itano et al (1987) and Clayton et al (1989) used a quasi-experimental design, whilst others used surveys (Dobbs 1988; Allanach and Jennings 1990; Goldenberg and Iwasiw 1993). A variety of established reliable and valid instruments were used; Corwin's (1961) Nursing Role Conception Scale which measures participant loyalty to bureaucratic, professional and service ideals and concepts (Itano et al 1987; Dobbs 1988), Lawler-Stone Professional Attitude Inventory and Lawler-Corwin Nursing Role Conception Scale (Goldenberg and Iwasiw 1993), Schwirian's Six Dimension Scale of Nursing Performance - 6D Scale (Clayton et al 1989) and the Multiple Adjective Affect Check List (MAACL) which measures the affective states of anger, hostility and depression (Allanach and Jennings 1990). Hsieh and Knowles (1990) used a qualitative design incorporating observation, debriefing interviews and diaries as data collection methods.

Samples included preceptors and students (Hovey 1990; Hsieh and Knowles 1990); senior Baccalaureate students (Itano et al 1987; Dobbs 1988, Clayton et al 1989); Baccalaureate and Diploma students (Goldenberg and Iwasiw 1993); and newly qualified nurses (Allanach and Jennings 1990). The length of preceptorships ranged from four to 15 weeks.

As in other preceptorship studies, findings were varied and often contradicted each other. Itano et al (1987) found no difference between their preceptored group and their control group. Allanach and Jennings (1990) report that there are no changes in the students' affective state over time. However, Dobbs (1998) asserts that preceptorship promotes anticipatory socialisation. This finding was replicated by Goldenberg and Iwasiw (1993).

Clayton et al (1989) found that preceptorship students score higher in the subscale of leadership, teaching and collaboration, interpersonal relationships and planning and evaluation than non-preceptored students and that the difference remains significant six months later.

Hovey et al (1990) report preceptorship students gaining in confidence in skills related to assessment, communication, planning and nursing care. Hsieh and Knowles (1990) report that trust and honest communication are crucial to the success of the preceptorship relationship.

Limitations of the studies were noted. There was a lack of randomisation (Itano et al 1987), lack of control (Dobbs 1988), lack of detail regarding study design and data analysis (Hovey et al 1990) and lack of control over the Hawthorne effect (Allanach and Jennings 1990; Hovey et al 1990). Generally sample sizes were small (Itano et al 1987; Clayton et al 1989; Allanach and Jennings 1990; Hovey et al 1990).

Studies indicating favourable results tended to exaggerate the benefits of preceptorship (Clayton et al 1989; Hovey 1990). Where results indicated that objective measures did not support the commonly held belief that role transition was an emotional one researchers revealed their biases in favour of preceptorship. For example Allanach and Jennings (1990) assert that from the meetings with preceptees verbalisation of psychosocial discomfort is expressed. Possible explanations for this are expressed as follows; the meetings provide a forum whereby negative feelings can be expressed, peer support can be gained and listening to others experiencing similar feelings may have provided "underscoring the normalcy of the emotions that have been tied to transition" (Allanach and Jennings 1990, p26); and the MAACL perhaps was not sensitive enough.

Goldenberg and Iwasiw (1993, p13) recommend further study and suggest "longitudinal investigations of professional socialisation might contribute additional information about this process...." Hsieh and Knowles (1990, p268) recommend that "more in-depth consideration is needed to understand the many variables that also influence the (student-preceptor) relationship." This longitudinal study addressed both Goldenberg and Iwasiw's (1993) and Heish and Knowles's (1990) recommendations.

Kennard (1991, p40) states that "regardless of ...apparent limitations, the literature is replete with views and recommendations supporting the development and success of preceptorship programmes ...Developing programmes based on assumption alone is a direct contradiction to research-led practice. There is an intuitive assumption, supported mainly through descriptive data, that a preceptor 'type' role is worthy of serious consideration".

2.8.2 Studies investigating the professional socialisation of student nurses

There have been three studies which have focused on the socialisation of student nurses. Melia (1981) interviewed a total of 40 first, second and third year 'traditional' RGN student nurses to explore how they perceived their experience of being learners. Data were collected by individual interviews and analysed using grounded theory methodology. Six conceptual categories were identified; learning and working, getting the work done, learning the rules, nursing in the dark, just passing through and doing nursing and being professional. To avoid bias, Melia argues she performed non-participant observation. However, on closer inspection of the methodology, an inconsistency arises, as rather than using non-participant observation, she used in-depth interviews. However, Melia's work is seen as seminal and providing a unique insight into the world of being a student nurse in the early 80's.

Wilson and Startup (1991) conducted a comparative research study to examine the professional socialisation processes of student nurses. The sample consisted of three cohorts of 'traditional' students. Students were interviewed during their introductory block and at the end of their first year. The teaching and ward staff responsible for students training were also interviewed. Wilson and Startup (1991) fail to disclose the size of the sample and the sampling technique which according to Polgar and Thomas (1995) and Sajiwandami (1996) can indicate that the sample was unrepresentative, biased and lacking external validity.

Wilson and Startup (1991) report it is the students' own peer group that helps students develop their practical skills, and inform them of Sisters' likes and dislikes. This replicates findings from Melia (1981, 1982, 1987). The type of placement most enjoyed by students invariably has 'good press' on the grapevine. What mattered most to students was that the Sister was approachable and had a positive attitude to teaching students on her ward. Students were able to delineate the qualities expected of a good nurse. The possession of empathetic nature is most often cited by students but this declines in prominence by the end of the first year. Since there are only two measuring points made in Wilson and Startup's study, no details can be given regarding the nature of this decline in prominence.

O'Neill et al (1993) conducted a comparative research study into the professional socialisation of Project 2000 students during the CFP. They used research diaries and semi-structured interviews and a five point Likert scale questionnaire with 170 students and a comparison group of 105 traditional students. From the results, they note that professional socialisation of Project 2000 students was a more gradual process than with traditional students. Clark et al (1996b) make the point that HE Diploma in Nursing students do not perceive themselves as nurses until they enter the branch programme.

Day et al (1995) conducted a qualitative study using Davis' (1975) theory of doctrinal conversion to examine progress in the process of socialisation. Data collection methods consisted of interviews and open-ended questionnaires. Both methods included the same questions, but Day et al point out that interviews allowed the probing of responses. The interview group consisted of 50 student nurses enrolled in a four year Baccalaureate in Nursing programme who were randomised into groups. A total of 81 students completed a questionnaire but the total number distributed and the corresponding response rate is not reported. Despite, students from first, second and third years being randomly selected, there are no details of how many students were in each group. This has implications for any future replication of the study. Data were analysed using content analysis.

Day et al report that first year students describe both positive and negative behaviours of trained nurses (provisional internalisation). Day et al (1995) note that in Davis' (1975) study, this ability was not identified until the third or fourth year. Day et al note that second year students are described as 'doing for' rather than 'working with the client.' Day et al compare this to Davis' Psyching out phase.

Third year students in Day et al's study emphasised the importance of performing tasks correctly and safely within the boundaries of hospital practice. Students also begin to talk earnestly about the need for holistic care and caring for relatives. Day et al note fourth year students emphasise accountability and responsibility for practice and develop a concept of nursing which they remain faithful to regardless of others' opinions which Day et al state is congruent with Davis's (1975) stage of stable internalisation. Day et al conclude that although the stages in Davis' model did not occur in the same sequence or at the same time described by Davis, it is a useful framework for understanding the observed behaviours.

2.9 Confusion regarding the use of terms mentor and preceptor in nurse education.

In distinguishing between the terms mentor and preceptor, two differences can be identified. First, the length of the relationship. Perry (1988), Prestholdt (1990), Anforth (1992), and Burke (1994) agree that a mentor relationship lasts a long time whereas a preceptor relationship is of a much shorter duration and can be just a matter of weeks.

Second, the focus of mentorship is on career and professional development (Perry 1988; Morle 1990; Prestholdt 1990; Burke 1994) whilst that of preceptorship is on specific learning needs of students whilst on clinical placement (Burnard 1988; Perry 1988; Armitage and Burnard 1991; Burke 1994). The emphasis of the preceptor is on teaching and learning within the reality of the workplace (Burnard 1988; Armitage and Burnard 1991; Brennan and Williams 1993).

Whilst acknowledging that teaching and learning is part of mentorship, an important factor is the development of a deeply emotional relationship (Burnard 1990; Prestholdt 1990; Armitage and Burnard 1991; Brennan and Williams 1993). Kelly (1991) asserts that some preceptorships can be almost totally impersonal.

Some authors cite role modelling as more of a function of the preceptor than of the mentor (Burnard 1988; Armitage and Burnard 1991; Allen 1993). Burnard (1988) and Armitage and Burnard (1991) believe that preceptorship encourages the 'sitting by Nellie' approach to learning where students learn 'on the job' by copying skills of clinical practitioners. Donovan (1990) believes that a role model can be passive in nature and that a preceptor has a more active part to play for as well as a role model, a preceptor teaches, supervises and coaches. This is a more satisfying perspective since it allows the view that as well as teaching by example, the preceptor has a part to play, not just in the development of the student's psychomotor skills but the related cognitive and affective skills.

There has been a lack of academic rigor by Colleges of Nursing when applying these terms. Almost arbitrarily, the label of mentor or preceptor is chosen to describe the person supervising the student nurse whilst on practice placement. By 1990, Morle had identified that the nursing profession in America was being accused of jumping onto the mentorship bandwagon without first being clear of why they should be adopting it. The same criticism can be levelled at the nursing profession in Britain. In expanding this point, Morle infers that despite the absence of a clear definition, the implementation of mentorship in Britain proceeded and suggested that the driving force was most probably the English National Board's directive and the need for compliance.

The Welsh National Board (WNB 1992) as cited by Phillips et al (1996a;b) counsel that mentorship is a broader, long-term relationship which aims at guiding the novice towards an established place in the profession, whilst preceptorship has a narrower focus on individualised teaching, learning and support provision in the practice setting.

2.10 Summary

Despite mentorship and preceptorship being reported in the literature over the last twenty-five years there is a dearth of empirical evidence to justify their use in nursing (Shamian and Inhaber 1985; Clayton et al 1989; Scheetz 1989; and Kennard 1991). Cahill (1996) asserts that accounts of poorly designed and conducted research studies and invariably biased and contradictory results fuel confusion about the already nebulous nature of the subject. It is therefore questionable as to why the term mentorship was incorporated into the design of Project 2000 when its research base was controversial.

Much of the research conducted into Project 2000 has been conducted using the first cohorts of students and thus some of the findings may be attributable to 'teething problems' (Elkan and Robinson 1995). The quality of the research conducted has been variable and the focus of the research broad and non-specific.

In their study investigating mentorship in Project 2000 students in Wales, Davies et al (1994, p119) state that "it would be valuable to analyse the mentor/student dependence to independence relationship, which has obvious implications for the preparation of the autonomous practitioner." In addition, Parker and Carlisle (1996) argue that there is a scarcity of empirical research focusing on issues such as supernumerary status and mentorship in Project 2000 courses from the students' perspective. An attempt has been made to meet the suggestions made by Davies et al (1994) and Parker and Carlisle (1996) in this qualitative longitudinal study. Further support for longitudinal research is provided by Wrightsman (1981) who argue that existing research on mentoring is 'frozen in time' and fails to take account of the unfolding nature of the relationship (Jacobi 1991). In this study, the intention was to present data as it occurred chronologically therefore the reader will be provided with an unfolding account of being a supernumerary student nurse who has a mentor during the three year HE in Nursing Diploma course.

CHAPTER III

Method and Main Study

3.0 Aims of the study

1. To explore the effects of supernumerary status on student nurses undertaking a three year higher education diploma in adult nursing.

2. To explore the effects of mentorship on student nurses undertaking a three year higher education diploma in adult nursing.

3. To generate either formal or substantive theory in relation to the above two questions.

The research question in a grounded theory study is refined as the study progresses (Strauss and Corbin 1990; Streubert and Carpenter 1995). At the commencement of this study, the research question was "to investigate the effects of supernumerary status and mentorship on student nurses following the 1992 HE Diploma in Nursing." As data were collected and analysed, the research question became more focused to: what are the effects of supernumerary status and mentorship on the professional socialisation of student?

3.1 Introduction to method

In areas where there is little known, qualitative research methods prove most useful whereas in areas requiring the verification and establishment of facts by statistical means quantitative research methods are most appropriate (Field and Morse 1985). According to Morse and Field (1996) the choice of a research method should be guided by the nature of the question or problem to be investigated and by what is already known about the phenomenon.

A qualitative design was considered to be most appropriate given the exploratory nature of the work and that little was known about the subject area. In addition, no longitudinal studies had been conducted previously into the effects of supernumerary status and mentorship from the students' perspective.

3.2 Choice of approach

Quantitative research originates from logical positivism (Burns and Grove 1987). The underlying assumption is that the social world is such that objective forms of measurement can be made and causal relationships derived (Burns and Grove 1987; Polit and Hungler 1991). Quantitative methods involve the collection of numerical data that is subjected to statistical analysis in order to test hypotheses proposed by researchers (Polgar and Thomas 1995). It involves reductionism in that situations or complex information is broken down into parts so that the whole may be understood (Carter 1996).

In conducting quantitative research, manipulation and control of variables is vital so that the relationships discovered between variables can be generalised. The measurement tools used should be valid and reliable (Burns and Grove 1987; Polit and Hungler 1991). In an attempt to eliminate bias and to control non-spurious relationships, large, randomly selected samples are used from the total population. In an attempt to remain objective, the researcher endeavours to remain detached from the research process (Carter 1996).

The aim of qualitative research is to record and interpret as far as possible a holistic account of the phenomenon from the perspective of the participants involved. The researcher attempts to capture the aspect under study in as natural and as familiar a setting as possible. It is important to obtain from participants, both subjective and objective views and experiences, so that the totality of the life event can be seen. What verification is to quantitative methods, exploratory is to qualitative methods (Bryman 1984).

Qualitative research evolved from the social sciences and the humanities (Leininger 1985; Burns and Grove 1987; Mason 1996). Its philosophical underpinnings are attributed to phenomenology, verstehen and symbolic interaction (Bryman 1984). There are different approaches to qualitative research with each approach based on its own philosophical orientation that influences purpose, sampling, data collection and analysis (Brink 1989; Burns and Grove 1993). For completeness, phenomenology, and ethnography will be discussed prior to presentation of the chosen method, grounded theory.

3.2.1 Phenomenology

Phenomenology is said to be derived from the Greek word phenomenon meaning to "show itself, to put into light or manifest something that can become visible in itself (Ray 1994, p118). According to Parse et al (1985) the term first appeared in the writings of the philosopher Franz Brentano in the last half of the 19th century. It was further developed by one of Brentano's students, Edmund Husserl. Husserl believed that the study of philosophy should not only have rigour but also humanism (Parse et al 1985).

Phenomenology is seen both as a philosophy and as a research method (Oiler 1982; Burns and Grove 1987; Beck 1993b; Burns and Grove 1993). Its aim is to describe experience as it is lived (Oiler 1982; Lackey 1991; Baker et al 1992; Burns and Grove 1993; Clifford 1997). In addition to the context within which the phenomenon manifests itself, the essence of the phenomenon under study is illustrated Parse et al (1985). It therefore does not seek to reveal any causal relationships or to explain phenomenon; rather its intention is to reveal the nature of the phenomenon as it is experienced (Parse et al 1985). According to Morse and Field, (1996) phenomenological studies provide rich and insightful reflections. However, since phenomenology is restricted to revealing only the nature of phenomenon as opposed to describing or explaining the phenomenon, it was considered an inappropriate method to adopt in this study.

3.2.2 Verstehen

Bogdan and Taylor (1975, p13) define the term verstehen as an "empathetic understanding or an ability to reproduce in one's own mind the feelings, motives and thoughts behind the actions of others." Melia (1983, p24) states that "the central idea of verstehen ... is that the understanding of meaning is essential to the explanation of human action; in other words, simply to observe is not enough." In using verstehen, there is an attempt to achieve a degree of empathy with the participant so that an awareness of what situations mean to the participant can be gained. This is achieved through an interpretative understanding of the participant's verbal and non-verbal communication (Smith 1983).

3.2.3 Symbolic Interactionism

According to Bowers (1989, p33) symbolic interactionism "was in part a reaction against the grand functionalist theories of social action which dominated sociological thought during the mid-nineteenth century." The differing emphasis is that symbolic interactionism focuses on the individual and how s(h)e acts. While the functionalist perspective focuses on the role the individual occupies by internalising norms and role exceptions derived from the social system in which they are a member (Bowers 1989). The most commonly cited works on symbolic interactionism are that of Dewey, Mead and Blumer. Symbolic interactionists believe that the organisation of social life arises from interacting with one another.

Blumer (1969) delineated three major facets to symbolic interactionism. First, human beings react to things in relation to the meaning that they hold for them. Second, one derives meaning from social interaction and thirdly, as the person deals with situations s(he) modifies the meanings appropriately. Thus meaning, according to symbolic interactionists, is created by experience.

According to Stern et al (1982) and Polgar and Thomas (1995) symbolic interactionists believe that people act and interact on the basis of symbols such as words and body language rather than reacting to objective aspects in the environment. Objects have no inherent meaning.

A social situation only has meaning from the manner in which people define and interpret what is happening (Blumer 1969; Bogdan and Taylor 1975; Stern et al 1982; Bowers 1989; Charmaz 1990; Morse and Johnson 1991; Morse 1991). Socialising involves a process whereby one person takes the role of the other in an attempt to view objects as others do. This sharing of meaning leads to conformity in understanding and action which in turn allows individuals to predict the behaviour of others around them (Bowers 1989).

3.2.4 Ethnography

Ethnography is one of the oldest field research traditions (Miller and Crabtree 1992). It developed from an anthropological perspective (Parse et al 1985; Burns and Grove 1993; Banister et al 1994; Clifford 1997) and has been used since ancient times by the Greeks and Romans (Holloway and Wheeler 1996). Culture is central to ethnographic research (Jacob 1987). Indeed it is through its focus on culture that ethnography is distinguished from other methods of qualitative research. Ethnography can be defined as "a social scientific description of people and the cultural basis of their people-hood" (Vidich and Lyman 1994, p25).

The aim of ethnography is to understand people, their ways of living, and the ways that people use cultural meanings to organise and interpret their experiences (Field and Morse 1985; Leininger 1985; Jacob 1987; Burns and Grove 1993; Clifford 1997). Parse et al (1985) argue that the quality of the data collected is dependent on the researcher's lived experience within the culture. Thus the researcher enters the world of their subjects to explore with them symbols, rituals, and customs (Lackey 1991; Miller and Crabtree 1992; Burns and Grove 1993; Clifford 1997).

Ethnography was considered inappropriate for this study as it requires the researcher to live in or become part of the cultural setting under study (Burns and Grove 1987). Since the study was to be conducted on a part-time basis the 'researcher' was unable to fulfil this requirement nor to become a student nurse again.

3.2.5 Grounded theory

Grounded theory did not develop in isolation. In part it was a reaction against the strict empirical approach of pure science. Methodological arguments centred around the nature of human experience, the extent to which human experience could be explored and the degree to which findings were necessarily contextualised. The emergence of grounded theory was an attempt by Glaser and Strauss (1967) to legitimate carefully conducted qualitative research.

Grounded theory differs from other qualitative methods in a number of ways. In most qualitative approaches, the researcher collects data and completes the analysis having left the field. In grounded theory, data collection and analysis continue together whilst the researcher remains in the field (Charmaz 1990). Grounded theory is more process-orientated (Clifford 1997) and "unlike ethnography, it does not seek to understand culture and cultural process, rather reality is perceived as a social construct" (Tuck 1995, p446).

Grounded theory is a "general methodology for developing theory that is grounded in data systematically gathered and analysed Theory evolves during actual research, and it does this through continuous interplay between analysis and data collection" (Strauss and Corbin 1994, p273). Grounded theory was first presented in 1967 by sociologists Glaser and Strauss. Strauss came from the University of Chicago where the emphasis was on qualitative methodology and where he was heavily influenced by symbolic interactionism and the works of Thomas, Mead and Blumer. Glaser, from Columbia University, had a more quantitative perspective and had developed an appreciation for systematic ways of coding and generating theory (Hardey 1994).

Both men combined their past experiences and training in research to develop a method that sought to fuse qualitative and quantitative methods. Grounded theory therefore uses both inductive (formulation of tentative theories) and deductive approaches (follows up ideas by further inquiry) in order to construct a theory (Stern et al 1982; Field and Morse 1985; Leininger 1987; Morse 1991; Janhonen and Vehvilainen-Julkunen 1992; Clifford 1997).

A grounded theory is generated from an understanding of human behaviour by focusing on the individual and collecting data from their perspective. The constant comparative method and theoretical sampling are fundamental to generating a grounded theory of conceptual and theoretical depth (Pidgeon 1996). As Glaser and Strauss (1967) point out, the constant comparative method is not a new phenomenon as it was developed by their sociological ancestors: Weber; Durkheim; Mannheim and social anthropologists.

Grounded theory's philosophical roots lie in phenomenology (Tesch 1990; Miller and Crabtree 1992; Stern 1994) and symbolic interactionism (Glaser 1978; Stern et al 1982; Field and Morse 1985; Leininger 1987; Lowenberg 1993; Hardey 1994). The constant comparative method ensures that theory is grounded in the collected data as opposed to being forcibly related to a theory that does not fit (Stern et al 1982).

When this longitudinal study began there was limited research available on Project 2000. Jowett et al (1991) had just produced an interim report on six of the 13 demonstration sites in England. In 1992, May et al had just begun their research in Scotland. According to Stern (1980) and Hutchison (1986) grounded theory is an ideal method to use when little or no information is known about a topic. Grounded theory was therefore the method of choice.

3.2.6 Longitudinal research

Longitudinal research studies allow the collection of data from the same sample over a period of time. Such studies must involve at least two collections of data (Breakwell 1995). The benefits of longitudinal studies are that changes or trends occurring over time can be established (Nieswiadomy 1987; Breakwell 1995). Leininger (1987) argues that a more detailed account can be obtained from a qualitative longitudinal study than from most quantitative experimental studies.

Longitudinal studies are not without their difficulties; for example, the retention of participants. To enhance retention, longitudinal samples require to be nurtured. Weinert and Burman (1996) advise the expression of positive regard, personal hand-written notes, and reminding participants of their importance to the study as examples of the types of nurturing required. Verma and Beard (1981) note that maintaining contact, and retaining interest of the participants over time can be minimised if the participants are attending an educational institution.

This study was conducted on a part-time basis over a period of five years. Therefore, there was the opportunity to conduct a three year longitudinal study. As this study aimed to explore the effects of mentorship and supernumerary status on students undertaking the HE Diploma in Nursing course, the opportunity to conduct a longitudinal study was seen both as appropriate and exciting. In addition it was innovative in terms of grounded theory.

3.3 Main Study: grounded theory - applied

3.3.1 Introduction

A detailed description of the methodology used in the main study is provided below as it forms the basis of an audit or decision trail (Mariano 1995) through which the quality and trustworthiness of the study can be judged (Lincoln and Guba 1985). The aims of the study were to explore the effects of supernumerary status and mentorship on student nurses undertaking a three year HE Diploma in adult nursing. Through the use of a longitudinal grounded theory study, the study aims were achieved. The longitudinal nature of the study allowed changes over time to be identified and explored through the use of the constant comparative method.

Initially, an outline of the study design is provided as an overview. A more detailed account then follows.

3.3.2 Study Design

This was a three year, longitudinal study. Data collection occurred between October 1993 and September 1996. Ten students volunteered to be interviewed throughout their course and agreed to keep an on-going diary to record their thoughts and experiences during their practice placements regarding supernumerary status and mentorship. The diary acted as an aide-memoire during interview. Students were interviewed at the beginning of their course and again on four subsequent occasions. The fifth and final interview took place at the end of the course.

In addition, a further seven students volunteered to participate in the study by diary-only. These students kept a diary recounting their experiences and thoughts about supernumerary status and mentorship. On completion of each of their clinical placements, their diary was sent to the 'researcher'.

These seven diaries were analysed pre-interview and informed the interview process. As the study progressed, the number of diaries submitted decreased.

3.3.3 Reflexivity and the qualitative researcher

Altheide and Johnson (1994) note that the issue of reflexivity gathered importance to qualitative researchers from the 1970's onwards. Steier (1991) defines reflexivity as bending back on oneself and attributes its origin to Mead (1962). Kahn (1993, p124) cites Lamb and Huttlinger's (1989) definition: "reflexivity considers the reciprocal influence of the researcher and that which is researched."

Regardless of the type of qualitative research being conducted, it is vital that the researcher actively adopts a reflexive mode throughout the study. By its very nature, qualitative studies require the researcher to become close to the participants and to develop trusting relationships. It is imperative for a qualitative researcher to be reflexive. Without reflexivity, the researcher would be unaware of the effect their own actions or decisions have on the meaning and context of the experience being investigated. The researcher's actions may affect the findings to the extent that the could be altered.

The essence of reflexivity is that the researcher is inextricably involved in the social world under study (Strauss and Corbin 1990; Hutchison 1993; Altheide and Johnson 1994; Hammersley and Atkinson 1995; Maxwell 1996). Through reflexivity the researcher realises that s(he) is part of the world being studied and that being neutral and detached from the data being collected, analysed and interpreted, is impossible (Henwood and Pidgeon 1993; Porter 1993; Mason 1996). Mason (1996) believes that reflexivity should occur every time a decision is taken.

It is argued that qualitative researchers can never be completely neutral or objective and therefore reflexivity is used to bring an understanding of the effects of the researcher on their own study (Smith 1996). In addition, Webb (1992; 1996) believes that reflexivity can be used to establish rigour through the frank discussion of the influences, choices and decisions made by the researcher.

Although not easy to practice (Soderqvist 1991), reflexivity is intended to be an honest appraisal of the researcher's own values, beliefs, prior assumptions and situational behaviours, all of which may impinge on their work (Jorgenson 1991; Porter 1993).

Furthermore, a study's credibility can be enhanced if the researcher remains self-aware (reflexive) throughout (Porter 1996). This can be achieved from the start of the study through the maintenance of a research diary and memos (Lincoln and Guba 1985; Aamodt 1991; Hutchison 1993; Huberman and Myles 1994; Skeggs 1994), so that reactions to various events and interactions can be recorded and monitored by the researcher (Borman et al 1986; Hitchcock and Hughes 1989; Koch 1994; Boulton and Hammersley 1996). Henwood and Pidgeon (1993) state that writing concerns, sampling decisions, hunches and observations in memos serves to increase the researcher's reflexivity as well as providing an audit or decision trail.

Prior to commencing the study, the 'researcher' was very much aware of the possibility that her role as senior nurse teacher might be confused with her role as 'researcher' in the eyes of the participants. For this reason, the 'researcher' took great care to separate both roles at every available opportunity.

3.3.4 Writing in the first person

Webb (1992; 1996) and Porter (1993; 1996) argue strongly for the use of the first person in research reports as this is purported to signal reflexivity. The use of the traditional third person is said to distance the researcher from the participant and is used to provide objectivity and neutrality. By using the first person, subjectivity is valued (Webb 1992).

Steier (1991) cites Bridgman (1959) who states that by writing in the first person, the researcher as observer, is acknowledged and is seen as having an active role. The Faculty of Medicine advocates the use of the third person when writing a thesis. The 'researcher' used her own name in conversations with the participants and refers to herself as 'researcher' throughout this thesis. The spirit of reflexivity is embodied throughout the study, particularly in the methods and findings section.

3.3.5 The role and skills of the qualitative researcher in a grounded theory study

The qualitative researcher is seen as having a very different role to that of the quantitative researcher. The qualitative researcher is flexible, copes with uncertainty, is active in the research, establishes a close involvement with the participants in the study (Bryman 1984; Maykut and Morehouse 1994; Leininger 1985; Porter 1996), and has an empathetic understanding (Bogdan and Taylor 1975). Maykut and Morehouse (1994, p27) state that the "human instrument is the only data collection instrument which is multifaceted enough and complex enough to capture the important elements of a human person or activity." In addition, Wolcott (1994) argues that it is critical that the researcher is able to be a story teller.

3.3.6 The use of a research diary and memos

Glaser and Strauss (1967) state that researchers should proceed in grounded theory studies without any preconceived theoretical assumptions or speculations. In terms of this study, although there was a lack of previous empirical studies on Project 2000, the fact that the 'researcher' was a nurse educator meant that she would inevitably have some biases. Since the 'researcher' was involved in the world of the participants, she took steps to sustain her level of self-awareness in terms of developing preconceptions, beliefs and values as the study progressed. Rather than attempting to 'bracket' knowledge as advocated in phenomenological studies (Anderson 1991), the use of a research diary was adopted to allow the 'researcher' to be reflexive.

Hutchison (1986), Hughes (1991) and Benton (1996) all suggest that the researcher keeps a diary or journal so that feelings and expressions can be recorded. This strategy was used especially during the early to middle stages of the study. Thereafter, self-awareness was monitored through the use of memos. This seemed a natural development as in the early and middle stages of the study, the 'researcher' was a novice in terms of using grounded theory. However, as the study progressed and more confidence in using the methodology developed, it seemed more appropriate for the 'researcher' to use memos as a vehicle for reflexivity.

Memos involve the researcher writing down emerging ideas that are sparked off by the data (Stern et al 1982; Charmaz 1983; and Charmaz 1990). Memos can also be derived from technical and theoretical literature and field notes (Strauss and Corbin 1990). Memos should be written throughout the research process (Charmaz 1983) to capture elusive and shifting connections made (Munhall 1989), thereby preventing their loss (Strauss 1987). "Not writing memos is the research equivalent of having Alzheimer's Disease; you may not remember your important insights when you need them" (Maxwell 1996, p12). Memos are therefore used to preserve emerging hypotheses, analytical schemes, hunches and abstractions (Stern et al 1982). They serve as an on-going record of theory development and methodological problems or decisions (Bowers 1989; Wainwright 1994).

The use of memos was considered by the 'researcher' as infinitely superior to the research diary since memos are individual written accounts that can be sorted and linked with other memos if appropriate. The 'researcher's diary entries had to be transposed into memo format as the study progressed. Memos could also be stored and indexed in a personal computer thereby preserving chronological order. When reading articles and texts, memos were often written in margins and inadvertently omitted from the computer record. However, these were always retrieved later.

3.3.7 Position of the qualitative researcher in the world of participants

The researcher must become immersed in the world of the participants, to achieve the level of personal interaction necessary (Hutchison 1986; Bowers 1989). Bowers (1989) however cautions that the optimal position for the researcher is to have one foot in the world of the participants and one foot outside it. This was achieved by the 'researcher' being unknown to the participants initially and not teaching during the CFP.

When the participants reached the Adult Branch where the 'researcher' was a senior nurse teacher, she ensured that she had no teaching or academic responsibility for them. On occasion, due to staff sickness, she taught the entire cohort (n=100) which, given the number, distanced the teacher from the students.

3.3 8 Ethical Issues

In any research study, ethical issues should be addressed at the planning stage and thereafter the researcher should be consistently aware of the ethical principles of autonomy, beneficence and non-maleficence throughout the study. The 'researcher' approached the local ethics committee for ethical approval to conduct her study as this was a requirement of the educational institution through which access to students was to be sought. Ethical approval was granted (appendix 1).

Following ethical guidelines (Field and Morse 1985; Ford and Reutter 1990; Dehyle et al 1992; Garity 1995; Holloway and Wheeler 1995; Rubin and Rubin 1995), each participant was given written information and signed an informed consent form (appendices 2 and 3).

In this longitudinal study, the nature of informed consent was especially important (Field and Morse 1985; Ramos 1989; Munhall and Boyd 1993; Miles and Huberman 1994). Informed consent requires adequate information, mental competence and freedom from coercion and vulnerability (Garity 1995), and is a means of ensuring that the respondents' rights are protected. However, in a longitudinal study, it cannot be assumed that the informed consent given at the commencement of the study will remain valid for the length of the study. Using in-depth interviews over three years meant that the 'researcher' was unable to specify the issues that would likely to emerge. The likelihood of participants' circumstances changing over time, might also influence consent (Ford and Reutter 1990).

Written consent (see appendix 2) along with consent prior to every interview and diary collection was also obtained from participants. Munhall and Boyd (1993) named this type of informed consent, process consent. In this way, the 'researcher' confirmed that the participants were still happy to continue in the study.

Participants' permission was sought and gained to tape-record their interviews and to photocopy their diaries. The 'researcher' was frank regarding the intended use of the research, stating that the findings might not help them directly (Rubin and Rubin 1995). Promises or guarantees given to the respondents regarding any aspects of the research process were honoured for as Smith (1992, p102) states "it could be argued that to be allowed a private view of another person's past or opinions or pain is a privilege."

Students were assured confidentiality and anonymity. Confidentiality is the active attempt to remove any elements from the research records that may identify any individual. Anonymity requires the participants' real names be obscured (Berg 1989). Care was taken not to mention any participant's name on tape (Ford and Reutter 1990) and each participant was asked not to name hospitals, wards or individual staff during the interview. At the final interview, participants were asked to pick their own pseudonym which would be used in the writing of the thesis.

Audiotapes were kept secured in a locked drawer and were transcribed as soon as possible. Once transcribed, the tape was erased as promised by the 'researcher' in the information sheet. Transcripts contained codes to identify participants and the list of names was kept separate from transcripts and any notes (Hammick 1996). Access to tapes and transcripts was restricted to the 'researcher'. Personal details of participants were also kept secure and were destroyed at the end of the study (Berg 1989).

Marshall and Rossman (1995) mention reciprocity, particularly in longitudinal studies. They state it may entail giving time to help, providing informal feedback, making coffee, being a good listener or tutoring. However they warn that whatever form the reciprocity takes, it should fit in with the constraints of the researcher's personal ethics and be within the constraints of maintaining one's role as researcher. In this study, the 'researcher' always provided coffee and biscuits at interviews and gave notebooks to students to use as their diary.

At the end of the study, approximately half the students stated that it had been good to talk to someone who was interested in listening about their experiences. Diary-only participants mentioned the benefit of being able to reflect back on what they had written previously and to see their progress over the years. A number stated that this had an on-going positive effect on their morale.

3.3.9 Sampling in grounded theory

The initial decision regarding sampling is the only pre-planned decision that the researcher makes in grounded theory (Glaser and Strauss 1967; Benton 1996). It is usual to begin with a purposive sample of participants who are known to have views and attributes related to the area of interest (Field and Morse 1985; Burns and Grove 1993; Dempsey and Dempsey 1996; Clifford 1997).

The size of the sample in qualitative studies is normally small (Leininger 1985). Where individuals either belong to the same subculture or have similar characteristics (homogenous) six to eight participants are suggested with up to 12 for maximum variation (Leininger 1985; Holloway and Wheeler 1996). Zyzanski et al (1992) regard size as secondary to the need for rich information. However Wolcott (1994) warns that large samples in qualitative research can be harmful because they may lack the depth and richness acquired through smaller samples. Following advice from a researcher with experience of qualitative research, the decision was made to begin with a sample of ten students.

In this study, the cohort of students commencing their training was divided into four groups of 50 students (made up of all branches and midwifery). When access to students was requested, the 'researcher' was allocated two groups from which to gain her sample. The allocation of the groups occurred by chance since it depended on the availability of a group coinciding with the availability of the 'researcher'.

The aim of the research was shared with the first group of 50 students. They were informed that participating in the study would involve being interviewed on five occasions during their course and that they would be asked to keep a diary whilst on placement. The latter was also a course requirement.

Students who were interested in participating and had opted for the Adult Branch were asked to remain in the classroom whilst the remainder left. From this first group, nine participants were recruited. Since the study was a longitudinal in design, the 'researcher' wished to recruit at least ten students in view of possible attrition. The second group of 50 students were approached and information shared as with the previous group. On this occasion, eight of the students destined for the Adult Branch, volunteered to take part. Only one student was required for the interview group. However, the 'researcher' was concerned that the remaining seven students might be disappointed in not participating. Purely intuitively, the 'researcher' asked all eight students whether they would like to participate by interview or by diary-only. All eight replied that they were more than willing to be interviewed or just keep a diary.

The student joining the interview group was randomly selected. In this way, ten students were recruited for the interview group and seven for the diary-only group.

It was the 'researcher's intention to draw from the 'diary-only' group should attrition occur or if a larger sample was required in the interview group to achieve saturation. This falls into the realms of theoretical sampling which was used to substitute the three participants who had to be replaced owing to discontinuation of their studies.

Theoretical sampling allows the sampling of appropriate participants in order to achieve theoretical saturation (Duffy 1985; Pidgeon 1996). Saturation means "that no additional data are being found whereby the sociologist can develop properties of the categories" (Glaser and Strauss 1967, p61). Despite the fact that saturation usually occurred by the ninth interview, all ten participants were interviewed on each occasion as it was considered important to maintain on-going relationships. It was also contemplated that by failing to interview each participant as outlined in the participant information sheet, the basis on which ethical approval had been given, would have been breached. Students were not interviewed in the same order each time.

3.3.10 Use of literature in grounded theory methodology

It is debatable as to whether a literature review should be conducted prior to data collection in a grounded theory study. It is argued that the overriding reason why a pre-study literature review should not be performed is that it may lead to pre-judgement, which in turn can lead to premature closure of ideas (Glaser 1967; 1978; 1982; Stern 1980; 1982; Munhall 1989; Charmaz 1990; Strauss and Corbin 1990; Procter 1995; Streubert and Carpenter 1995; Benton 1996). According to Charmaz (1990, p1163) the absence of a pre-study literature review "decreases the likelihood of being locked into preconceived conceptual blinkers." Glaser (1992, p31) warns that "it is hard enough to generate one's own concepts without the added burden of contending with the 'rich' derailments provided by the literature in the form of conscious or unrecognised assumptions of what ought to be found in the data."

Those who advocate a pre-study literature review believe it prevents the reinvention of the wheel (Morse and Field 1991; Porter 1996) and a pre-study literature review is necessary in preparation of a research proposal (Field and Morse 1985; Cobb and Hagemaster 1987; Holloway and Wheeler 1996). Once the pre-literature review is completed Morse and Field (1991) suggest that the researcher bracket or try to forget the data and return to the library at a later date.

The literature in a grounded theory study is treated as any other data. It is examined, coded and analysed and then woven into the fabric of the researcher's own data analysis (Stern 1980; Stern et al 1982; Cowley 1991; Benton 1996). The literature is used to explain, support and extend the emerging theories (Stern, 1980; Hutchison 1986; Streubert and Carpenter 1995). It also helps to determine the fit of findings from earlier studies and existing theories within the study's findings (Cobb and Hagemaster 1987).

The use of the literature is said to be an on-going process (Chenitz 1986; Benton 1996). Field and Morse (1985) advocate that the literature should be used as data are collected and analysed. However, Strauss and Corbin (1990) and Benton (1996) contend that literature should be used once the categories have been established. In this study, the 'researcher' followed the guidance of Glaser and Strauss (1967), Charmaz, (1983), Charmaz (1990), Glaser (1992), Streubert and Carpenter (1995), and Talbot (1995) and waited to search the literature until the categories had been generated. The decision to wait until the 'researcher' completed data analysis before searching the literature is supported by the following quote from Glaser (1992, p32) "...the researcher may be hard put to know which substantive field his theory is in until it has emerged sufficiently." In other words, it is not until the data analysis is complete that the areas of related literature become obvious. In this way, the theory can be placed within the context of the literature and previous research findings. Glaser (1978), Charman (1990), and Cowley (1991) all stress that added data from other research and literature must fit with the emergent theory rather than being forced. It should fit 'naturally'.

When data are discovered from research literature that are inconsistent with the emerging theory, the researcher must investigate these as negative cases (or contradictory evidence). Negative cases to the researcher's emerging theory must be tested out (Mason 1996) and interpretations either refuted or amended (Strauss and Corbin 1990; Morse 1991; Oleson 1994). Attempts were made to adhere to this guidance (see data analysis).

Introduction to data collection

Although data collection and analysis occurred simultaneously in the study, for ease of discussion they will be dealt with separately.

3.4 Data collection methods

There were three methods of data collection used: in-depth interviews; one focus group interview; and diaries.

3.4.1 Interviews

Guba and Lincoln (1981, p158) define an interview as "an exchange of information and impressions, carried out in a variety of styles." Burgess (1984) calls it a 'conversation with a purpose.'

Charmaz (1990, p1167) states that "to use grounded theory method effectively, the researcher needs rich, detailed data. Grounded theorists have been accused of not attending carefully to data collection and of skimping on sampling. However, grounded theorists need detailed, vivid data on which to base their analysis." It is argued that an in-depth interview was the most suitable type to use in this study.

3.4.2 Types of interviews

There are three different types of interviews that reflect the amount of control exerted by the researcher. Most control is exerted in structured interviews where the sequence and wording of questions are set prior to the interview. The interviewer is instructed not to deviate from this format and the respondent is asked to answer with very little or no opportunity for self-expression (Guba and Lincoln 1981; Leininger 1985).

In semi-structured (or non-scheduled standardised) interviews, there is less control. Interviewers are permitted to alter the sequence of questions, repeat questions using alternative language and use neutral probes to elicit a clear response. Although there is more flexibility, semi-structured interviews were considered inappropriate for this study as the in-depth exploration of unexpected avenues would be inhibited (Bowers 1989; Couchman and Damson 1990).

Little control is exerted in unstructured interviews and an exploration of the interviewee's responses is permitted which may increase the depth of information gained (Waltz et al 1984). Researchers such as Leininger (1985), Walker (1985), Couchman and Dawson (1990), Ely (1991), May (1991), Hardiman (1993), Mason (1996) and Wilson (1996) argue that an unstructured interview is impossible because judgements and decisions made by the interviewer must give some structure to the process. They prefer to use the term in-depth interview as this more accurately describes this type of interview. This was the term adopted in this study.

Silverman (1985) states that in-depth interviews are the preferred choice in qualitative studies as they allow individuals to express themselves in a unique way and to introduce topics deemed relevant by the respondent as opposed to the researcher following a schedule. The in-depth interview is designed to obtain 'rich soft' data and was considered the most suitable type to use in this grounded theory study (Glaser and Strauss 1967; Glaser 1969; Becker and Geer 1970; Glaser and Strauss 1970; Glaser 1978; Strauss 1987; Strauss and Corbin 1990; Glaser 1992).

This is further supported by Miller and Glassner (1997, p99) when they state that "information about social worlds is achievable through in-depth interviewing." The use of in-depth interviews would enable the 'researcher' to gain insight into the students' experiences of supernumerary status and mentorship. In effect this approach facilitated viewing the students holistically and valuing their thoughts and feelings.

3.4.3 Relationship between interviewer and participant

According to Burgess (1984), and Rubin and Rubin (1995), the relationship between interviewer and participant is crucial, particularly in qualitative research. In this study, the 'researcher' strove to ensure that the participants viewed her as researcher and not as teacher. In all communications with participants, the term researcher was adopted and no college stationery was used.

At the end of every interview, an informal note was hand-written to each participant, thanking them for their contribution to the study and mentioning when the next interview was planned as suggested by Melia (1981).

3.4.4 Pre-testing of in-depth interviews

Advice regarding pre-testing of in-depth interviews is contradictory. Leininger (1985) believes that pre-testing is unnecessary because the interview data are derived from the perspective of the participant and the need for replication is unlikely. However, French (1993) advocates carrying out two or three trial interviews so that any problems encountered can be addressed prior to the main interviews.

In this study, four trial interviews were conducted with HE Diploma in Nursing students from an earlier cohort to allow the timing of interviews to be estimated and to permit practice using an unfamiliar tape recorder and transcriber. At least one hour between interviews was found to be necessary to retain concentration and no more than three interviews were conducted in a day.

Interview tapes were transcribed verbatim and coded to estimate the time involved in transcription and to provide an opportunity to become more familiar with the coding procedure. An experienced secretary was asked to transcribe verbatim two of the tapes and to record the length of time it took for each tape. The other two tapes were transcribed by the 'researcher' and time noted. The secretary's transcription notes were checked for accuracy by the 'researcher' listening to the tape and the time taken noted. A number of inaccuracies were found in the secretary's transcripts. Discussion with the secretary revealed that she had difficulty with one of the student's accents and often misheard or misunderstood words. The 'researcher's transcripts were more accurate and had the added advantage of including non-verbal details which the 'researcher' remembered from the actual interview. Overall the time difference between the 'researcher' transcribing and checking for accuracy and the secretary transcribing and the 'researcher' checking for accuracy was negligible.

Debate exists regarding whether a secretary or the researcher should transcribe interview tapes (Melia 1981). Lofland (1971), Gorden (1980), Swanson (1986), Silverman (1993), Maykut and Morehouse (1994), and Dunne (1995) recommend that the researcher transcribes her tapes as self-transcription stimulates analysis and provides an opportunity to re-live the interview and become more familiar or immersed in the data. Researcher transcription also reduces errors, since the researcher is more likely to pick up the participant's words if audibility or accents are a problem. Important non-verbal communication can also be noted (Gorden 1980; Waltz et al 1984; Swanson 1986). In this study, the 'researcher' transcribed all tapes (excluding pre-test tapes) within 48 hours as advised by Swanson (1986), Maykut and Morehouse (1994), and Dunne (1995). This allowed coding and constant comparison of data to be continuous throughout the process of data collection. Occasionally, due to pressures of time, tapes were not transcribed until 72 hours later.

3.4.5 Conducting interviews

Interviews were held after students had recently completed a practice experience and were in College for a theoretical component. All interviews were conducted at the students' convenience and on the campus of their choice. Planning is one of the keys to gaining success in interviewing (Gray 1994). Interviews took place in a private room and care was taken in establishing an informal environment (Gray 1994).

The environment should be friendly and relaxed, private and free from distractions to facilitate a free flow of ideas, thoughts and feelings. Privacy is essential as to reduce ego threat as it prevents the respondent being seen or his or her words being overheard (Gorden 1980). Hospitality needs to be considered carefully (Rubin and Rubin 1995). Walker (1985) warns that judgement should be used as to when refreshments are offered. If offered in the middle of the interview it can disrupt the flow of conversation and at the end it can detract from the interviewer's professional neutral manner, particularly if sensitive topics have been discussed. For these reasons the 'researcher' offered refreshment at the beginning of the interview a means of ice breaking. It also facilitated an informal atmosphere to be achieved.

The 'researcher' also planned her opening question in advance as it was felt too important to leave to chance. Positive responses were gained from using a non-threatening, easily answered question. It was considered vital to gain the students' confidence, particularly in the first few minutes of the initial interview. If students became uneasy or suspicious, confidence, trust and the willingness to participate would be lost. Field and Morse (1985, p66) illustrate this when they write "the researcher establishes relationships with the informants during the first interview which will be relatively shallow and polite. The informant will be 'sizing up' the interviewer and making silent decisions about whether or not the interviewer is agreeable and can be trusted."

Day of interview

The 'researcher' always arrived early to prepare the room and position and check the tape recorder. Chairs were placed such that the 'researcher' and student were seated at approximately right angles to each other to allow eye contact and observation of non-verbal communication without appearing threatening. To emphasise informality no desk or table was between the parties. Questions asked early were non-threatening to ensure that the student's answers would not make them uncomfortable.

The 'researcher' conveyed to the student that she respected and valued their expertise and believed that they were the only ones appropriately placed to answer her questions. Every interview revolved around two issues; the effects of supernumerary status and mentorship. Issues were explored as the student introduced them and the 'researcher' allowed them to describe their thoughts and feelings in their own way, and to ensure courteous and friendly responses which reflected a genuine interest in what the student was saying.

The 'researcher' found that she had to be flexible and alternate between an active and passive role depending on the nature of the interview and the amount of probing required to encourage the student to share information. Topics arose within the interviews which required to be explored and interesting leads were pursued. To achieve this the 'researcher' kept the purpose of the interview in mind and was aware of the value of critically evaluating the information received from the students (Gorden 1980; Stevens et al 1993). Decisions had to be continually made regarding the sequencing and phrasing of questions in the light of the responses received. This required concentration and a good memory. It was considered crucial that any misunderstandings were identified and rectified. If the 'researcher' was hesitant, she followed the topic through to further examples offered by the student, otherwise the misunderstanding could have led to irrelevant connections being made and important leads being missed (Becker and Geer 1970).

The 'researcher' followed Chenitz's (1986) advice that there is no such thing as a right or wrong answer particularly when conducting in-depth interviews.

Closing the interview required planning. The last question posed always ended the proceedings on a positive note. This was vital in this study since repetitive interviews were used. At the end of every interview, the researcher wrote to the respondent thanking them for their participation and mentioning when the next interview was planned. In the 'researcher's opinion the manner in which the interviews were conducted reflected the outcome, quality and depth of information gathered.

Taping of the interviews not only facilitated analysis but also gave valuable feedback on how well the 'researcher' as interviewer had performed, self-awareness, criticism and commitment aided the development of improved technique. There were only three students who were lost to the study. Two were discontinued at the end of the CFP because of academic reasons and one student left for personal reasons. These students were replaced by two students from the 'diary-only' group.

3.4.6 Focus group interview

In this study, one focus group was held to clarify an issue which emerged as a result of the emergence of a phenomenon in one set of interviews. A focus group interview is a "qualitative technique to obtain data about feelings and opinions of small groups of participants about a given problem" (Basch 1987, p414). Focus groups are used when a range of perspectives on particular topic is required quickly (Boulton and Fitzpatrick 1994; Krueger 1994). In this study, it was important to explore and clarify the phenomenon before the next round of interviews took place.

The suggested focus group size is between four and 12 individuals (Morgan 1988) with six to eight as the optimum (Krueger 1994; Millward 1995; Clark et al 1996a). During the analysis of interview and diary data, it became apparent that the mental health placement was causing difficulty for some Adult Branch students.

To investigate this further a decision was made to interview mental health students to establish whether they had similar difficulties to Adult Branch students. The principle of theoretical sampling was used. Eight students intending to follow the Mental Health Branch and who were from the same cohort as the other students participating in the study, were recruited but only five students actually took part. The other three had forgotten when the interview was to take place. The interview focused on differences between their adult and mental health placements. The use of a homogenous group of students sharing the same common experiences worked well. The focus group interview lasted about 45 minutes and having gained prior consent from the participants, was tape-recorded.

The tape was transcribed and analysed in the same manner as the individual interview tapes as advised by Boulton and Fitzpatrick (1994), Krueger (1994), Henderson (1995), and Kitzinger (1995). Furthermore, as advised by Clark et al (1996a), the group itself was viewed as a unit of analysis.

3.4.7 Diaries as data collection tools

The terms diary and journal are not synonymous. In Wagenaar's (1984) opinion a diary is where one regularly records events, thoughts and dreams and is generally private. A journal is a method whereby respondents describe their thoughts, feelings, observations and experiences with the intention of encouraging reflection and analysis (Wagenaar 1984; Landeen et al 1992).

The use of a diary as a data collection method during a longitudinal study has been used before but only for one year (Oleske et al 1990). Diaries are a powerful way for participants to describe their experiences (Clandinin and Connelly 1994) and are a rich source of data (Field and Morse 1985; Holloway and Wheeler 1996). According to Burgess (1984, p135) "...the diary provides a first hand account of a situation to which a researcher may not have direct access.

Secondly, it provides an 'insiders' account of a situation and finally, complements that materials that are gathered through observation and interview by the researcher."

In this study, diaries were used for two reasons. First, the timing of in-depth interviews meant that participants were expected to recall at interview, their experiences, thoughts and feelings that could have occurred some considerable time before. Therefore, the problem of memory decay had to be addressed. Events are less likely to be forgotten if diaries are used as they help to minimise recall error and reduce the possibility of memory lapses (Moser and Kalton 1971; Cavanagh and Snape 1993; Richardson 1994; Ross et al 1994). This was the principal reason why all study participants were requested to keep a diary whilst on their clinical placements. Students were asked to bring their diary to the interview to act as an aide-memoire (Richardson 1994).

According to Butz and Alexander (1991), Bennett and Kingham (1993) and Richardson (1994) participants report more detail when a diary is kept as opposed to the data obtained from retrospective interviews. Richardson (1994) states that validity and reliability is more likely to be evident in diaries since the participants are not using recall. These assertions are gleaned from their impressions from their own research rather than having any empirical basis.

The diary-only participants sent in their diaries at pre-determined intervals. The receipt of diaries was planned so that the 'researcher' would receive them before the interviews commenced so that the diaries could be used to inform the in-depth interviews. All diaries were transcribed and coded in the same way as interviews.

3.4.8 Format of the diary

There are three different types of diaries (Bennett and Kingham 1993), (see Table 8). In structured diaries respondents record information requested by the researcher. According to Bennett and Kingham (1993), this type of diary may stifle creativity and spontaneity since the respondents are directed to record specific events or frequencies of activities. In a semi-structured diary, the researcher outlines key themes for the respondents to focus and write upon. No instructions are given, as this would be considered over-structuring.

The unstructured diary is very much like keeping a personal diary where the respondents not only decide what to write but also when, how long for and how often.

In this study a semi-structured diary format was used. Students were asked to consider two key themes were given broad guidelines on keeping their diary (appendix 3).

Table 8 The diary continuum (adapted from Bennett 1993)

STRUCTURED DIARY	SEMI-STRUCTURED DIARY	UNSTRUCTURED DIARY
Researcher-centred	researcher/respondent centred	respondent-centred
Quantitative orientation	Qualitative or quantitative	Qualitative orientation
Time and context for diary recording specifically defined by researcher	Time and context for diary recording broadly defined by researcher	Time and context for diary recording left open to respondent

3.4.9 Frequency of diary recording

Varying advice is available regarding how often entries should be recorded in diaries from daily (Dewing 1990; Parahoo 1992b; Cavanagh and Snape 1993) to weekly (Wells 1987; Burnard 1988). Wells (1987) cautions against daily entries as reduced compliance with a falling off of both quality and quantity of entries is likely to result.

Cavanagh and Snape (1993) reported a poor response rate when they asked for daily diaries to be kept. Wells (1987) argues that daily entries are impractical. He advocates asking students to keep daily entries for the first three days of the practice experience, then every third day for the following three weeks, and thereafter on a weekly basis. In Wells's experience, this strategy helped to avoid the falling off problem in completing entries, particularly if the practice placement was lengthy.

Bennett and Kingham (1993) suggest it is more productive for participants to keep their diary intensively for a day, a week or a fortnight and for a specific purpose and thereafter maintain a general diary.

The practice placement experiences of the students participating in this study were four to five weeks in length. A semi- structured diary format was used and students asked to write it up on a weekly basis. Students recorded their thoughts, feelings and experiences on two themes: first, what has it been like being a supernumerary student nurse this week? and second, what has it been like having a mentor? Students could write in their diaries at any other time if they wished.

3.4.10 Compliance in diary keeping

Compliance is often cited as a potential problem in diary keeping, particularly if participants are expected to maintain it over lengthy periods (Verbrugge 1980; Butz and Alexander 1991; Paterson 1995). For this reason, Norman (1982 cited in Richardson 1994) argues that there should be a time limit of using diaries as a means of data collection.

Breakwell and Millward (1995) suggest that a postcard or telephone call in longitudinal studies improves sample retention. In this study, the 'researcher' met with the diary-only participants, gave written guidelines and offered a diary note-book to use for the purposes of the study. Nearing the end of each placement, students were sent a hand-written note requesting their diary be sent in the envelope provided. A second reminder note was sent as necessary. Once received, the diary was photocopied and returned to the participant with a personal letter of thanks.

Both the interview group and the diary-only group maintained their diary keeping until the end of their second year in the study. Thereafter the pressure of assignments and rostered service were stated as reasons why compliance diminished or stopped. Only one student maintained her diary throughout the study.

3.4.11 The 'researcher's experience of using diaries as a method of data collection

Keeping a diary as experiences occurred helped the students to describe and record their thoughts and feelings which they experienced at the time rather than using hindsight or relying totally on recall. It also helped to prevent chronological confusion. This was important as the student whilst trying to recall the nature of the event may have otherwise used hindsight when interpreting past events. In this way it was considered a more accurate memory was evoked. Richardson (1994) asserts that validity and reliability are likely to be more evident in diaries as the participants are not using recall.

The 'researcher' followed Dewing's (1990) guidance. Dewing advises using specific ground rules to ensure that trust and mutual respect are maintained. The student's diary should be regarded as the student's property and they should feel free to write as much or as little as they wish and be confident in the researcher's commitment to confidentiality.

There are a number of documented benefits in using diaries as a means of collecting data. Events are less likely to be forgotten (Moser & Kalton 1971). Indeed, Ross et al (1994) believe the use of diaries in their study helped to minimise recall error and reduced the possibility of memory lapses. This benefit is echoed by Richardson (1994). Diaries also provide a perspective of events, thoughts and feelings over time (Faithfull 1992) which is particularly valuable in qualitative research studies as they furnish the researcher with rich data. According to Richardson (1994) participants report in more detail when they keep a diary as opposed to the data obtained from retrospective interviews. These advantages were evident in this study.

Compliance is often cited as a problem but Verbrugge (1980) found co-operation was high. More than 85% of her respondents agreed to keep a diary and continued up until the end of the study. Verbugge, however, noted that the level of reporting tended to drop off after two to three months. For this reason Norman et al (1982) cited in Richardson (1994) argue that there should be a time limit of using diaries as a means of data collection. It is argued here that diaries should not be used for any longer than between 12 and 18 months (see page 279).

Lack of motivation and understanding of respondent on exactly what is expected of them (Moser & Kalton 1971) is also cited as a disadvantage. The 'researcher' found that although the students were given written guidelines, she had to meet with them to explain and emphasise what was required. She also used this opportunity to provide them with a small hardbacked notebook to use as their diary if they so wished. Faithfull (1992) states that difficulty in reading handwriting can be a problem, however this was not encountered in this study.

Diaries can also be time consuming not just in terms of their analysis (Richardson 1994) but for the respondents who have to write them up. The latter point is suggested by the 'researcher' as a contributing factor in the reduction in compliance once there were competing demands on the students' time during the later part of the course. Once the pressure of academic work was felt, diary-keeping was no longer seen as a priority.

To date it is becoming more popular to use diaries in terms of self assessment or reflective practice than as a research tool (Burnard 1988, Dewing 1990, Richardson 1994). This is unfortunate since during this study students who have kept their diaries have provided the 'researcher' with valuable information. The students seemed content with completing their diary on a weekly basis and those who are participated by diary-only sent their diaries as requested. The diary-only participants provided the 'researcher' with some rich data and because they usually arrived before she interviewed the other students, their entries informed the interview process.

3.5 Data analysis

3.5.1 Audit trail

An audit trail enables corroboration at every stage of the data analysis, by allowing another person to follow decisions made by the researcher (Kirk and Miller 1986; Yonge and Stewin 1988; Beck 1993b; Mason 1996; Porter 1996). The use of diagrams and memos can make the audit or decision trail more explicit (Wainwright 1994). Throughout this thesis, the 'researcher' endeavoured to provide a detailed account of the research to allow the reader to follow the processes involved in the research.

3.5.2 Theoretical sensitivity

There are two fundamental commitments to analysis in grounded theory: constant comparative method and theoretical sensitivity analysis (Benton 1996). Theoretical sensitivity is a personal quality of the researcher (Strauss and Corbin 1990). It is an ability to recognise the subtleties in the meaning of data and to separate the pertinent from the irrelevant (Strauss and Corbin 1990). According to Strauss and Corbin (1990), Tuck (1995), Holloway and Wheeler (1996) the sources of theoretical sensitivity come from reading, personal and professional experience.

As an experienced nurse teacher, the 'researcher' was well read in nurse education literature and therefore theoretically sensitive. Indeed, Charmaz (1990) asserts that during memo writing, the researcher can use her own theoretical background in order to deepen the analytical insights of the developing theory.

3.5.3 Constant comparative method

Using the constant comparative method, collected data were coded, compared with other data and memos, and reduced into concepts and categories (Wainwright 1994). Pidgeon and Henwood (1996) insist that during the early stages of the study, the researcher should be allowed maximum flexibility, to facilitate creativity in category generation.

Charmaz (1990) adds that leads and hunches which are sparked off through data collection and analysis should be followed up in order to gather more data. Thereafter developing categories should be checked.

From the transcripts, the 'researcher' read paragraph by paragraph, tentatively labelling phenomenon that she perceived to be relevant. Usually the previous interview had been transcribed and coded before the next interview was conducted. Thus data collection and analysis occurred simultaneously (Lieher and Marcus 1994). Ideas that emerged during the analysis were recorded in memos and stored chronologically.

3.5.4 Open coding

Initial coding of the data is called open coding (Strauss 1987). According to Strauss (1987) its aim is to produce provisional concepts that fit data. Strauss and Corbin (1990) define concepts as the building blocks of theory. During open coding, codes are generated quickly, but it is vital that each code is verified to ensure that it fits with the aim of eventually saturating the code (Glaser 1978). During this phase, it is important to cogitate creatively to prevent becoming trapped into tram lines thinking (Coffey and Atkinson 1996). Strauss and Corbin (1990) advocate that each discrete incident, idea or event is given a name that represents the phenomenon. Using the participants' own words (in vivo codes) is very useful as they are seldom forgotten by readers as they are usually so colourful (Strauss 1987; Charmaz 1990).

Table 9 provides an example of how codes were condensed into categories from data gained from the first interviews and diaries.

Table 9 Example of condensing codes into categories

Codes	Category
Don't know what to expect What will be expected of me? Fear of disrupting their routine Fear of forgetting how to do things Fear of doing something wrong What will staff think of me? Fear of being like a lost sheep Fear of being a nuisance	Fear of unknown
Ward staff think we are the dreaded P2000 students Staff have bad attitudes towards P2000 We are not liked Labelled a P2000 student, not a student nurse Uniform makes us different Everyone puts us down even before we have a chance to prove ourselves They treat us differently to the 'old' students Ward staff seem threatened by us	Stigma

3.5.5 Axial coding

Once open coding was achieved, the codes were compared with one another and those which were similar were clustered into categories. In this study, analysis of the first interview transcripts resulted in 44 open codes which were then condensed into eight categories. Categories are then compared in order to identify connections. This is termed axial coding by Strauss (1987). It involves the researcher investigating the conditions and context under which each category exists, how the categories act and interact with one another and the consequences of such interactions (Strauss and Corbin 1990).

3.5.6 Selective coding

Eventually, when all interview transcripts and diaries were coded and categorised, the final aspect of analysis, selective coding was performed. Twenty-eight categories were collapsed into five major categories: fear of the unknown; reality hits home; becoming a branch student; total surrender of supernumerary status; and the end is nigh. Through this critical process, in which relevant literature was also reviewed, the core category emerged. Literature is treated as data and undergoes the constant comparative method along with the researcher's developing theory (Glaser and Strauss 1970; Glaser 1978; Strauss 1987; Strauss and Corbin 1990; Glaser 1992; Lieher and Marcus 1994; Strauss and Corbin 1994). The core category emerged as 'the professional socialisation of a HE Diploma in Nursing student nurse.'

3.5.7 Core category

The goal of grounded theory is to generate theory which occurs around the core category (Hutchison 1986; Strauss 1987). Holloway and Wheeler (1996) emphasise that the core category must be discovered as it links all other categories. The 'researcher' used the Buzan (1974) strategy which Turner (1981) advocates at this stage of analysis.

The core category is said to have seven characteristics:

1. It recurs frequently (Strauss 1987) and develops as a pattern (Holloway and Wheeler 1996).
2. It links various data together (Holloway and Wheeler 1996) and relates easily to other categories (Strauss 1987).
3. Since it is central it explains a lot about the variation in the data (Strauss 1987; Holloway and Wheeler 1996).
4. It has implications for a more general or formal theory (Hutchison 1986; Strauss 1987).
5. It becomes more detailed as the theory moves forward (Hutchison 1986; Strauss 1987; Holloway and Wheeler 1996).
6. It permits maximum variation in analysis (Hutchison 1986; Strauss 1987).
7. It is usually found towards the end of the research (Corbin 1986; Holloway and Wheeler 1996) as it takes longer to define its precise nature (Strauss 1987).

3.5.8 Use of computer soft-ware packages in analysis of qualitative data

Software packages specifically designed for qualitative data analysis have been available to researchers since 1984 (Tesch 1991). According to Richards and Richards (1994) although most qualitative researchers use computers, few utilise software designed for qualitative analysis. This may be one reason why there is little or no empirical evidence regarding the usefulness of such programmes. The available literature regarding the advantages and limitations of software programmes is primarily anecdotal in nature.

During this study, use was made of the software package 'NUD.IST' (non - numerical, unstructured, data, indexing, sorting and theorising) which was designed principally for studies using grounded theory (Richards and Richards 1994). It allows users to organise their codes into a tree-like structures and is categorised as a theory-building programme (Russell and Gregory 1993).

The advantages of software packages, such as NUD.IST, are stated anecdotally as:

- time saving (Ely 1991; Tesch 1991; Russell and Gregory 1993; Mason 1996)
- less cumbersome process than manual method (Holloway and Wheeler 1996; Kvale 1996)
- provides tireless, efficient clerical assistance (Baker 1988)
- increases productivity and efficiency (Anderson 1987; Russell and Gregory 1993)
- allows analysis to proceed more quickly (Burns and Grove 1993)
- encourages more accurate and comprehensive analysis since good analysis requires efficient management of data (Benton 1996; Holloway and Wheeler 1996).
- ensures more thorough analysis since no individual data pieces can become lost or overlooked (Tesch 1991).

The use of computers in analysing qualitative data has caused some concern. Russell and Gregory (1993) warn that novice researchers are especially vulnerable to potential traps. It is inevitable that personal bias will be involved in anecdotal and personal comments. For example, Ely (1991) attributes any cited limitations to be due to the researcher's work style rather than due to a problem with the programme. She asserts that those who criticise the use of software programmes in qualitative research are non-computer literate individuals who do not know better.

This is in direct contradiction to limitations cited by Richards and Richards (1994) the designers of NUD.IST and Seidel (1990) the designer of ETHNOGRAPH. These individuals appear to have a more balanced view since despite promoting their programmes, they are able, albeit anecdotally, to offer some limitations of their own products. Dey (1993, p62) advises that "all that is required is to retain a sense of proportion about the role of the computer, to recognise its limitations and to keep a firm focus throughout on the analytic as well as the technical tasks to be accomplished." The 'researcher' believes that reflexivity aided this process.

Seidel (1990) cited by Holloway and Wheeler (1996) mentions 'analytical madness' as a potential problem of using qualitative computer software. This involves the researcher, particularly those with a quantitative mind set, to be tempted to collect and manage large quantities of data, which results in a superficial analysis that lacks the depth and richness desired of a qualitative study. Seidel (1990) also suggests that the relationship between researcher and programme can become mechanistic, causing a lack of the conceptual thinking required to reveal the real meaning of the phenomenon. Finally Seidel (1990) suggests that using a software programme may distance the researcher from the data, a point echoed by Ely (1991) and Becker (1993 cited by Holloway and Wheeler 1996). The 'researcher' found the opposite to be the case. The 'researcher' felt totally immersed in the data, having conducted all the interviews personally, and completed the transcribing and coding of data using NUD.IST entirely by herself.

The 'researcher's feeling of total immersion could also be attributed to the combination of conducting the interviews and transcribing alone, however, during coding, the 'researcher' often experienced flashes of inspiration and ideas that were recorded as memos.

It is important to consider what a software package can and cannot do. It does not use artificial intelligence and therefore cannot think, review, interpret or analyse data (Anderson 1987; Tesch 1991; Burns and Grove 1993). It is definitely the researcher's role to analyse the data (Ely 1991).

Mason (1996) suggests that the researcher conducts a trial run with the programme before using it in the actual study. In this study, the 'researcher' did not gain access to NUD.IST until after the first set of interviews had been coded and analysed by hand. On reflection this was an advantage because the 'researcher' already had an understanding of the process of coding before using NUD.IST for the first time.

When the opportunity of using NUD.IST arose, a decision was made to have a trial run using NUD.IST with the raw data from the first set of interviews. The time saved in the initial coding process was noticeable. However this may have been attributable to previously coding the same data. Nevertheless NUD.IST was used thereafter with all subsequent data collected and a reduction in time remained noticeable.

It should however be noted, that there was a considerable investment of time in the early days of learning to use the programme. Russell and Gregory (1993) suggest that it can take between 20 and 100 hours to learn how to use a qualitative software programme. On balance, it was felt to be a worthwhile investment both in time and money, particularly since the study was a longitudinal one that created an enormous amount of data.

3.6 Evaluating qualitative research studies

According to Yonge and Stewin (1988, p61) reliability and validity are terms which "refer to accuracy, consistency and equivalence in research that is designed for quantification in the natural sciences." However there is an increasing debate in qualitative research circles regarding the appropriateness or otherwise of using reliability and validity as means to evaluate qualitative studies (Leininger 1985;1992; 1994; Lincoln and Guba 1985; Sandelowski 1986; 1993; Yonge and Stewin 1988; Carr 1994).

It is argued that validity and reliability should be rejected as terms used to evaluate qualitative research studies since the concepts of reliability and validity are derived from positivistic assumptions apropos instrumentalism, reductionism and objectivity (Lincoln and Guba 1985; Yonge and Stewin 1988; Leininger 1992; Beck 1993b; Sarantakos 1993; Leininger 1994; Smith 1996). A clear example of the effect of differing research paradigms and philosophies is that of objectivity and subjectivity.

Quantitative researchers strive for objectivity through standardisation and require the researcher to remain distant and remote from the subjects of the research (Sarantakos 1993). This is in obvious contrast to qualitative researchers who strive for a closeness between themselves and their participant (Stake 1995). Rather than being seen as a problem, qualitative researchers view subjectivity as a strength (Wolcott 1994) and a resource for a theoretically and pragmatically sufficient explanation (Banister et al 1994).

As yet there is no consensus within the community of qualitative researchers as to which criteria should be used (Smith 1996). The literature related to reliability and validity in qualitative research is complicated by researchers using different terms for the same concept (Brink 1991). Amongst the most notable qualitative researchers are Lincoln and Guba (1985), and Leininger (1992, 1994). Leininger (1994) explains her six criteria for evaluating qualitative studies as credibility, confirmability, meaning in context, recurrent patterning, saturation and transferability, whilst Lincoln and Guba (1985) offer the terms credibility, transferability, dependability and confirmability. As can be seen in Table 10, the terms used by Lincoln and Guba (1985) and Leininger (1992, 1994) overlap both in definition and methods of establishing achievement. Methods identified include member validation, outside validation, audit trail and exploration of negative cases.

Table 10 Usage of terms in evaluating qualitative research

TERM	TERM USED BY:	DEFINITION	HOW ACHIEVED
Credibility	(Lincoln and Guba 1985; Leininger 1992; Leininger 1994)	Credibility is said to measure how vivid and faithful the description of a phenomenon is (Beck 1993b). It also refers to the truth, value or believability of findings (Leininger 1994).	Accomplished by taking data and interpretations to the study participants and ascertain whether they believe the findings to be plausible (Guba and Lincoln 1981; Borman, LeCompte et al 1986; Yonge and Stewin 1988; Koch 1994), that is, member checking (Mariano 1995). When other people read report and recognise the experience (Glaser and Strauss 1967; Sandelowski 1986) that is outside validation.
Confirmability	(Lincoln and Guba 1985; Leininger 1992; Leininger 1994)	Confirmability exists when the researcher has demonstrated that the findings are fully grounded in the data (Avis 1995). Confirmability is a criterion for neutrality (Yonge and Stewin 1988; Chalmers 1992).	If the participants and others believe that findings are meaningful to their 'lived experience' then confirmability has been achieved (Yonge and Stewin 1988; Chalmers 1992; Leininger 1994). Also called member or respondent validation. For a study to have confirmability, methods must be described in detail, an audit trail and reflexivity of the researcher should be evident and negative cases should have been explored (Huberman and Myles 1994).
Meaning in context	(Leininger 1992; Leininger 1994)	"...refers to data that have become understandable within holistic contexts or with special referent meanings to the informants or people studied in different or similar environmental contexts" (Leininger 1994, p106).	Achieved through member validation (Leininger 1992; Leininger 1994).
Recurrent patterning	(Leininger 1992; Leininger 1994)	Refers to instances, events or experiences that reoccur over time either in the same or different contexts (Leininger 1994).	Established through member validation (Leininger 1994).
Saturation	(Leininger 1992; Leininger 1994)	Detailed exploration of phenomenon until knowledge gained is comprehensive (Leininger 1994).	The adequacy of the data is assured by saturation of categories (Morse 1991) which is an important aspect of grounded theory methodology (Glaser 1992).
Depend-ability	(Lincoln and Guba 1985)	Included in recurrent patterning (Leininger 1992). Is dependent on credibility (Holloway and Wheeler 1996).	Established through member validation (Leininger 1994).
Transfer-ability	(Lincoln and Guba 1985; Leininger 1992; Leininger 1994)	Transferability refers to how findings can be transferred from a representative sample to another similar context or situation whilst preserving meanings and interpretations from original study (Lincoln and Guba 1985; Leininger 1994; Holloway and Wheeler 1996).	(Henwood and Pidgeon 1993, p27) consider the issue of transferability and grounded theory when they state "in our view, rich and dense grounded theory, which is contextually sensitive at diverse levels of abstraction, will in itself suggest its own sphere of relevance and application"

3.6.1 Member validation

Member validation is at the heart of establishing credibility (Ely 1991) and is advocated by Schatzman and Strauss (1973), Lincoln and Guba (1985), Stern (1985), Patton (1990), Ely (1991), Webb (1993) and Koch (1994). Although strongly advised, member validation is not often performed (Huberman and Myles 1994). Member validation involves participants reading the research findings and indicating whether the findings are true to their experience (Holloway and Wheeler 1996; Clifford 1997). If participants endorse the findings, this validates the researcher's interpretation (Stern 1991; Dickson 1995), increases confidence in the data (Walker 1989; Pidgeon 1996), and verifies the information (Burns and Grove 1993). Stern (1991) asserts that since the ultimate experts are the participants, their judgement should not be over-ruled.

Silverman (1985) and Sandelowski (1993) hesitate in using member validation for fear of influencing participants and thus altering their future behaviour. Huberman and Myles (1994) suggest that member validation is performed after the final analysis because by that time the researcher will know more, will be able to plan member validation more effectively and incorporate findings clearly and systematically. For these reasons, member validation in this study was not performed until after the final interviews. By performing member validation, an ethical obligation to respondents is also met (Fuller and Petch 1995). Disadvantages of member validation are that it is time-consuming and provides difficulties in report writing (Fuller and Petch 1995).

3.6.2 Outside validation

Hinds Scandrett-Hibden et al (1990), Hagemaster (1992), Silverman (1993), Pidgeon (1996), and Pidgeon and Henwood (1996) claim that reliability can be improved by comparing the analysis of some data by other researchers (panel members) with that of the researcher. There is strong opposition to this by Stern (1991) and Sandelowski (1993) who argue that to develop a well-integrated theory, one requires to have substantial knowledge of the data, categories and hypotheses and be immersed in the data. This type of outside validation was not performed in this study.

Burns and Grove (1993) offer a more reasoned argument for validation by outsiders. Rather than using researchers as panel members, validation is accomplished by readers who have had similar experiences to the research participants. Burns and Grove (1993) believe the findings can be intuitively verified in this manner. Following the final interviews in this study, a diary of a HE Diploma in Nursing student was written by the 'researcher' from the findings. Copies of the diary were given to the research participants, and the remainder of the cohort from which the participants were derived. They were also given to another cohort of HE Diploma in Nursing students, who were at the same stage in their course as the study participants, but in another College of Nursing and Midwifery. The results of this procedure are discussed in Chapter VII.

3.6.3 Negative cases

Huberman and Myles (1994) state that to be credible, a qualitative study should have thick descriptions and ring true, that any areas of uncertainty are made explicit and negative cases or rival explanations are considered. Several authors have stressed the importance of searching for and considering negative cases (Patton 1990; Ely 1991; Morse 1991; Mays and Pope 1995). The reasons cited are an attempt to explain why the study findings are at variance to other findings (Mays and Pope 1995), it is intellectually honest and politically strategic (Patton 1990) and to elicit variation, re-examine the findings and expand the developing theory (Ely 1991; Morse 1991).

Despite the emphasis on negative cases, there is no guidance available with regard to how to search for such cases (Glaser and Strauss 1967; Patton 1990). In this study, the 'researcher' explored negative cases as literature was incorporated into the analysis.

3.7 Summary

Grounded theory was adopted as the method of choice in this study as according to Stern (1980) and Hutchison (1986) it is the ideal method to use when little or no information is known about a phenomenon. The longitudinal nature of the study permitted students to be followed over the course of three years. Data collection occurred between October 1993 and September 1996. Ten students volunteered to be interviewed throughout their course and agreed to keep an on-going diary to record their thoughts and experiences during their practice placements regarding supernumerary status and mentorship. The diary acted as an aide-memoire during interview. Students participated in in-depth interviews at the beginning of their course and again on four subsequent occasions. The fifth and final interview took place at the end of the course. In addition, a further seven students volunteered to participate in the study by diary-only. These students kept a diary recounting their experiences and thoughts about supernumerary status and mentorship. On completion of each of their clinical placements, their diary was sent to the 'researcher'. These seven diaries were analysed pre-interview and informed the interview process. As the study progressed, the number of diaries submitted decreased.

Throughout the study, the 'researcher' was conscious of the importance of being reflexive and used memos as a means to achieve this. The 'researcher' also attempted to separate her role as researcher from the role of senior nurse teacher. Ethical principles were adhered to throughout and process consent was obtained.

Coding of data was aided by the use of NUD.IST which is a computer software programme specifically designed for use in grounded theory studies. Data were analysed in accordance with Glaser and Strauss's (1967) constant comparative method until a core category emerged.

In order to illustrate the credibility of the study findings, member and outside validation were used.

PRESENTATION OF FINDINGS

CHAPTER IV

ANTICIPATORY ANXIETY

4.0 Introduction

Rubin and Rubin (1995, p261) state "the goal of writing is to represent the world of your interviewees accurately, vividly and convincingly." The findings from each interview and related diary entries are presented in separate chapters. Chronological integrity is maintained allowing the reader to follow the students' development over time (Wolcott 1990). Quotations from the students are used to demonstrate that theory is grounded from the data (Bowers 1989). Students are identified by their chosen pseudonym to enhance understanding, clarity and credibility (Rubin and Rubin 1995).

4.1 Data Analysis Process

Once the data were analysed, the findings were compared and contrasted with existing literature and other theoretical perspectives. Literature was examined, coded and analysed and woven into the fabric of the existing data analysis (Stern 1980; Stern et al 1982; Cowley 1991; Benton 1996). The literature was used to explain, support and extend the emerging theories (Stern, 1980; Hutchison, 1986; Streubert and Carpenter 1995). Like Seed (1991), the 'researcher' found that theory generation pervaded all aspects of her world. Even when not actively engaged in the research, ideas seemed to occur almost unconsciously resulting in the 'researcher' making theoretical memos (see Chapter II for more details).

The findings are presented using the emerging categories as headings. As Burns (1989, p47) states "it is the categories that provide a picture of the phenomenon ...." "Here you become the storyteller, inviting the reader to see through your eyes what you have seen, then offering your interpretation" (Wolcott 1990, p27-28).

Saturated sub-categories or categories are indicated by using students or all students, whilst sub-categories or categories which were not completely saturated are indicated by the use of most, majority or some. Once initial analysis was completed, the literature was searched to add data to the analysis and to search for negative cases.

4.2 Introduction to the study participants

For reasons of anonymity and confidentiality only the participants' pseudonym, age, whether they had previous experience as an auxiliary, and the method of participation is provided in Table 11.

Table 11 Study Participants

Name	Age	Previous auxiliary experience	Method of participation
Claire	28	✗	Interview & diary
Jayne	30	✓	Interview & diary
Sarah	20	✓	Interview & diary
Mary	33	✗	Interview & diary
Karen	38	✗	Interview & diary
Amy	22	✗	Interview & diary
Laura	23	✗	Interview & diary
Yvonne	43	✓	Interview & diary
Barbara	40	✓	Interview & diary
Elizabeth	18	✗	Interview & diary
Lynne	23	✗	Interview & diary
Fiona	37	✓	Diary only
Louise	30	✗	Diary only
Anthea	25	✗	Diary only
Kirsty	22	✗	Diary only
Susan	23	✗	Diary only

4. 3 Anticipation of first placement experience

In order to avoid 'teething problems', the study did not commence until the course had been established 18 months. The cohort from which participants were derived were the third group to have commenced the course. Although it cannot be known if 'teething problems' were avoided, this would seem to be the case, because during the interviews students often remarked that problems occurring in previous cohorts were not as acute for them.

4.3.1 The first interview

Students were interviewed four to six weeks prior to their first clinical placement (Appendix 4 gives an outline of course programme). Students expressed great pleasure and excitement of getting into the wards after spending six months in College without seeing a patient! It was seen as a momentous event. However, the pleasure was accompanied by ambivalence. Students discussed their hopes and fears of what lay ahead but struggled to determine the cause of their concerns. They were about to embark on one of the most important aspects of the course without knowing what to expect. Bradby (1989, p176) states that, "Perhaps this is the greatest hurdle to undertake, to step into a ward in uniform without much knowledge or experience, to be on the duty rota thereby implying that there are certain expectations of performance, and to be on a stage before an audience of patients, visitors and other staff who are unaware of this fact."

The phenomenon of fear of the unknown has been documented in previous studies involving 'traditionally' trained nurses (Birch 1979; Birch 1983) and Project 2000 students (MacKenzie 1994; Phillips et al 1996a;b). Reider and Riley-Giomariso (1993) call this phenomenon 'diffuse anxiety' stating that it is related to non-specific concerns.

During analysis, numerous codes related to types of fear were identified: fear of being a nuisance; fear of disrupting the routine; fear of forgetting how to do things and looking a fool; fear of doing something wrong; fear of adopting an auxiliary role and fear of what staff would think of them. Collectively these formed the category entitled 'anticipatory fear'.

4.3.2 Anticipatory fear

Students who had prior experience of working in hospitals or nursing homes reacted differently to those who had no prior experience. Students with no prior experience felt at a disadvantage because they did not know what to do in a ward and found it difficult to see the relevance of the theory being taught.

Amy: *"I have never done any nursing before and I am worried that I won't be able to work quick enough or that I will do something wrong."*

Elizabeth: *"At the moment I am not sure what other nurses are going to expect from me because I have never done any placements before. I feel you are going into a situation that you have never been in before and its like being dropped into the middle of the ocean and you are lost."*

In contrast, students who had prior experience expressed both advantages and disadvantages. The advantage was that it reduced some of the fear of the unknown as they had some insight of how things worked on the wards. The disadvantage was a fear of adopting their auxiliary role rather than a student nurse role.

Jayne: *"I think it would be quite easy to forget that you are a student nurse and go back into the role of being an auxiliary because you know how it works and how hard the staff have to work and that the work has to be done and I would go in and do it because I know how its done."*

Previous nursing experience therefore seemed to mitigate effects of the fear of the unknown.

Feelings of fear heightened as time to begin their placement drew nearer. The students' grapevine was such that they heard all sorts of stories about practice staff in general and this served to fuel speculation about what the staff would think of them. Rumours were rife and seemed to dominate the students' life in this first pre-placement period. Rumours were always negative and fuelled fears and misconceptions causing a great deal of concern and anxiety in some students.

Jayne: *"There are a lot of stories going about, and I know you shouldn't listen to them, about how Project 2000 students are being treated." They don't like Project 2000 students anyway."*

Laura: *"There is a rumour going around that the wards don't want us."*

Barbara: *I am feeling quite disheartened actually. Oh my God what are we doing here? If its really going to be as bad as this why are we doing this course ....?"*

Orton et al's (1993) study had two aims: to develop a research-based audit tool for assessing the quality of the learning environment for Project 2000 students and to conduct a small scale replication of Orton's (1981) study. Data collection occurred over two years and students, service and educational personnel (n=700) were interviewed either individually or in groups. A questionnaire derived from the analysis of the interviews was distributed to 800 traditional, HE Diploma in Nursing and degree students, teachers, nurses, midwives, and support workers. The final stage involved testing the audit tool and improvement of the learning environment via action research.

Orton et al (1993, p45) state that in their study "some students appeared to perceive their supernumerary status as conferring a right to refuse to do any task that they did not feel confident or proficient enough to carry out. This apparently reasonable position can be contrasted with the view of a small number of other students who felt that they had the right to refuse any request indiscriminately."

In this study, the reported refusal to participate in care was repeated on a number of occasions and participants generally felt that other students were abusing their supernumerary status. Some students attributed the behaviour of previous students as the cause of the staff's resentment.

Sarah: *"I think a lot of students have taken it (supernumerary status) too far. Fair enough they should be observing but you still have to do it (practical care). Some nurses say no I am just observing, I can't do it. That's just abusing it. They won't learn doing it that way."*

4.4 Stigma

Even before the students had placement experience, they expressed that as Project 2000 students, they felt stigmatised. They had heard stories from previous cohorts of students about the stigma associated with being a 'Project 2000' student.

Louise: *"There has been a stigma attached to the Project 2000. Right away it's 'Oh you are a Project 2000 student'. You are not a student nurse, you are a Project 2000 student."*

Students generally perceived that the staff and other 'traditional' students did not like them and they felt that they were resented.

Elizabeth: *"I have heard a lot about how the old students (1982 programme of training) hate the Project 2000 students. Its just like everybody is down on us and we haven't had the chance to prove ourselves yet. When we were out on a visit to an adult placement one of the old students took us around the ward. She explained to Sister that we were Project 2000 students and that we had come for a look around the hospital. She asked 'is it convenient to let them have a closer look at the ward?'. The Sister turned round to the student nurse and said 'Project 2000 students, it's never a good time for Project 2000 students' and stormed off. Half of the students were literally in tears because if that is what we are going to be met with when we go onto the wards...."*

Stigma is applied to a condition, attribute, trait or behaviour that is deemed culturally unacceptable or inferior (Williams 1987). Stigma is said to be the end result of stereotyping and prejudice and can be harmless to others unless acted upon (Hallawell and Brittle 1995). Essentially whether it is acted upon depends on attitudes.

Hallawell and Brittle (1995) describe an attitude as consisting of three aspects; cognitive, affective, and behavioural. The cognitive aspect relates to stereotypical thinking which generally entails the thoughtless application of labels to people who are perceived to possess negative traits (Field 1993). The affective aspect involves feelings which can be a precursor to prejudice. According to Giddens (1993) prejudice mostly operates through stereotypical thinking. When someone thinks stereotypically and feels prejudice towards someone else and acts upon these, the behavioural part of an attitude, is activated. What that person actually does with their stereotypical thinking and prejudiced feelings is acted out into stigma (Hallawell and Brittle 1995).

The result of stereotyping is not being treated as an individual but rather treated as a set of characteristics regardless of differing personalities and needs (Norton 1993). In other words, those who stereotype, generalise (Leyens et al 1994). According to Luker (1984), the reason why degree students in her study were stigmatised was that trained staff were frightened that the new course would become superior to their own course. "Consequently they wish(ed) to take sanctions against those who seem(ed) to be trying to take away their existing privileges and position"(Luker 1984, p3).

It is argued that the same can be said of HE Diploma in Nursing students in that stigma has been documented elsewhere by a number of authors researching into Project 2000 (Davies et al 1994; Martin 1996; McCormack 1996). It is postulated that staff interpreted the Project 2000 course as a threat (cognitive component) and consequently applied the label of Project 2000 negatively. This was accompanied by the feeling (affective component) of resentment towards Project 2000 students regardless of individual traits. Thoughts and feelings were manifested in the actions (behaviour component) of staff towards these students.

Students in this study were not only on a different course but they had a different uniform to the traditionally trained students and this only served to compound the difference between the two types of students. A uniform is a symbol that embodies a mutual understanding about the way people should associate with one another (Abraham and Shanley 1992). It is also a conspicuous symbol of office (Holloway and Penson 1987; and Jolley 1995).

Initially the students were very excited about donning their uniform but once they realised it was not the same as the 'traditional' uniform they were more guarded. Wearing a different uniform would make them more conspicuous and they were concerned they would be seen as and treated differently not just by staff but also by patients and their relatives. They report that in addition to believing that they would be stigmatised when they began on the wards, students also believed that as Project 2000 students they would be restricted in what they would be allowed to do by the staff. Some students attributed this to trained staff's inexperience with Project 2000. Perhaps this reflects the remnants of 'teething problems'.

Sarah: *"I can see that the old style (traditional students) are getting a lot more leeway in their work than the Project 2000 are." The ward staff are unsure of what they should be doing. The students are not sure what they should be doing and neither are the staff."*

Similar findings have been found in Project 2000 students by Macaskill (1994) and White et al (1993). Other studies have noted problems in respect to what supernumerary status students are allowed to do. Some trained staff report that students should be 'observers only', while students feel they learn by participating in the delivery of care (Leonard and Jowett, 1990; Elkan and Robinson, 1992; Orton et al, 1993; White et al, 1993; 1996; Davies et al 1994; Jowett et al, 1994; May and Domokos 1993; May et al 1995; 1997; Wilson-Barnett et al, 1995). Friend (1991) contends that early cohorts of Project 2000 students had to run a gauntlet of misunderstanding, ignorance, bitterness and prejudice from placement staff.

In summary, the stigma perceived by the students emanated from many sources; resentment of the new course, lack of knowledge of the course and the uncertainty in staff of practice placement expectations. Rumours seemed to fuel students' feelings of being stigmatised and the belief that they were unwanted in the clinical areas.

4.5 Supernumerary Status

When students were interviewed initially they were asked to define supernumerary status. It was considered important to obtain an understanding of what the students' perceptions of supernumerary status were, before they actually experienced it.
Students perceived supernumerary status to mean that they were:

- not part of the ward team;
- not a pair of hands;
- not forced to work certain hours;
- observers on the ward but at the staff's discretion they could be allowed to do selective things but not on a repetitive basis;
- able to observe something two or three times and then when they were happy they could then practice it;
- entitled to voice their concerns if they were uncomfortable about doing something;
- supervised.

In this study, some of students' perceptions of supernumerary status reflect findings from other studies. Students in White et al's (1993) study unanimously refer to 'not being counted in the numbers' while those in Jowett et al's (1992) study mention they would be able to stand back a little and have time to learn.

Some students were sceptical that supernumerary status would actually work.

Elizabeth: *" I know everybody says you are not counted as a pair of hands. I know it gives you the opportunity to turn round and say I am not happy about doing this, I don't want to do it. Even though they say to you, you have supernumerary status you don't have to do anything you don't want to, I think I might be too scared to turn round to my mentor or anybody else and say I can't do this. I don't think it will look good."*

In the pre-placement interview, despite the absence of practice experience, students could readily identify both advantages and disadvantages of being supernumerary.

4.5.1 Advantages and disadvantages of being supernumerary as perceived by students

In terms of advantages, students gained comfort from the thought that it was acceptable to acknowledge ignorance and uncertainty when on the wards. If they did not feel sufficiently confident, they did not need to perform care. They would be seen as students who were there to learn and that this would reduce the pressure of having to remember what they had been taught. They would have the opportunity to observe something from beginning to end and to choose what they would like to learn and practice.

Laura: *"I think you are going to learn a bit more. We are going to be shown stuff where the other (traditional) students were left to get on with it. We will be shown a couple of times and then be asked if we want to do it and I would have the chance to say no I really don't understand. Can you go over it again with me? I think things should be better (than traditional style of training)."*

The same advantages have been also noted by other 'Project 2000' students (Orton et al 1993; Robinson 1993).

The main disadvantage was not being part of the ward team. Again, this reflects findings from previous studies (Jowett et al 1992; Orton et al 1993). Students in this study felt they would be left standing on the sidelines, particularly if their mentor was not on duty with them.

Anne: *"Well just the fact that you are following somebody about all the time and you are not going to be part of a team really. That's the main thing because I have always worked as part of a team and I think you need to feel that you belong don't you?"*

Barbara: *"Well you are not so included as part of the team. You know if you are sort of left standing there, which I have heard of before. If the mentor is not on that day, you aren't working with them that day, not on the same shift, you can be pushed to the side a wee bit and think what do I do now sort of thing."*

Not being part of the ward team was viewed differently depending on whether students had previous experience or not. Students who had previous experience of working with patients, would rather be counted in the ward team and be a pair of hands but learning at the same time while those without prior experience could see a positive side to not being part of the ward team.

Sarah: *"I would rather be a pair of hands but learning at the same time. I am going to find it quite hard going out as I have been an auxiliary before."*

Elizabeth: *"There is not so much pressure on you if you know you are not looked on as part of the staff because I think you will probably be. I think it just means that they might not expect so much of you."*

Another perceived disadvantage was the need to be diplomatic when ensuring that their learning was educationally-led rather than practice driven. Amy describes this well:

Amy: *"...you have to be very diplomatic as well. You can't just go in in the morning and say right I don't want to do that again today. I quite fancy having a wee look at this. You really need to be diplomatic. It could cause rifts if again you have the wrong personality going in. But I mean hopefully it (being supernumerary) should work and its a good way of learning. And your mentor should be able to help you with what you should see. But hopefully that will work and if it does it will be brilliant."*

There was also a concern expressed by some that supernumerary status might allow them to stand back and observe for too long and delay their progress. Generally students wished for a balance between the opportunity to observe and to practice and saw the mentor as playing a leading role in creating this balance.

4.6 Mentorship

Students were asked their views about having a mentor. All viewed having a mentor positively.

Yvonne: *"Well I think it will be good because you are going to have someone you can relate to and have the one person to a certain extent."*

Elizabeth: *"I think it's a really good idea. It's like somebody to go to, somebody in particular that you feel you have a right to go to. I think if you were on the wards and you didn't have a mentor and there was nobody in particular to look after you and if you had a problem you might think there is nobody that you could go to. You know you have your mentor and if you have a problem, then you know that they are there for you to go and say I have a problem."*

It is interesting that Elizabeth used the words 'you have a right to go to'. This seemed indicate that their mentor was there exclusively for them and could be disturbed at any time. The opposite applied to other staff nurses as students believed they would be hesitant in disturbing them.

4.6.1 Role of mentor

Students had very clear views regarding the role of the mentor. Students listed supporter, guide, assessor, and supervisor as components of their mentor's role. Their views mirrored those already documented by Kelly (1978; 1991), May et al (1982), Merriam (1983), Darling (1984; 1985a), Bracken and Davis (1989), Cahill and Kelly (1989), Arnoldussen and White (1990), Prestholdt (1990), Wright (1990), Fields (1991) and Cameron-Jones and O'Hara (1995).

<u>Supporter</u>

According to students their mentor would provide them with support, advice and sort out any problems, anxieties or worries they had. The mentor was seen as an ally and as a friend who would be there for them. Some students saw the support being in terms of being nurtured. It can be argued that this is a rather idealised view.

However, when it is considered that student nurses enter with lay perceptions of nursing (Davis and Olesen 1963; Davis 1975), it is not surprising that they believed this way about their future mentors. In conjunction with the students' anticipatory fear of their first placement, the belief that their mentor would be there to support them and be a friend is understandable.

Karen: *"I would like her to be a mother hen ..."*

Amy: *"To take you under her wing and show you the ropes, show you how to do things. When they are busy someone else will."*

Anne: *"Keeping you right as to the way things are going on the ward and make sure you don't do anything stupid. Keep an eye on you really, watch over you. I wouldn't expect them to be my mother or whatever but somebody to talk to. You would need to know that you could go and speak to her if there was something that you weren't sure about or something you were a wee bit worried about."*

Guide

The mentor was there to guide students in terms of their learning so that students learnt how do things properly. Students believed that mentors would share their views and feelings about nursing and be a role model.

Elizabeth: *"It makes me feel a lot better actually because somebody in particular you can turn to if you have a problem and also while I am trying to find my feet I am glad there is somebody in particular to guide me. I don't think I will feel as bad going up to my mentor and saying 'look I don't know how to do something, can you show me how its done or explain this to me.' I don't think I would feel as easy going up to any of the other staff nurses because I think that they have enough on their plate so I shouldn't be bothering them. Whereas I know that is what my mentor is there for."*

Students believed that feedback on their performance would accompany the guidance they received from their mentor. They believed this would indicate if they were progressing or not.

Elizabeth: *"If you are doing something wrong she (the mentor) will tell you. You need to know. If you are in a situation where you are working with four nurses and all of them realise you have a problem with something and none of them want to take the initiative to tell you then you are never going to know that you have a problem. Equally if you do something right, she (the mentor) is going to say well done which I think is good."*

Assessor

In addition to guiding the student, the mentor was seen to have a role as an assessor. Although assessment was seen as important, at this point in their course, students did not appear to be unduly concerned about it.

Laura: *"I think it's the mentor's job to make sure you do things right. It's quite important that your mentor is there to assess you as well, see how you are doing and how you are coping."*

Supervisor

The anticipation of the supervision part of the mentor's role caused comfort for some students and frustration for others. Those students who had little or no previous experience tended to view supervision positively.

Karen: *"It's not implicit in supernumerary but we do get supervised which is quite a comfort."*

Claire: *"I wouldn't like to think that I was going in there and being let loose so to speak."*

However those students who had prior 'nursing' experience, were more suspicious about the amount of supervision they would receive.

Sarah: *"Project 2000 students are getting supervised on everything they do, where I don't think the old style were getting that. They were just left to do it (nursing care) whereas if you asked a Project 2000 nurse to do it (nursing care) there would always be someone at their back checking them."*

From Sarah's comments, it is obvious that Project 2000 students were not immune from stereotyping their colleagues.

Students saw their mentor as the linch pin of their practice placement and as such would be a very important person in their learning.

Amy: *"I think the mentors must be really really good and be able to have good relationships with people because if you have a first placement that you hate and you could in the future be a really good nurse but that could just break it all so its really really important that they put you in good placements and have really good mentors. You can't click with everybody but mentors should have the ability to put that aside. They don't need to be best friends or anything."*

4.6.2 Desirable qualities of the mentor

Students indicated that mentors would have to possess certain qualities if they were to fulfil their role well. Only one student had entertained the idea that her mentor might be male; the remainder assumed she would be female. Generally, students felt that their mentor should be nice, approachable, be a good communicator, be understanding, allow them to try things, and be respected by other members of the ward team.

At this point, some students returned to expressing their uncertainty about how much they would be allowed to do while on placement. These students saw achieving the balance between observing and doing as in the hands of mentors. Students were concerned that staff who believed that they were incapable of performing tasks would either over-protect them or prevent them from participating as fully as they would like. At the other extreme there was a fear that they would be left to get on with things themselves.

Mary: *"I think it might come to the stage where I feel that I am capable, want to be doing things and yet qualified nurses might take over. As long as I don't feel like a sort of lemon with very little to do then I think it (supernumerary status) could be a disadvantage."*

Students were aware of the potential dangers of becoming too dependent on their mentor. For example, Sarah stated that the

"(Mentor is) somebody you can focus in on but you have to take a bit of everybody. You have to take a lesson from everybody in the ward, you can't just be a puppet of this person and follow them around."

There was also a perception that the role of the mentor might change depending on the type of placement. For instance Claire said

"I need a mentor in (the) adult field because I will need to learn practical skills but when it comes to something like mental health I would think that the role of the mentor will be perhaps very different."

4.6.3 Perceived potential problems with mentor

There was considerable trepidation and apprehension expressed regarding the vital relationship between students and their mentor. Students had an awareness of the frailty of human interaction and the fact that personality clashes could occur.

Claire: *"The relationship you develop between yourself and the mentor is the key to being integrated within the team. The better the relationship the better the development."*

Anne: *"The only thing that would worry me would be if I got a mentor that I didn't get on with. It's awfully important to me to feel that you can go and speak to somebody if you are feeling a wee bit down or you were feeling you weren't picking up the way you should. I think its awfully important to get on with your mentor. If you don't get on with someone, it must be terrible."*

When considering the consequences of not getting on with their mentor, most students said it would be difficult to complain. Some students would live with the situation, whilst others would say something to either the ward or college staff at the end of the placement. All students were concerned about causing repercussions if they complained.

Amy: *"I would definitely say something if I didn't believe my mentor was good for the next people coming in but I would probably try and struggle on otherwise there could be bitchiness or people saying she said so and so. It just wouldn't be worth it because it would be difficult enough to cope on the ward without having bad feelings."*

During the CFP, students worked 30 hours per week in the practice placements. They were informed that they should negotiate their hours from an educational basis which meant that they should be on duty when they were able to meet their learning outcomes. In terms of negotiation, the feeling of not wanting to 'rock the boat' was expressed, as well the desire to work on as many as the same shifts as their mentor.

Mary: *"I am hoping to work as much as I can, especially the first placement, with my mentor. Whatever hours she works I will just work and hopefully that will be ok with her/him and with the charge nurse. I would feel safer and happier if I could just work alongside my mentor as much as I can. You know that somebody's there all the time."*

A few weeks prior to her first placement commencing, Louise had visited the ward to ask about her hours of work. As can be seen she was given the opportunity to negotiate her working hours but declined to do so.

Louise: *"The Sister did say 'Did I have any preferences?' I said 'No I wasn't fussy' because I didn't want to say oh I want to work this way and pick and choose. I said 'No I wasn't fussy - whatever you think is going to be of the most benefit for my learning - so whatever you think".*

The consensus expressed by students was they would like to work alongside their mentor on early shifts, starting in time for the ward report and leaving earlier in the afternoon.

Barbara: *"I would like to work the same shift or sort of time as my mentor. I would be happier to come in early in the morning and get the report with her rather than coming in later on in the day because I wouldn't like that."*

4.7 Summary

In the pre-placement interview, students experienced anticipatory fear associated with their first practice placement. The fear was compounded by the feeling of the stigma attached to being a Project 2000 student. The spread of negative rumours served to heighten the fear felt by the students. However, students had invested faith in their future mentors to support and to help them learn. The mentor was viewed as someone who would support, guide, assess and supervise students and for many, this was a great comfort. Supernumerary status was seen both as an advantage as well as a disadvantage by some students, particularly those who had had previous hospital experience. In addition to enhancing their learning, students perceived that supernumerary status might inhibit their development if they consistently chose to observe rather than participate in the delivery of care. While students were desperate to start their placement, they felt quite anxious about what lay ahead. However it seemed that their enthusiasm for getting out of College for the first time in six months would carry them through!

CHAPTER V

REALITY HITS HOME

5.0 Introduction

The second round of interviews occurred after the students had had four, five week placements in adult, mental handicap, mental health and paediatric areas. The sequence of placements was not the same for all students. Diary-only participants sent in their diaries at the end each placement. Large amounts of data were derived from the interviews and diaries. To preserve the chronological nature of the data, data derived from interviews and diaries from the first two placements (term 3) were separated from data derived from interviews and diaries from the third and fourth placements (term 5).

Data from term three were coded into 57 codes. These were compared and contrasted and initially were condensed into 15 sub-categories. Further analysis, allowed these categories to be further reduced into 6 sub-categories: having supernumerary status; stigma; having a mentor; transition from placement to placement; task versus holistic care; and change-in- self over time.

Data from term five interviews and diaries were coded into 47 codes. These were compared and contrasted and initially were condensed into 15 sub-categories. Further analysis, including comparison with data from term three, allowed these categories to be further reduced into the same 6 sub-categories as derived from term three placements. These were further condensed into one category; 'reality hits home,' as this was considered to encompass the students' feelings and experiences during their first four placements in the CFP.

Saturated sub-categories or categories are indicated by using students or all students, whilst sub-categories or categories which were not completely saturated are indicated by the use of most, majority or some. Once initial analysis was completed, the literature was searched to add data to the analysis and to search for negative cases.

5.1 Having supernumerary status

There was a marked contrast in the students' perceptions of supernumerary status and how they felt in reality. Most students agreed that supernumerary status did not really exist on their clinical placements. This reflects findings from other studies (White et al 1993; 1996; May et al 1995; Ramprogus 1995). The extent to which students were supernumerary depended upon four factors: the mentor, the staff's knowledge of the course, the staff's confidence in Project 2000 students and how busy the staff were. As reported in other studies (Smithers and Bircumshaw 1988; Clifford 1989; Wilson 1989; Leonard and Jowett 1990; Robinson 1992; May and Domokos 1993; O'Neill et al 1993; Orton et al 1993; White et al 1993; 1996; Jowett et al 1994; May et al 1995; Wilson-Barnett et al 1995), there was ambiguity in how supernumerary status was defined. Some staff opted to allow students to observe only, while others seemed to disregard it and expected students to participate in care as previous 'traditional' students had done. A clear definition prior to the introduction of the course would have helped in this respect.

Students continued to believe that supernumerary status was a source of perplexity and resentment for the staff as Laura writes in her diary:

Laura's diary: *"The staff nurses seem to forget that I want to be a nurse and that I did not choose to do the diploma course instead of the '82 style of training. They appear to blame us for being supernumerary."*

Students who were observers only, felt pampered, frustrated, angry and concerned about achieving their learning outcomes. Those who were expected to participate, often felt they were given too much responsibility.

Anthea's diary: *"Personally, I don't think the idea of being supernumerary worked. I think you were either very supernumerary or you weren't supernumerary. It was very difficult when supernumerary status was taken at face value and you were just to watch everything - it came from a misunderstanding of it. I think they (the staff) thought that you were solely there to watch. I was never really counted in the numbers... I think its really difficult because I am not sure how I would have coped if I had been thrown in at the deep end but I found sometimes they took supernumerary status at face value and that wasn't ideal either. I think it's very difficult. I can see why they tried to strike a happy medium but I don't think they managed it."*

Some students reported having good experiences of being supernumerary as Elizabeth states:

"I was never once left in a situation that I felt 'oh no.' I always felt that I could say I don't feel right in this. I never thought I was just another pair of hands. I never felt like that. I thought it was good."

All students believed that they learnt more by participating in care so they resisted being an observer-only. Approximately two weeks into a placement, students were usually given their own patients to look after. This coincided with the students' ability to have learnt the ward routine and to function independently in some basic nursing tasks such as bathing and feeding. Students were quick to realise the value of getting to know the ward routine as quickly as possible. Menzies (1960) argues that routines serve the purpose of reducing anxiety as they increase the distance between the nurse and the patient. Routines are said to be useful in areas where there is high turnover of staff as they allow newcomers to 'learn the ropes' very quickly with the minimum of input from the permanent staff (Davies 1976; Melia 1981; Fretwell 1982; Procter 1989; Seed 1991).

During data analysis in this study, the issue of routine was explored further by searching the literature. Melia (1981) conducted 'conversational style' interviews with a purposive sample of students at three different stages of their three year training. Data from the interviews were analysed using a combination of Schatzman and Strauss (1973) work and the constant comparative method of Glaser and Strauss (1967). Amongst other findings, Melia identified external and internal routines. External routines are imposed upon the ward by the 'wider hospital context'; for example meal times and visiting hours. Melia (1987) contends that once learnt, the student merely applies this to any ward situation.

Internal routines, according to Melia, are specific and controlled by each ward; for example, when patients should be bathed, when ward reports are given, and when coffee breaks are taken, etc.

Fretwell (1982) used ten wards in two districts in England to develop ward sisters' and charge nurses' teaching role and to their ability to create a good learning environment. An unknown number of questionnaires designed to rate the learning environment were distributed to students and trained staff. Although omitting specific details, Fretwell reports a good response rate with students (n=138) and trained staff (n=182) returning completed questionnaires. Each of the ten wards received a short report based on questionnaire data, two days of observation and informal interviews. Since Fretwell was using action research, she left the ward sister and her staff to decide upon change objectives and the action to be implemented to meet them. In this way, the staff had ownership of the intended change and its implementation. Questionnaires to evaluate the effect of the implemented changes were then completed by trained staff six months later, and by students at six and twelve months. Response rates again were reported as good, although Fretwell omits specific detail, with students (n=124) and trained staff (n=171).

Fretwell offered a different perspective of routines from Melia (1981). According to Fretwell temporal routines tell students when to do the tasks and motor routines tell them how to do them. She describes routine as the automatic performance of physical care that has no part to play in the learners' education.

Procter (1989) anticipated that the prevalence of ward routines would be reduced when students became supernumerary. However, Hale (1991), Rafferty (1992) and Hislop et al (1996) are less optimistic and believe that due to staffing problems, ward routines will persist and that they will discourage the learning of individualistic care. In this study, students felt it was their place to 'fit in' with the ward routine and once learnt. they commonly 'just got on with it' independently. This feeling of 'fitting in' is reported by Melia (1981).

Seed (1991) conducted a study using a grounded theory approach that was informed by the phenomenological perspective described by Schutz. It was a well conducted, longitudinal study of the emergent views of a cohort of student nurses during their three year training for general registration. Seed had a purposive sample of 23 student nurses and used participant observation and unstructured interviews as data collection techniques. Students were interviewed at the beginning and again at the end of their course. Seed performed approximately 1000 hours of participant observation during the three years. Every student, had on average, a four hour visit in each of their placements, excluding community. Seed reports that in addition to learning the routine, traditional students feel they must discover what Sister likes in order to 'fit in'. This is supported by Melia (1981).

By 'fitting in' the student is more likely to receive a good assessment (Melia 1984; Leonard and Jowett 1990; Clark et al 1996b), feel more emotionally supported which reduces anxiety (Revans 1964 cited by Orton 1981) and be better prepared for their working role (Leonard and Jowett 1990). Clark et al (1996b) believe that like their previous counterparts, Project 2000 students fit in to survive.

Elizabeth's diary: *"I am a lot happier with this mentor than the last placement. She asks me if there is anything I want to know or see and is always around to answer questions that I may have. The other nurses on the ward are also very good, they are all prepared to teach me and treat me as one of the team. I feel that I have fitted into this ward better and I know what is to be done and prepared to get on with it."*

Students in the present study also wanted to know what was expected from them. However the emphasis was more on their mentor's expectations rather than the ward sister's. It is argued that the difference was due to the emphasis students place upon their mentor as the linchpin of their placement.

5.2 Mucking in

'Learning the routine', 'fitting in' and 'mucking in' all dove-tailed into one another. The reality of the workplace quickly impinged on all students. All students felt an obligation to 'muck in' especially when the ward was short-staffed and patients were in need of care. There was a distinct obligation felt towards the patient's welfare to the extent that students would willingly give up their supernumerary status and the opportunity to see or practice other things. Mary explains this well:

Mary: "*...and it was really really busy on the ward and the physio was going to take me away to do things but when she came I was in doing baths. And maybe Anna (mentor) would say well you look after a couple of ladies but I was having to do their baths and doing everything for them and the physio was saying can you not come away with me just now while I show you this. I just knew it was impossible because I am looking after these ladies' welfare and so it wasn't completely supernumerary because you didn't want to leave them with somebody else coming into the bath or whatever.*"

Being able to do even the simplest of tasks made students feel more like a nurse. Students explained that because they 'mucked in' it facilitated activities that otherwise the patients would not have had. This was particularly evident in their mental handicap placement. When asked if there was a pressure on them to 'muck in', students invariably replied that they would feel guilty if they did not do so.

Karen: "*Well I think I don't feel what you would call pressure. I feel that is probably one of the duties that is placed upon you... it's an obligation really to try and fit in with what's going on in the ward. I wouldn't call it a pressure. In fact I would say it's something I would expect to do. A brief placement, I would think you are going in there to try and learn what you can. You are not going in there to stir it up.*"

According to May and Domokos (1993, p21) "the students' natural inclination seems to be to help where possible, both as a means of easing their presence in the organisation concerned and in response to their own strong motivation to become professional carers." This was reinforced by students in this study. When they saw that there was no one else to attend to the patients, they 'mucked in' and give up any thoughts of going off to observe or practice something else.

Leonard and Jowett (1990) conclude the reality of the work environment is such that supernumerary status is voluntarily rescinded in favour of getting the work done. Students in Parahoo's (1992c) study reported that their consciences dictated they assume a 'token form of supernumerary status' to resolve the conflict between giving service and pursuing achievement of their learning outcomes. (Details of Leonard and Jowett 1990 and Parahoo 1992 a;b studies were discussed in Chapter II.).

Students developed their own way of managing the conflict between learning and 'mucking-in.' They were prepared to work hard on the ward as long as they could exert their right to be supernumerary when learning opportunities arose.

Mary: *"The thing is having the ability to say that you are supernumerary so you can see something else that is going on that you want to see, like I haven't seen that done or whatever, you can actually use it then to say, right I am going to see that."*

All students believed the opportunity to go and watch new activities, visit other departments and follow patients through their investigations and treatment was advantageous to their learning. Feelings of resentment arose when, despite the students working as a pair of hands, they were denied their prerogative to exert their right to supernumerary status. It was almost as though students viewed their right to supernumerary status as a reward for all their hard work.

Anthea's diary: *"Felt as if I was an auxiliary nurse today. Claire, a different staff nurse was in charge. I don't mind running errands but I really didn't get to learn anything by going to and from pharmacy and if she'd taken the time to show me a few things I'd probably have been less put out."*

Lynne's diary: *"...I had to do the breakfasts all by myself, dish them out, feed the one resident who can't feed himself and supervise the rest!! I am now at the stage where I am just doing whatever is asked for a quiet life and hoping that the last two weeks go quickly. Today the Charge Nurse angrily told me I had not shaved one of the residents properly 'He looks a total mess!' she said. After doing the breakfasts again, bathing, dressing and changing incontinence pads for six men completely on my own I didn't know whether to react angrily or to cry! Instead, I just got the resident concerned and shaved him again and did not reply (which was probably the best thing to do!). I really do like it there but that is normally when I am talking to the residents. Put me near the staff or in the bathroom on my own and then I feel uncomfortable."*

Fiona's diary: *"My opinion on both my placements is that being supernumerary does not really work. I found quite a lot of resentment against P 2000 students because of this. Depending on the type of individual you are makes a difference too. I do not like to stand around doing nothing and was quite happy mucking in. The staffing levels do not seem adequate to cope with supernumerary status."*

Parahoo (1992b, p37) states that "the extent to which each student feels used also affects morale and how he or she learns." This was certainly the case in this study. Often students voiced concerns that they were seen only as pairs of hands to do menial tasks which would otherwise be performed by auxiliaries. However, by 'mucking-in' they could see that they made a difference; both to staff and patients. They soon came to realise that their learning was secondary to the needs of the patients.

Although most trained staff were in agreement with supernumerary status and mentorship, May and Domokos (1993) and May et al (1995) state that trained staff are sceptical about achieving the necessary staffing levels required. English studies of Project 2000 cohorts note that there are widespread complaints about insufficient numbers of trained staff to supervise students (Jowett et al 1991; Elkan and Robinson 1992). The Northern Ireland study by O'Neill et al (1993) concurs with these findings. Staff-shortages are therefore a UK wide problem.

There was a connection between 'mucking in' and their assessment. Students were concerned that if they did not 'pull their weight,' they would receive a poor assessment which had implications for achievement of learning outcomes and progression in the course. Students quickly realised the need to maximise any free time the staff had.

Laura: *"I think if you want to get on and you want to get a good ward assessment you have just got to do it (muck in). I don't mind it. To me that's what it is all about, is the practical hands on but you could do with a bit more supervision from the qualified staff."*

5.3 Part of the team

There was also a link between 'mucking-in' and feeling part of the team. Farley (1992) suggests that not only is there a desire to fit into the team but there is also an organisational need for students to do so. Omerod and Murphy (1994) note supernumerary students wish to become part of the team as quickly as possible. Being part of the team is prized because students feel useful and it increases their enjoyment of the placement (Mackay 1989; Bradby and Soothill 1993; Davies et al 1994; Phillips et al 1996a;b). Feeling useful is linked to an obligation to give something back (White et al 1993) and a wish to contribute to patient care (Jowett et al 1994; Hamill 1995). Being part of the team was very important to the students in this study because it meant feeling accepted.

Yvonne: *"You don't want to be different. That is the thing, you don't want to be different. You are standing in a different uniform and you don't want to be different. You want to be the same and be included. I would try and find out what the ward routine was, what they did and when they did it so that you knew what was going on and what have you. If you could find out the ward routine it did help."*

A placement being described as good invariably coincided with the student reporting that they were part of the team. On average, it took students two weeks to feel a team member. Some students remarked that it was only when their mentor was on duty that they felt like a member of the team. This finding is reflected in White et al's (1993) study.

Not being part of the team caused students to feel excluded (Mackay 1989). According to Melia (1987) the transient nature of the students' placements usually precludes them from being treated as part of the team. Students in this study cited a number of aspects that led them to feel they were not part of the team. They were restricted in what they were allowed to do; were not included in the distribution of the work; and were excluded from information.

Other aspects reported related more specifically to how they felt themselves. They felt ignored and believed that staff lacked interest in their development and learning. Staff broke promises to them and because they did not 'fit in', no-one had time for them. This all seemed to be reinforced by the attitudes of staff, particularly the auxiliaries. This in turn affected the quality of their learning. Often because the staff were not bothered about them, the students became demoralised and lost interest in learning. All they could focus on was 'getting through' the placement with minimum trouble.

Summary

Students had varied experiences of being supernumerary depending on their placement. However students felt optimistically that things would improve over time. Table 12 compares the advantages of supernumerary status both as perceived by (pre-placement interview) and as experienced by the students, along with findings from other studies.

Table 12 Advantages of supernumerary status as stated in the literature compared with first and second interviews in this study (i.e. perceived and actual advantages)

Advantages of supernumerary status cited in other studies	Perceived advantages cited by students	Actual advantages cited by students
Observe procedures on and off ward (Elkan and Robinson, 1991; Jowett et al 1992; Orton et al 1993)	✓	✓
Able to fulfil set aims and objectives (Elkan and Robinson 1991)		
Not used as pairs of hands (Elkan and Robinson 1991)	✓	
Able to question accepted practices (Elkan and Robinson 1991;1993c)		
More time to learn (Elkan and Robinson 1991;1993c; Clark et al, 1996b)	✓	
Arrange off duty to maximise learning opportunities (Elkan and Robinson 1991)		✓
Only given responsibility related to level of experience (Elkan and Robinson 1991)	✓	
Better supervision (Robinson 1993)	✓	
Nurtures confidence in practice (time to get it right) (Clark et al 1996b)	✓	
Facilitates patient contact/relationship (Clark et al 1996b)		

As can be seen in Table 12, students in this study did not identify three advantages cited in the literature: an ability to fulfil set aims and objectives; an ability to question accepted practices; and facilitating patient contact/relationship. Each approved placement area had a teaching and learning plan for each level of student with appropriate aims and learning outcomes. Students may therefore have attributed fulfilment of these to the success or otherwise of the teaching and learning plan as opposed to their supernumerary status.

Students in this study, cited questioning of practices as an advantage, but in terms of aiding their understanding rather than questioning the rationale or research-base of the practice. Some students suggested that they were not ready to question practices at this stage of their training.

Laura: *"It's difficult for you as a student for you to say this is not how we should be doing it, this is the way we should be doing it. You sort of sit back and say 'oh God, here we go. 'Do I say something? do I not?.... You don't want to get yourself a bad name or be thought of as a trouble maker by saying I know this better than you sort of thing. It can be difficult."*

No mention was made by the students regarding supernumerary status facilitating patient contact, although students did welcome the opportunity to be with patients.

Table 13 compares the disadvantages of supernumerary status both as perceived and actually experienced by the students, along with findings from other studies.

Table 13 Disadvantages of supernumerary status as stated in the literature compared with first and second interviews in this study (i.e. perceived and actual advantages)

Disadvantages of supernumerary status cited in other studies	Perceived dis-advantages cited by students	Actual dis-advantages cited by students
Not included in team (Elkan and Robinson 1991; Jowett et al 1992; Orton et al 1993; White et al 1993; Clark et al 1996b)	✓	✓
Misused due to misunderstanding (Elkan and Robinson 1991; May and Domokos 1993; Clark et al 1996b et al)		✓
Discriminated against (Elkan and Robinson 1991; Jowett et al 1992; Orton et al 1993)	✓	✓
Resented by ward staff and traditional students (Elkan and Robinson 1991; Jowett et al 1992; Robinson, 1993)	✓	✓ **(but only by ward staff)**
Seen as an elitist group (Elkan and Robinson 1991)		
Seen as different as worked different hours (Elkan and Robinson 1991; Jowett et al 1992; Orton et al 1993)		✓
Fight to gain acceptance (Elkan and Robinson 1991)		✓
Undervalued (Elkan and Robinson 1991)		✓
Inhibits practical skill acquisition (Clark et al 1996b)	✓	
Service demands take precedence over learning (Clark et al 1996b)		✓

As can be seen in Table 13, students in this study did not identify with being seen as an elitist group. Although not explicitly stated by the students, it could be implied from their feelings of being stigmatised that they were seen as different and perhaps elitist.

5.4 Stigma

As mentioned in Chapter IV, students felt stigmatised even before their first placement. When faced with the reality of the work situation, stigma remained a feature for most of the students. Ogier (1989), Orr (1990) and Davies et al (1994) argue that stigma is the result of a failure to meet the needs of staff who are facing changes in their role.

Ryan (1989) considers that 'Project 2000' has been constructed back to front because of this very situation. He asserts that students are having to educate staff in the practice setting about their course because staff were not prepared properly before its commencement.

Some students in this study told of being introduced to patients as a Project 2000 student who does not become involved like the other students. They also expressed hurt when ignored by some ward sisters for the entire placement.

Jayne: *"I don't think she (ward sister) liked Project 2000 students whatsoever because she was OK to the other students who were there on the old course. She made conversation with them. One girl came in from the old course and she said 'oh hello I am Sister' you know and 'What's your name?' I thought I've been here two weeks and you have never introduced yourself to me, never once."*

This feeling of being labelled as a Project 2000 student was not confined to working on the ward. They noticed that Project 2000 was written beside their name on the off duty unlike the other students. Macaskill (1994) describes 'Project 2000' students in her study expressing negative emotions because they appeared noticeably different from others within the ward setting. Jayne explains what happened when she was admitted hospital for treatment: *"They had my occupation as student nurse but they had written Project 2000 on my notes. I said that isn't allowed because that's you stigmatising me."*

Elizabeth: *"I feel that the staff nurses have got into their head that Project 2000 nurses are all stupid. You are going in there and know nothing. Maybe we don't know as much as the old course students, it's only, I would say it's quite reasonable because we don't have as much ward experience so we don't know as much but I think sometimes they get a surprise. You are not as hopeless as they all expect. If they go expecting you to be hopeless you kind of get them patronising you by saying can you manage that (incredulous tone)."*

Over time, students realised that the 'older' trained nurses and auxiliaries had the most difficulty with their course. Students noted that often the remarks were made in general and not specifically directed at them. As Green (1990, p15) points out "getting to know a person as an individual is the best way to learn that a stereotype does not fit."

Students generally replied to jibes about being Project 2000 by stating that they had not specifically chosen the diploma course; it was all that was available. However, this did not seem to remove the feeling that the staff blamed them for being supernumerary. Students had anticipated that they would have difficulty with the 'traditional' style of training students. Jowett et al (1992) mention that this fear is often fuelled by unhelpful encounters. In fact, the opposite was true in this study. Traditional students actually supported and taught them. Perhaps because unlike Jowett et al (1992) who looked at the first cohort of students, nearly two years had passed before these particular Project 2000 students began their placements.

Elizabeth: *"I was really worried about it because there are always rumours about - they are RGN students and we are Project 2000 students and don't talk to them. But when I went on to that ward, the old course students were absolutely brilliant. They were really good. I don't know what I expected them to do but they were just magic."*

Amy's diary: *"I was so thankful for the other students as I really don't think I would have got through the five weeks without their help and support. They were always around to help me - the staff nurses were not."*

5.5 HAVING A MENTOR

5.5.1 Introduction

Having a mentor remained an important issue with students in the study. They all continued to see 'having a mentor' as crucial to their learning.

5.5.2 Need for mentorship

In Orton et al's (1993) study, both education and service managers agree that there is a definite need for mentorship although they were reticent in how it could be achieved in reality. Orton et al note that if students have problems or require guidance they normally go to their named mentor in the first instance. From the students' perspective, in this study, the need for mentorship seemed to equate with the time it took to become used to the ward routine. Once the students were confident about what was expected of them and that they knew the routine, their dependency on their mentor was reduced. They would seek out help and guidance as it was needed.

After four placements, students maintained their positive view of having a mentor. Oliver and Endersby (1994) declare it is vital, particularly in the early stages of their learning, that students are provided with safe experiences to ensure that learning is a positive experience. In another study, mentors are valued principally for providing a 'safety net' for students (Jowett, et al 1992).

In this study, students viewed their mentor as someone who was specifically for them. Students gained comfort and security from feeling they had the right to interrupt this person at any time should they required help or guidance. The corollary was they felt inhibited in approaching or interrupting any of the other staff nurses for help or guidance, particularly if their mentor was not on duty.

5.6 Reality dawns

In their pre-placement interviews, students had had the impression that their mentor would be the linchpin of their learning on the wards. Students felt that their mentor would be the centre of their world, and that they would in turn be important to their mentor. Students very quickly realised that their mentor had competing priorities.

Karen: *"I think as a student you are very aware of how your mentors are pulled and pushed in so many directions and it is difficult in certain areas to actually sit down in a way and get the time to spend together. Perhaps you are a tenth of your mentor's duties and it's been good for us to put that into context. I think that's what actually happens when you are out there. On your first placement you believe you are the most important thing apart from the patients on the ward for your mentor but you certainly soon realise, perhaps within the space of perhaps an hour (both laugh) that you are one of the many pressing priorities."*

Students rapidly learnt to take advantage of learning opportunities as they arose and were appreciative of the perceived effort made by their mentor to achieve some quality time for their learning. Having one to one sessions with their mentor was important as they could observe and participate in safety and be sure that what they were doing was correct.

5.7 Role of the mentor

Students had a very clear idea of what the role of the mentor should be. There were parallels with what they felt in their pre-placement interviews. (Summaries can be found on pages 182-183). Students retained similar views in relation to the roles of supporter and guide but now added the role of teacher to their list. Their view of supervision changed from their pre-placement interviews.

5.7.1 Teaching role of mentor

Students knew what they wanted from their mentor in terms of teaching and guidance. The most important aspect was that their mentor would be genuinely interested in them and want to help them learn. These views have been expressed by 'traditional' students (Vance 1982; Earnshaw 1995; Cahill 1996; Spouse 1996) and by 'Project 2000' students (Baillie 1993; White et al 1993; Phillips et al 1996a;b).

Laura: *"I think mentors also have to want to help you. Its all very well if they are approachable but if they don't want to help you or teach you anything well they aren't much use."*

Students wanted their mentor to take time to explain things. The amount of time was not so important as long as there was specific time was set aside exclusively for them. Students appreciated their mentor organising and arranging for them to see different procedures and visit different places. Some mentors made up programmes for students so that their learning would continue while they were away on holiday.

Students expected their mentor to be knowledgeable and skilled in their field of nursing. The aspect of being knowledgeable was linked to how they perceived their mentor as a practising nurse.

Karen: *"I quite admired the way he handled his job and himself and the relationships he had with patients. He was really good, he was excellent and really professional and he always had an explanation for everything that I asked him, rationales for everything that was done. He would discuss the bits of the system that didn't work very well as well as what was good."*

Students defended their mentor in light of any criticism, as long as their mentor was interested in their progress.

Karen: *"I think as a student you are very aware of how your mentors are pulled and pushed in so many directions and it is difficult in certain areas to actually sit down in a way and get some time to spend."*

A valuable part of teaching and guidance involved feedback on their performance. Students commented on how useful it was to be told how well they were doing but they complained that it could be difficult to get their mentor to give them constructive criticism. Feedback is seen as one of the key roles of the mentor by students in Philip et al's (1996) study. Little or no feedback is said to delay the development of self-confidence (Mackay 1989; Watts 1989; Cahill 1996). Inadequate feedback is attributed to staff being unwilling to praise individuals (Mackay 1989) or that they are attempting to protect the student's feelings (Lewis 1986). In Orton et al's (1993) study, 53% of Project 2000 students (n=117) and 73% of traditional students (n=99) agree that they do not receive sufficient feedback from trained staff. Project 2000 students in Jowett et al's (1994) study also complain about the lack of feedback.

Karen: *"Some were more willing to talk to you about your progress than others. Sometimes I got the impression it was very difficult to pin somebody down and say 'Look where are my weaknesses? What do I need to improve on?' They were quite happy to talk to you about your strengths but when it came to your weaknesses -- sometimes that was difficult."*

5.7.2 Supervision role of mentor

Students changed in their expectations of supervision after their placement experiences. They wanted their mentors to supervise them more at the beginning of a placement and then allow them to function more independently as they learnt more and more. This is summed up by Amy who responded to the question 'What do you want from your mentor?'

"Just guidance if I was unsure of something. I could ask, no matter how many times that I ask. Letting you get on with it and giving me the enthusiasm and do things by yourself without having to check. For them to really let you use your own initiative."

Students preferred to work alongside their mentor at times and on other occasions they liked to work with other staff. In this way they saw and learnt different approaches to care. This finding contrasts with Orton et al (1993) where students feel that working on the same shift as their mentor on a regular basis is important. However, White et al (1993) and MacKenzie (1994) note that students in their study felt similarly to those students in this study.

5.8 What makes a good mentor?

Students agreed that having a mentor was a good idea but that having a good mentor was just the luck of the draw

Anne "*...I think it's much more luck than anything else. You can get somebody who has had four excellent placements and they got on brilliantly and you can get somebody else that got four rotten placements.*"

Not surprisingly, having had placement experience, students' views and descriptions about what made a good mentor were more detailed than in pre-placement interviews. All students had experienced what they felt was a good mentor in at least one of their placements and valued a good mentor in line with other studies (White et al 1993; Phillips et al 1996 a;b). Good mentors were perceived as staff nurses who felt genuine concern for students as individuals and wanted to be a mentor. The latter is noted by Davies et al (1994), Neary et al (1996), Phillips et al (1996a;b). The concern for students as individuals was reinforced by their mentor being their ally and advocate. A common example was when the student wanted to take advantage of a learning opportunity when the ward was busy a good mentor would defend the student's right to exert their supernumerary status.

Mary: " *...she would back me up and say 'Oh Mary's not seen that, or she thinks she should go and see this and I think she should too'.... A couple of times I think it did happen that we were very busy on the ward and I had a visit to Art Therapy and it was obviously all hands on deck that morning and we were all busy. I said to my mentor 'Look do you want me to stay?' and she said 'No no.' It was made clear to everybody, I was supposed to be supernumerary so I should go to Art Therapy.*"

Students believed that good mentors possessed good teaching ability and would pace their teaching to match student need. From their descriptions, an obvious continuum emerged with students being moved along the continuum from observation to participation. Good mentors incorporated feedback when teaching students and were considered to be good role models.

Sarah: *"He just spent so much time with me. I was so inquisitive about what was wrong with some of the residents, as they were called, but he just spent so much time going through it. He had a very pleasant manner, he was very funny, very open. I just took to him right away you know, he was great. Especially him because he made you feel what you said was valued. If you had anything to say he would say go write it in the care plan. You didn't have to ask to write things down or have to ask was this important enough to be documented. He was just so confident in me. I was not supervised at all, well virtually."*

Amy: *"...she was very much a perfectionist and a real role model you know. How could I ever be like that?"*

Related to teaching ability, was the willingness to spend time with students, involving students in ward activities, developing enough confidence and trust in students to allow them to use their initiative and gradually withdrawing direct supervision of students. Trust is seen to emanate from the mentor befriending the student (White et al 1993; Spouse 1996).

Mary: *"She really knew her stuff - particularly supernumerary status. She knew what was expected of me and that it was my first placement and she knew what I could and couldn't do. At the beginning she did supervise a lot of the things I was doing but by the end she did give me things to do by myself. I think it was great."*

Good mentors had realistic expectations about the student because they understood the course. Without knowing what stage students were in their course, how could their mentor guide and teach them appropriately? The importance of their mentor being knowledgeable about the course is echoed in other studies involving Project 2000 students (May and Domokos 1993; Orton et al 1993; White et al 1993; Davies et al 1994; Watson and Kiger 1994; Jowett 1995; Neary et al 1996; Phillips et al 1996a;b).

Since students mentioned the gender of their mentor in the pre-placement interviews, this was pursued in the second interviews. Students were asked whether there was a difference between being mentored by a male as opposed to a female. The majority of students believed there were no gender differences but what mattered most was whether mentors were approachable or not. This finding reinforces Segerman-Peck's (1991) belief that the gender of the mentor is irrelevant. It is the manner by which the role is executed that is the key to successful mentoring. Given a choice, a minority of students stated that they preferred to have male mentors as they felt they were less inclined to gossip, and they were able to form better relationships.

Darling (1985a; 1989) believes that mentor-bonding is related to how well an individual bonded with adult figures in early life. According to Darling these early bonding experiences influence gender, type and personal characteristics of mentors in life. This is an area that requires further research before any conclusions can be drawn. The quality of the relationship students, in this study, had with their mentor often related to how quickly both parties met and 'bonded.' When there was a delay in meeting their mentor, students often felt uncared for and insecure.

Karen: *"I think my mentor was away for most of the first week that I was there so I never got to meet her until later on. That's the one thing that struck me - she never introduced herself as my mentor. I had to make the initial introduction - 'I believe you are my mentor, I am Karen.' Even then once we had met she never once said she was my mentor. I had to say you are my mentor - I thought that was quite strange. I must admit that of all the mentors I had she was the one I had hardest work to perhaps establish a rapport but we got there."*

Students described good mentors as approachable, confident in their own ability, good communicators, professional, organised, enthusiastic, friendly, possessed a sense of humour, caring, patient and understanding. All these characteristics have been highlighted in previous studies (Orton et al 1993; Davies et al 1994; MacKenzie 1994; Cahill 1996; Neary et al 1996; Phillips et al 1996a;b; Spouse 1996).

Additional characteristics cited in this but not in other studies were that good mentors invariably keen and enthusiastic about their job, yet realistic in their expectations. Students talked of how it was like a breath of fresh air to have a mentor who was still enthusiastic about her job and not planning to leave the profession or feeling demoralised. It gave them hope for the future when they came across such positive role models.

5.9 What makes a poor mentor?

By the time the students had experienced four different practice placements, all but one student had been exposed to what they felt was a poor mentor. Poor mentors were described as lacking knowledge and expertise, possessing poor teaching skills, having no structure in their teaching and consequently chopping and changing their minds about things. Poor mentors tended either to over-protect their student by allowing them to observe only or were unclear on the students' capabilities.

Darling (1985b) discusses what she calls a gallery of toxic mentors: avoiders; dumpers; blockers; and destroyers/criticisers. Darling's research is criticised in Chapter II due to its lack of detail but the concept of toxic mentors is seen to have application in this study.

Avoiders are mentors who make themselves scarce when it comes to having anything to do with the student. Wilson-Barnett et al (1995) call this type of toxic mentor an absent mentor. These mentors make little or no time for students (Orton et al 1993), and students drift through the placement without any meaningful learning occurring (Glover 1996; Spouse 1996). Avoiders tended to ignore students or make them aware of how much of a nuisance they are. Laura and Mary both gave examples of avoiders.

Laura: *"I went on to the ward and I couldn't find out who my mentor was. They kept saying 'I don't know who it is.' Eventually, I think about in the third week, I found out who it was. She never filled in any of my forms even though I asked her. Even on the last week I said 'Remember you have my end of term assessment to do.' 'Yes' she said. She never did anything with me at all. Eventually on the last day, I said 'You have got that assessment to do for me.' 'Yes' she said but she went off the ward at 12 o'clock and never came back ... so I had to get someone else to do my assessment."*

Mary: *"I am sure if we had been off they wouldn't have realised that we should have been in that day. I am sure because we would sit all morning and they would have their tea breaks and we were never included in tea breaks or anything. So if we were sitting out we would have to ask them can we have 15 minutes now or whatever. Then they would have what they called trained staff meetings. They would all go away and it would only be the nursing assistants that sat out. I asked if we could go in. 'No it's a trained staff's meeting' I was told."*

Dumpers according to Darling (1985b) have the deliberate philosophy of throwing students in at the deep end, hoping they swim in the process. Dumpers literally abdicate all responsibility for the student and her/his learning. In this study, some students stated that their mentors would push them into doing things perhaps before they felt ready or forced into doing things for which they could see no relevance.

Blockers are mentors who refuse to meet students' needs. They do this in three ways. They can positively refuse (Refuser) to help the student, for example, telling them that they can learn that later. They can deliberately withhold (Withholder) information, knowledge and skills (Melia 1987; Cahill 1996). Lastly, blockers can inhibit the student's development by too close supervision (Hoverer). Students in this study who experienced 'tight' supervision commonly expressed relief when their mentor was not on duty as they became more involved in patient care as a consequence.

Susan's diary: *"I actually like when my mentor is off. I feel I get more to do and I don't have to stick to her."*

Amy: *"I felt you were kept on a really tight rein and what you can and what you can't do. It's not their fault directly you know. They were very different in their own way. With some mentors you weren't allowed to do anything to a patient unless they were there. With others you go in and you know the routine and you just get on with it and if you need help you ask, which I much prefer anyway."*

Destroyers/Criticizers are described by Darling (1985b) as either occurring subtlety as Underminers or more overtly as Criticizers/Belittler. No students experienced this type of toxic mentoring during their four placements in the CFP.

Probably the worst attribute of a poor mentor was described as a failure to keep promises.

Elizabeth: *"She promised me from the day I went there to the day I left that she would sit and go through her case load with me. We never got to. I don't blame her for that. It was just the situation that she was in but at the same time, I thought this is a waste of time, a complete waste of time. I did learn a lot there but I could have learnt a lot more."*

The effect of having a poor mentor was well expressed by Louise in her diary: *"I've still had precious little contact time with my mentor....I still feel that I am getting next to no guidance about what the goals of the individual care of each resident are, beyond keeping them clean and intermittently amused. As far as the mentor relationship goes, it seems to me that I have far less input than under the old 'standing next to Nellie' approach to training, since I do not stand next to her and have no model whatsoever to emulate, question or reflect upon."*

Regardless of how poor they perceived their mentor to be, students very rarely attributed blame to their mentor. Usually they would defend their mentor by apportioning the blame to staff shortages and how busy the ward was. However when the student perceived their mentor to be unprofessional, they did not defend them in the same way.

Amy:"...*I didn't like the way she (mentor) spoke to the patients and things like that. Even when she was doing things like doing medication, I didn't like the way she would just rush through it. Either you'd be reading it and she would be doing it but you would never check or anything, especially when you didn't know the patients and you don't know the drugs. You could say something wrong but she didn't mind at all and just got on with it."*

Students seemed to learn from these negative experiences, looking on them as learning exercises in themselves.

Amy: *"I have enjoyed all of them (placements) but the mentors in mental health and child were appalling and I'd never want to come across that again. But again, it's made me more aware of what I don't want to be like so you can turn it round in a way."*

5.10 Problems encountered having a mentor

A number of students commented that changing wards every five weeks also meant changing their mentor. Elizabeth explains just how difficult this problem was:

Elizabeth: *"It was difficult, it is difficult. I find... it's like starting a new job every five weeks. You are faced with X amount of new faces who you don't know and you have got to try to get to know all the patients and all their problems. You are trying to learn things and remember things, and there are all the staff nurses and staff. It's not just staff nurses, you've got all the other staff in the team, the physios and all the rest of it. You are trying desperately to try and get to know people. Its so difficult. What's so frightening is the fact that again, yet again, you are going to another ward, you don't know anybody, you've got to start again."*

Students believed they were disadvantaged if their mentor was not there for them on their first day. White et al (1993) and MacKenzie (1994) note that this expectation related to first placements, while Jowett et al (1992) state that this anxiety is related to all placements. The need for their mentor on their first day on a placement was a recurring theme throughout the CFP. Students feel more secure and supported when their mentor is present (Davies et al 1994).

Fiona's diary: *"I haven't met my mentor yet and won't see her until my fourth day. I don't think this is fair. I feel she should have been around to help me settle into the ward. I appreciate that she can't always be around but I feel I need her now more than ever. I feel that I am just standing around doing nothing; what will the other staff think?"*

Clutterbuck (1991;1995) and Earnshaw (1995) note that a mismatch between student and mentor is a common cause of the relationship failing. Students in this study complained about not liking their mentor's attitude to patients or themselves. Their solution to this problem usually involved doing nothing for fear of reprisal. Both Amy and Jayne were frightened of 'rocking the boat' which has been well-documented in studies of 'traditional' students (Orton 1981; Melia 1987; Cahill 1996). It persists with Project 2000' students (Clark et al 1996b).

Amy: *"...you don't want to rock the boat (both laugh). It creates more problems for yourself and you have enough with having to try and get on with someone you don't particularly like and you don't agree with their practice. The last thing you are going to say is something which is going to bring it all down on you."*

Jayne: *"I have come across a situation where there was one student in another placement and she didn't get on with her mentor at all and she ended up with a bad report. I thought dearie me, that won't look good on either of them. You reflect the college as well so its quite important."*

5.11 Role of the other staff nurses

Since the mentor was seen as the linchpin of their learning while on placement, the role of the other staff nurses was considered. According to the students, on most occasions, other staff nurses would facilitate their learning. Students therefore were not solely dependent on their mentor.

Elizabeth "*...all the staff, if there was ever anything, and it wasn't just my mentor, it was all the staff would say come and see this or come and watch me do this or come and give me a hand with this. That was really good because they were all really willing to help you to learn."*

At other times, the other staff hindered their learning. Karen: "*...in the first placement I used to find when he (mentor) was on a day off, I used to help out with the usual sort of chores and things but nobody was actually prepared to actually say to me come and I'll show you how to do this and do that. On the days he was off I just kind of tag around one of the other nurses and help out. The days he was on, which might be a sign of how good a mentor he was, because he made a point of making sure I did things and got a chance to do things."*

Students reported they would tag along with other members of staff when their own mentor was not there, particularly in the first week. Sometimes students perceived other staff were reluctant to teach them. Students attributed this to staff nurses either being glad they had no teaching responsibility for students or that they were encroaching on the mentor's territory. Some students reported that all staff took an active part in their learning. This seemed to relate to whether the students considered that the other staff were approachable or not.

Anne: *"All the staff there were great. You got as much experience that they could give you. If there was anything going on you would be informed and asked if you wanted to go and that kind of thing."*

Some students experienced having two mentors in one placement - a mentor and a co-mentor. The advantages were that students had sanction to interrupt either of their mentors, and they enjoyed learning different things from each one. Having two mentors was useful particularly when there was a 'personality clash'. However, having two mentors was not without difficulty. As the following student explains it often meant sharing your mentor with another student.

Karen: *"But there was also another student on the ward one of whom already had the same mentor who was to become my co-mentor so I felt that in a way I wasn't getting the attention that perhaps I needed from the mentor. I wasn't getting the full attention from one person, it was split."*

There was also a feeling of loss and abandonment when their mentor with whom they had developed a relationship and a degree of trust went away on holiday and they had a co-mentor appointed. Invariably students experiencing this were concerned about their assessment because they felt their mentor knew them better than their co-mentor and this would result in an assessment that was not a true reflection of their capabilities.

Students were surprised how much they learnt from their peers, particularly when those peers were students following the traditional style of training. Indeed, the students recognised that they often learnt more from their peers than trained staff.

Elizabeth: *"I was surprised how much I learned from other students. You think you are just going to learn from like the staff nurses but a lot of the time you can learn more from the older students than you do from the staff nurses."*

Amy's diary: *"Despite the fact that I was not allocated to her any day she day (student who is a RMN converting to RGN) taught me how to do naso-pharyngeal secretions and spoke to me about diabetes and meningitis. In fact I have learned more from her than any of the staff nurses on the ward."*

Peers who taught them were seen to have more time, were better at explaining things, were able to pass on tips and hints and were friendly and approachable. Students easily identified those students who were keen to share their knowledge and skills from those who had no interest in helping them learn. It would be interesting to determine if poor teaching ability in students predicted poor mentoring as a staff nurse.

5.12 Settling into a new placement

In this study, prior to going on to a new placement, some students felt so worried they often lost sleep. This is at odds with Davies et al (1994) and Phillips et al (1996a;b) whose students settled remarkably quickly into their placements. The time taken for students, in this study, to feel settled in any placement ranged from a few days to three weeks. Many expressed the frustration that they were just becoming used to the ward and beginning to learn when it was time to leave.

Elizabeth: *"And it takes you a wee while to settle in and by the time you are settled in and you are really beginning to enjoy your placement and you are whipped out again."*

The students seem to settle once they knew the ward layout and routine. Amy's diary: *"It is getting better basically because I am more used to where everything is and what happens day to day in the ward."*

Students were more concerned about going to their mental handicap and mental illness placements than their adult or children's placement. This is supported by the work of Jowett et al (1992). Concerns related to the unknown nature of the clients being nursed, that in mental illness placements there was no structure to the day, and that they had no past experience to draw upon. Students used the term 'being frightened' when explaining how they felt and as they did not know the routine, it could not afford them any feeling of safety or security. Mackay (1989) points out that the confidence that is built up in one placement disappears the moment the student sets foot on the next placement.

Students in this study were unsure of how about coping with the clients in mental health and mental handicap placements. These students are not unique in feeling this way. Jowett et al (1992) reports that 25% of students responding to their questionnaire (n=317) state they were apprehensive about going to these areas. Students in this study expressed the shock they felt moving from their adult placement to mental health placement as particularly upsetting. Everything was different; the ethos of nursing, staff attitudes, and patients.

Some students in Elkan et al's (1993c) study report that their worst placement was mental health while others voiced their appreciation of the learning opportunities it afforded them.

Mary: "*It's a real culture shock going from the adult to mental health. It was the staff's attitude to you, to the patients, everything was completely different and how they communicated with one another was completely different - It just seemed such a shock going from one right to the other. It was like top gear, chop, chop, run round, doing a lot of task orientated jobs (in adult ward) plus it looked bad if you did sit down really. Where it was the opposite, if you were rushing about it looked bad at (mental health placement). You were just supposed to sit about and have coffee. They were far more relaxed in how they spoke with each other. Not so technical. The handovers were very precise and technical in the (adult placement) whereas the handovers were like a wee conversation over coffee at the (mental health placement) and it wasn't so formal.*"

Students also experienced a different relationship with staff in their mental health placement. About half of the students felt it was more difficult to become part of the team. Students felt extremely restricted in what they were allowed to do. Most of their time was spent observing, drinking coffee, and playing games with the patients. This feeling that they were deemed incapable of participating in the care of individuals with a mental illness caused the students anguish and created a feeling that they were not wanted within the team. They had no role to play other than implementing the simplest of tasks. Students commonly felt they were neither needed or valued by the patients. Most students coped with their mental health placement but one student felt so unhappy and unsupported that she went off sick with stress. Students who were unhappy believed because they were doing the adult type of nursing, they were not important and the staff did not place any importance on their learning.

Anne: "*The other students were allowed to take patients out and allowed to do close observations. There wasn't any experience by sitting by your mentor doing close observations. It seemed to be a really long five weeks and I thought I could have got more out of it than I actually did.*"

In short, some of the students felt excluded in their mental health placement and as a consequence learnt little. This did not manifest itself in the mental handicap or child placement. In these placements, there was opportunity to practice tasks. Again this made them feel that they were making a contribution (Heyman 1984; Windsor 1987; Nelms 1990; Seed 1991).

Orton et al (1993) offer another possible reason for students not enjoying their mental health placement. They found that students whose branch was not mental health, tended to lack motivation in learning about caring for patients with a mental illness, preferring longer time in adult wards instead.

To explore this further, a decision was made to investigate whether mental health students experienced a similar phenomenon on their adult placement or was this phenomenon unique to Adult Branch students entering mental health placement. The 'researcher' used theoretical sampling to recruit a small group of students (n=8) who had elected to take the mental health branch and were in the same cohort as the students already in the study. Five out of eight mental health students arrived and participated in a focus group interview. The mental health students believed their supernumerary status was ignored in the adult placement because the emphasis was on participating in task-orientated care. There was no choice but to participate as the wards were so busy. However in their mental health placement they felt secure and enjoyed the learning opportunities open to them. They too experienced the shock of moving from the adult placement to mental health. Although the students had learnt from their adult placement they were all glad to leave it.

Sue: *"I feel I was just used as an auxiliary on my adult placement. It was really busy and you didn't really know what you were doing but ... patients required to be washed and others needed a shave. The nurses never had time to stop and show me things really. You are supposed to be supernumerary but I think if I hadn't been there they probably would have had to have got someone else. There were three or four Project 2000 student nurses and a couple of nurses. Without the student nurses there the ward would have collapsed."*

The mental health students much preferred being in their mental health placement, where the atmosphere was found to be more relaxed and friendly. They felt that they learnt more in their mental health placement.

Sue: *"I felt I got a lot of support there although my mentor was only in two days a week. She was part-time but the whole atmosphere was so laid back, so relaxed. People did show you things. It wasn't just my mentor. Everyone chipped in. Everyone was nice."*

The students recognised that their attitudes may have differed between the two placements. They felt a bond between themselves and the staff in mental health that was not present in their adult placement. In their chosen branch they felt secure and motivated to learn and indeed offered this as a solution to why students who were doing their Adult Branch felt as they did in mental health placements.

Judy: *"I felt like going into mental health was like going home and whether you are aware of it or not you are more willing when you know that is your branch and that is what you are going to be most enthusiastic about. I knew from day one that was what I wanted to do and loved it. Your attitude I think maybe shows and the staff pick on it because they can see that you are enthusiastic (agreement from others)."*

Clark (1991) cites Usher (1982) where she describes differences between general nursing students and mental health students. She asserts that mental health students have a more positive attitude towards their chosen client group than general nursing students. The latter group has a more negative attitude that is similar to that of the general public's view of the mentally ill. Clark criticises Usher's study in terms of its methodology but Clark does state that Usher's findings support the intuitive view that some people are more suited to psychiatric nursing than others and vice versa with adult nursing. It could be argued that Adult Branch students in this study reacted the way they did because of their lay perception of mentally ill people. However, Adult Branch students offered another explanation. This is expressed well in the following diary excerpt.

Fiona's diary: *"I am afraid that if you are not doing mental health as your branch programme, you were left to get on with it. I did appreciate the reason for this sometimes as it does take a long time to build up trust with some of the clients and it may be off putting for them to have students listening in. I found the most newly qualified members of staff more helpful. The only time I was ever asked to do anything was to strip beds and empty buckets."*

Since there were little or no tasks to do in the mental health placements, Adult Branch students complained about the lack of structure to their day. They were unable to become used to a non-existent routine and, as a consequence, did not feel part of the team at all. However, not all the students felt this way about their mental health placement.

Jayne stated: *"I just felt my heart opened to them. I felt so vulnerable for them, you know, it opened my eyes. I think you go to somewhere like that and you have heard all these stories about the residents who are in there. You know, you think they are all mad and that they'll go for your throat or whatever (both laugh) and you go in there and it's totally different. The residents were lovely, really nice residents."*

5.13 Task versus holistic care

Learning in the adult placement was principally task-orientated. The learning of tasks was of paramount importance to the students in the study. This category became saturated quickly. The limited time students had in the placement undoubtedly influenced this. Students had their own list of tasks in which they wanted to achieve some proficiency. The acquisition of skills made them feel more confident in their ability. It was noticeable that the students equated their ability to do some tasks with learning to be a nurse, because that was what nurses did. It was as if they needed to master the tasks before they could see the patient as a whole.

Mary: *"Well I think the basics of nursing care are a lot of tasks. In the few weeks that we are there in the placement you have sort of get over the tasks and do the tasks before you can go on to look at the person. You master tasks first but it's until you are getting near leaving, that you actually realise what the person's real needs are."*

Seed (1994) found that 'traditional' students in her study appeared so engrossed in learning specific tasks that they found it difficult to view the patient as an individual. According to Seed this skill only develops with maturity.

In this study, being proficient in tasks made the students feel a worthwhile team member as they had something to contribute and a role to play and consequently the feeling of being useless and a 'spare part' diminished. At times the student would weigh up which tasks to either watch or participate in, bearing in mind the objectives they had to achieve by the end of their placement.

Laura: *"I am going on to my branch and there are things I haven't done, like injections. To me I should have done injections but the kind of ward I was on, I saw one being given and that was it. One of the girls says she hasn't even bathed anybody yet."*

According to Lamond (1974) by the end of first year on the 'traditional' style of training students are expected to be proficient in a number of specific skills. Nelms (1990) interviewed Baccalaureate nursing students (n=17) using a phenomenological approach. Nelms notes that students are continuously aware of the need to master certain skills and knowledge at different points so that they progress in their course. Students in this study were also aware that they had to achieve all prescribed learning outcomes to the level of 'C' before they could transfer onto the branch programme. Eraut et al (1995) report that being unable to perform tasks such as taking temperature, pulse and blood pressure is a major threat to students' confidence. They continue to state that students seem to spend their clinical experiences struggling to gain competence and acceptance.

Students in this study felt that performing tasks not only helped the ward staff but was a necessary part of their learning as they more active they were, the more they learned. As the students became proficient at specific tasks, they were allowed to perform them with no direct supervision. Students interpreted this as progress and gained confidence. Most students stated that they would not hesitate to ask for help or guidance. There seemed to be a greater concern for their practice and its consequences than of interrupting trained staff.

Fretwell (1982) notes that once students accomplish basic care skills after two or three performances, they view these tasks as routine. Students in this study expressed similar views. The desire to learn skills is not a new phenomenon as Windsor (1987) reports students see the practice of nursing skills as fundamental to their learning in the clinical environment.

Andersson (1993) notes that university students in her ethnographic study, were overwhelmingly task-centred. O'Neill et al (1993) explored the professional socialisation of 'traditional' students and 'Project 2000' students who were in their CFP. They confirm other findings that 'traditional' students tend to see nursing as a series of tasks to be performed.

O'Neill et al (1993) and White et al (1993) note that 'Project 2000' students, like their traditional counterparts, define their role as a series of tasks. O'Neill et al (1993) state that while 'traditional' students define their role in terms of tasks related to the physical care of patients, Project 2000 students are more likely to list interpersonal skills such as listening and counselling. This finding was not discovered until much later in this study. It could be argued that the desire to learn tasks is related to the professional socialisation process. However, this was not considered until nearer the end of the study when the core category was established.

5.14 Change-in-self over time

Students were asked if they felt they had changed over their first four placements. All students felt that they had gained in confidence; were more knowledgeable; were more assertive; more mature; and happier with their interpersonal skills. A similar improvement is noted by Bradby and Soothill (1993) and MacKenzie (1994).

Allanach (1988) believes that confidence originates from an internal state which as Reider and Riley-Giomariso (1993) and Hallett et al (1996) state arises from the acquisition of skills and the ability to accomplish role requirements. This adds weight to the argument of the importance of learning tasks until students are confident enough to move on to holistic care.

Students confirmed that they had changed their views, particularly in relation to dealing with individuals with a learning disability or mental illness. They had become more open-minded and now tended to think about things in more detail. They were also beginning to reflect on practice.

Students realised that they had learnt about hospital culture.

Mary: *"I am more confident about hospital culture and what goes on and who you report to and who you don't. I think it's just as well you know you are still at the bottom of the rung and you know you have so much more to learn... whatever ward you go on to now you can go on and do something and know you can do something well. Even if it's just making the beds or doing a simple dressing. You can do something that you know fine that I can take responsibility for that and I will do that well. So you are not just hanging about."*

They had learnt how to 'fit in,' how not to 'rock the boat', how to quickly learn the ward routine and how to find out what their mentor liked being done. They were aware that non-conforming students were unpopular and tended to receive bad assessments. Since first impressions were considered important, students took trouble to create the right impression. It could be argued that they had learnt survival skills.

Karen: *"You are aware from the first day that you go there, if not assessed, you know are given the once over. Everybody does it, makes a judgement, first impressions and things like that. For me that means giving a good impression initially. But I think as the placement develops you can maybe relax a wee bit more so you can be a wee bit more outspoken on certain things."*

It could be argued that students complied with the ward norms because they believed that better relationships were formed which usually led to a good assessments. Alderton (1983) and Mackay (1989) report that in order to receive a good report, traditional students conformed. Compliance is defined by Kramer (1974, p34) as occurring "when an individual accepts influence from another person or group because he wants a favourable reaction from them. He does not adopt the induced behaviour because he necessarily believes in its content, but because he wants social approval, a promotion, a raise, or perhaps just simply holding onto his job." By being compliant and conforming, students' anxiety is reduced (Gott 1984).

Farley (1992) believes that supernumerary status means that Project 2000 students feel isolated and therefore conform in an attempt to 'fit in.' An opposite view is voiced by Charlwood (1993) who feels that supernumerary status reduces the pressure on students to conform as was the case with Jowett et al's (1994) students.

5.15 Summary

Having experienced four placements, the students articulated that supernumerary status did not really work. They could see its potential benefits and exerted their rights to supernumerary status principally when they felt the ward work allowed. Students quickly realised the benefit of learning the routine and mucking in - they were more likely to feel part of the team and feel like a nurse. Students began to view being allowed to be supernumerary as a reward for hard work.

Their perceived fears of being stigmatised as Project 2000 students were experienced, but mainly by 'older staff' and auxiliaries. Students were particularly surprised that traditional students did not stigmatise them; rather they supported and taught them.

Their mentor was the linchpin of their placement and was viewed as vital to their development. A great deal of emotional investment was expended in terms of wanting a good mentor. Students were very clear regarding the characteristics of good and poor mentors, with all students experiencing both good and poor mentors in their four placements.

The transition from placement to placement was an extremely unsettling time for students. Not only did they need to learn new routines but they also had to develop new relationships with staff and patients. It was like starting a new job every five weeks. Students tended to take one or two weeks to settle into a placement.

Once students had learnt the ward routine, they were keen to learn practical tasks, so that they would feel able to participate in some form of nursing care and, if possible, to do so unsupervised. This made them feel they were learning and that they were actually 'being' a nurse.

Students noticed that they had changed over the period encompassing the four placements. They were more confident and most of the students felt they had become more assertive. They had learnt about hospital culture and essentially the rules of achieving satisfactory assessments. Summarised comparisons of the students' perspective of the mentors' role, the students' perspective of a good mentor, and the students' perspective of a good mentor and a poor mentor from the pre-placement interview, the second interview and diary data can be seen in Tables 14, 15 and 16 respectively.

Table 14 **A summarised comparison of the role of the mentor from the pre-placement interview, the second interview and diary data**

Pre-placement expectations	Views after 4 placements
Supporter - give advice, sort out problems or worries they had, be there as an ally and friend	**Supporter** - give advice, sort out problems or worries they had, be there as an ally and friend
Guide them in their learning, to share views and feelings about nursing, be a role model and give them feedback	**Guide and teacher** - seen as the linchpin. Take time to explain things, organise and arrange visits etc., be a role model, move them along the continuum between observing and doing and give them feedback on their performance
Supervisor	**Supervisor** - more at the beginning than at the end, allow gradual independence
Assessor	**Assessor** - need to make a good impression but not foremost in their minds. Important to be involved in their assessment

Table 15 **A summarised comparison of a good mentor from the pre-placement interview, the second interview and diary data**

Perceptions of what is a good mentor (Pre-placement interview)	Views of what is a good mentor (From second interview)
Nice	Enthusiastic and friendly
Approachable	Approachable
Understanding	Patient and understanding
Respected by others	Good working relationships with staff and respected by peers
Good role model and good communicator	Good role model, professional, organised, caring, confident in own ability
	Possess sense of humour
	Knowledgeable about course and has realistic expectations
	Be an ally and speak up for them
	Involve student in activities
	Good teacher and incorporated feedback
	Gradually withdraw supervision
	Make effort to spend time with student
	Genuinely concerned and interested in student
	Confident and trust in student's ability
	Allow use of initiative
	Pace teaching and steadily move along continuum from observer to participant

Table 16 **A summarised comparison of views of a good mentor and a poor mentor from interview 2 and diary data**

Views of what is a good mentor (From second interview)	Views of what is a poor mentor (From second interview)
Enthusiastic and friendly	Less friendly and less supportive
Approachable	Unapproachable
Patient and understanding	
Good working relationships with staff and respected by peers	
Good role model, professional, organised, caring, confident in own ability	Lack of expertise, poor role model
Possess sense of humour	
Good communicator	
Knowledgeable about course and has realistic expectations	Lack of knowledge about the course. Unrealistic expectations
Be an ally and speak up for them	
Involve student in activities	Ignored student
Good teacher	Poor teaching skills, not given the opportunity to learn
Gradually withdraw supervision	Tendency to allow student to observe only and not participate in care
Make effort to spend time with student	Ignored student
Genuinely concerned and interested in student	Not valued either as a colleague or individual. Made aware of how much of a nuisance they were. Seen as a threat to ward routine.
Confident and trust in student's ability	Tendency to over protect and not clear of the student's capabilities
Allow use of initiative	
Pace teaching and steadily move along continuum from observer to participant	No structure in their teaching, chopping and changing their minds about things
Incorporated feedback in their teaching	Unlikely to give feedback

CHAPTER VI
BECOMING A BRANCH STUDENT

6.0 Introduction

These data are derived from the third set of interviews and collection of diaries. The students had had three placements since they were last interviewed. As before, the constant comparative method was used and initially 80 codes were established. Eventually these were condensed into 5 sub-categories: transition from supernumerary status to rostered service; evolving as a student nurse; placements; mentors; and mentor or no mentor. These 5 sub-categories made up the category, becoming a branch student.

Saturated sub-categories or categories are indicated by using students or all students, while sub-categories or categories which were not completely saturated are indicated by the use of most, majority or some. Once initial analysis was completed, the literature was searched to add data to the analysis and to search for negative cases.

Great excitement was expressed by students about getting to their branch programme at last. Many felt the 'real' learning would now start. Mangan (1992) and Eraut et al (1995) report that students in their studies were generally more positive about their branch programme. This was attributed to having greater clinical involvement and feeling more like nurses than they had in the CFP.

Susan and Yvonne failed to progress into the Branch because of academic failure and Anne left for personal reasons. Lynne and Sarah, from the diary-only group now agreed to be interviewed and keep a diary for the remainder of the study.

The students remained supernumerary for their first placement in the branch and continued stating that supernumerary status did not really work. As Amy stated in her diary: *"Supernumerary status. I've decided that it reminds me of the Community Care Act - it's good on paper but in practice it's not working."*

Students continued to complain about the lack of time their mentors could spend with them. Staff-shortages meant that learning opportunities were often missed because hard-pressed staff forgot to include students. This led students to adopt a pro-active approach by persistently asking to be involved. These findings replicate evidence from previous studies (Jowett et al 1991; Elkan and Robinson 1992; Watts 1992; May and Domokos 1993; White et al 1993; Ormerod and Murphy 1994; Eraut et al 1995; May et al 1995; Neary et al 1996).

6.1 Transition from supernumerary status to rostered service

In this study, the transition from supernumerary status to rostered service occurred after a three week holiday, and caused significant upset and brought unexpected pressures. The extra hours to be worked (now 37.5 instead of 30) caused the students to feel tired. Students quickly realised that they were now experiencing the 'real world.' Kirsty's diary: *"I was so shattered working rostered service, I didn't do a lot of diary writing - welcome to reality eh!"*

Students began to mourn the loss of their supernumerary status. It seemed that did not fully appreciate the worth of supernumerary status until they had lost it. Without doubt students felt this as a great loss as they passed through into rostered service. Students found it difficult to reconcile the loss of learning opportunities supernumerary status had afforded them with the staff's attitudes towards their learning now they were on rostered service.

Lynne: *"I would say can I go and see that and they (the staff) would say we can't let you go because there are not enough staff on. You feel that it would be such a good learning experience and you might never get the chance again. There was one time I went on a home visit and when I came back, the ward had been so hectic that I could feel the vibes from the other staff. You know, she's been swanning away on a home visit and we have been rushed off our feet here. I kind of felt guilty."*

6.2 Changing expectations of staff

As students moved from being supernumerary to rostered service, the expectations of the trained staff changed. Students were expected to plan and manage the care of allocated patients without too much support, to work independently and give total nursing care to their patients. This expectation came as a shock to many students and in some cases caused quite severe stress. It is argued that these students were encountering role ambiguity as they did not have the necessary skills or knowledge to fulfil the role expected of them.

Role ambiguity is the incongruity between the information or the skills available, and those required for satisfactory accomplishment of the role (Ogier 1984; Levenstein 1985; Gerrish 1990a; Dunham 1992; Bradby and Soothill 1993).

Students were daunted by the transition and worried greatly about what they felt was their lack of knowledge. The added responsibility seemed to stem from being put into situations that seemed beyond their capabilities. Their worst fear was of not doing things correctly or forgetting to do something vital.

Jayne: *" ...she (Sister) said, 'This is what I expect of a term eight student' and there were things that I hadn't done before. It all depends on the kinds of placements you have had previously, what kind of experience you get. I hadn't had much experience to do with drips or blood transfusions whereas she was expecting me to go and change a drip and I said there was absolutely no way I could do that. I was thinking oh God, they are expecting me to know all this!"*

Mary: *"... the patients were divided up equally between the staff nurses and myself and I was expected to organise their care, dressings, give report, do everything. I think if I had been a junior staff nurse it wouldn't have been any different. I told her (mentor) I felt I was getting out of my depth. She said that I had coped very well with everything. It was maybe too much though because I would be on the bus going home when I would remember that I have forgotten to say this or that. It was important things too."*

During the transition phase, students experienced emotional turmoil and at times stress. It was difficult for them to adjust as quickly as was expected by ward staff.

Amy's diary *"Responsibility for my patients has hit me like a ton of bricks and I don't like it. Everything feels like it's up to me and if something doesn't go according to plan, it's my fault. I find this frightening as I'm still not experienced enough to carry out total care."*

It is argued that students in this study also experienced role strain since they felt acutely the role expected was beyond their capabilities at that time in their course. Project 2000 students in Jowett et al's (1994) study felt similarly. Role strain is the "...felt difficulty of fulfilling role obligations due to a lack of resources or the possession of many roles or a role which is too complex" (Martin 1989, p53).

Once students had adjusted to the transition they could see the positive side. They experienced a huge learning curve during their first rostered service placement. Confidence in their abilities returned. They learnt more by working complete shifts, being a team member and being allocated their own patients. Despite feeling unhappy with the added responsibility, most students acknowledged that they had learnt a great deal. The elation of realising that they had grown through the experience was evident.

Amy: *"...it was a really good way to learn and it was extremely effective because I did learn a lot and I got a lot of confidence and that was excellent. It was good just to get on with it."*

Mary: *"I think I learnt more from that placement than probably any of my placements but it wasn't good learning - I was stressed the whole time. I do feel that I have learnt things but at the time I was dreading going in in the morning because I just knew I had to get through the day and get everything written up and give my report."*

For Elizabeth, the stress engendered by being allocated her own patients without being given adequate support was almost too much: *"...it has really shattered my confidence and really got me considering alternatives. I don't think that I will get to the stage where I would resign because there are always the good things that make you want to stay in nursing."*

Students coped with the transition from being supernumerary to providing rostered service is a number of ways:-

Amy's diary: *" I decided that from that shift that enough was enough and the next time I feel out of my depth to say so. It's not fair on my patients."*

Louise's diary: *"Perhaps I should try to have a little more confidence in my abilities and not compare myself unfavourably with much more experienced members of staff. I'll have to try to be more assertive about articulating my learning needs, I suppose."*

White et al (1993) describe how students in their study were not always ready for the transition from supernumerary status to rostered service. Bradby and Soothill (1993) describe how some students are overwhelmed by this status transition.

Jowett et al (1994) warned that as well as supernumerary status, rostered service causes confusion in its implementation for both students and staff. In this study, rostered service did not cause confusion but it certainly caused stress.

6.3 Task versus holistic care

During interviews it became apparent that students had made another transition while moving from supernumerary status to rostered service. Students began to change their view of nursing. This finding has not been documented elsewhere. As discussed in Chapters IV and V, while in the CFP, students were aware that they focused on learning tasks. It is interesting that during our conversations, students agreed that their learning could only progress after they had learnt the tasks involved in delivering basic nursing care first.

Karen: *"Yes, you were very anxious about tasks because we felt that practical tasks were what made us nurses and if we didn't know how to do this and that, we wouldn't be nurses, which you can still argue is the case."*

Students appreciated how important basic nursing care was but once they were able to deliver it competently, they then equated its delivery to something that auxiliary nurses did. Their focus changed as they became branch students with a strong desire to learn technical tasks since that was perceived to be the difference between the roles of a staff nurse and an auxiliary nurse.

Amy's diary: *"I know it is something that I will always be improving on (delivering basic care) but I am having to become a nurse not an auxiliary. I don't have a clue about the paperwork especially writing care plans. I just want to get lots of practice so I'll feel competent when I qualify. I've never done anything but basic nursing care in all my placements. I will ask to be more involved next week when I have found my feet more."*

6.4 Glorified Auxiliaries

During their first three placements in the branch, students commonly complained of feeling like glorified auxiliaries. This seemed to be linked to the students' perception of how the ward staff viewed them. Some students were given the impression from trained staff that they could not trust them with anything beyond providing basic nursing care.

Elizabeth: *"I was at the end of my second year and even if I went near a drip they were 'Oh are you sure you are alright? Are you sure you can do that?' I said of course I can do it, I wouldn't be trying it if I wasn't. I would never do something that I wasn't positive and confident that I could do. I don't know what they were expecting of us but they just didn't give you any encouragement at all. They just seemed to think that you were just playing at being a student nurse. They seemed to have this thing that we think that we know it all and yet they treat you like you are silly."*

Karen: *"...you are excluded from information which allows you to deliver holistic care and then it does become tasks and then you just become a glorified auxiliary because you spend all day trotting up and down to the bathroom."*

The exclusion from information replicates evidence from Melia (1981) and 'nursing in the dark.' She states that basic nursing care is dismissed as something that anyone can do and therefore not seen as prestigious work. According to students in this study the role of the auxiliary was to deliver basic nursing care. Since students wanted to learn real nursing; there had to be something more than acting like a 'glorified auxiliary.' For students in this study, Stuart and Sundeen (1991, p376) make a valuable point when they state that self-esteem is "obtained by analyzing how well his (her) behaviour conforms with his (her) self ideal." Students were upset at being seen only to fulfil the role of an auxiliary as opposed to their self ideal which was a second year student nurse. An inextricable element of self-concept is self-esteem (Norton 1993).

Essentially self-esteem is derived from oneself and from others and is an individual's personal judgement of how worthwhile a person they are (Stuart and Sundeen 1991; Norton 1993). It could be argued that the students' self-esteem was threatened because their concept of self was incongruent with their self-ideal. This may well have contributed to the overwhelming and almost disabling feeling some students experienced in the transition.

As Stuart and Sundeen (1991) contend a positive self-concept allows the individual to function more effectively. Linked to a positive self-concept, a high degree of self-efficacy permits individuals to function to the best of their ability, whereas a perceived low self-efficacy causes stress (Abraham and Shanley 1992). The fact that students were two thirds through their course and felt as though they were not progressing in their goal of becoming a nurse was very frustrating.

Amy: *"You are a year to go before qualifying and you don't know how to write up a care plan or do a dressing without somebody watching you."*

Karen: *"You also get to a certain stage where you are doing the same things day in and day out because there is this invisible hurdle about responsibility and what you can and can't do ..."*

Instead of viewing nursing care as a series of tasks, the students were now aware that they had developed a more holistic approach. It is as though they had to go through the process of learning tasks that focused on physical care before they could progress to thinking about meeting their patients' psycho-sociological and spiritual needs. There is perhaps a link here with Maslow's Hierarchy of Needs (Maslow 1987). The application of Maslow's Hierarchy of Needs to student nurse development and progress has been attempted by Williams and McLean (1992) and Nicklin and Kenworthy (1995). The Application of Maslow's Hierarchy of needs to Student Learning can be seen in Table 17.

Table 17 Application of Maslow's Hierarchy of Needs to Student Learning

Maslow's Hierarchy	Williams and McLean (1992)	Nicklin and Kenworthy (1995)	Gray (1997)
5. Self-actualisation	Is potential being maximised?	A fulfilled practitioner demonstrating nursing excellence. Aware of the needs of others to reach this level.	Beginning to develop intuition. Student feels s(h)e is ready to take on the role of staff nurse although aware that this will involve more learning accompanied by a movement back down hierarchy until more confident in new role.
4. Esteem needs	Are achievements acknowledged? Is recognition given by self and others?	• Respect by clients. • Professional registration • Recognition of clinical expertise by others • Striving for excellence	Beginning to feel like a nurse because has learnt basic care tasks. Now able to progress to more technical tasks and to look at the patient/client from a more holistic perspective
3. Belonging needs	Does the learner feel accepted by colleagues, peers and the client group? Does the learner feel that nursing is the 'right' profession?	• member of professional group • part of student group • member of a college • working towards professional esteem	Once levels 1 and 2 are accomplished, student begins to feel part of the team and also gains pleasure from patients' recognition of their part in their care.
2. Safety needs	Is the learner aware of her own limitations and abilities? Does she feel comfortable about expressing these?	• Security of position as student or employee • Safe environment to learn • Striving to belong	Associated with gaining competence in tasks involving physical basic care needs, student aware of the need to maintain safety of client by asking relevant questions.
1. Physiological needs	Does the learner get sufficient rest and nourishment? What are the effects of night duty and shift patterns on the learners?	• The same pre-requisites as everybody else needs in order to advance • Striving to secure these needs and progress	Student aware s(h)e needs to learn tasks associated with physical care of patients quickly. Easily accomplished as they promptly become routine.

The 'researcher's application is illustrated by these students:

Sarah: *"...I handled quite a few emergency cases with ruptured ectopic, well that involved quite a lot of psychological care apart from her obvious physical care. The post-op side of care was done without thinking. You did that as routine. You knew what you were doing so you didn't have to constantly say what am I doing now. I would say that did free you up to think well she is going to be really quite upset when she wakes up or she is going to need quite a lot of explanation."*

Amy: *"...I now look with a more holistic approach. Like not just saying right I am doing a dressing and worry about making sure that the dressing is ok. I will worry about the patient and whether it is sore and whether they are comfortable whereas before I would have been thinking more just about the procedure and not taking everything else into account."*

Claire gave a particularly good analogy of how she felt about the development of being able to look at patients more holistically.

Claire: *"I suppose it is very much like learning to drive a car. At first it is all the mechanical things that just seem bewildering and overpowering. Once you have got those on board and you are quite happy with it, you realise the importance of looking in your mirror and signalling .... Not just being told by the instructor do this and do this, now do this, now do that. You have got the hang of doing the mechanical aspects of it and you are realising how it all fits into clockwork action."*

It is proposed that as the learner moves up Maslow's Hierarchy of Needs, they become more able to expand their repertoire of skills and develop a wider picture. They have to proceed from one level to the next in ascending order, otherwise their skill level will be inadequately developed. Students must achieve level 1 of learning and delivering basic physical care before they can progress any further. The full argument supporting the application of Maslow's Hierarchy of Needs to learning needs is not evident until the findings of the final interviews and diaries are presented.

6.5 Evolving as a student nurse

Accompanying the recognition that they were now able to think holistically about their patients, was the impression of evolving as a student nurse.

Sarah's diary: *"Even in the short time that I have been here I feel myself evolving as a student nurse. I just get on and do things and then consult the staff on this. They seem happy about this My confidence is rising and so hopefully are my capabilities. I've needed less and less guidance from the staff this week."*

Fiona's diary: *"For the first time I felt like a nurse rather than an auxiliary."*

Students reported a rise in their self-esteem and self-confidence. This seemed related to coping successfully with the responsibility of determining and delivering care for their allocated patients. Students believed that they did not rely on their mentor as much as they had done in CFP because they felt more self-reliant and knew the routine. However they acknowledged that it was still a comfort having their mentor around so they could ask questions or discuss issues with them.

Karen: *"I certainly feel more confident in myself about basic nursing skills and I would feel quite competent to deliver that to different levels and to even totally dependent patients. Six months ago I would look at somebody who was bed bound and think where do I start, what do I do. I feel I have passed all that and feel comfortable with basic nursing skills. I don't need confirmation as to whether I am doing it the right way or not."*

It could be argued that in reaching level four of Maslow's Hierarchy, the students' self-esteem and self-efficacy had been heightened to a degree where they were much happier with their own performance. Role ambiguity and role strain seem to have greatly diminished. This change seemed to occur insidiously.

Claire: *"...you just build up your capabilities. It's something that just creeps on you really. You don't realise that it's happening."*

Generally students felt they were beginning to mature in their role as a student nurse. They had gained more experience and skills, particularly in relation to communication. There was also an increase in their assertiveness skills which students described as necessary to fulfil the role of patient advocate or to achieve their learning outcomes. With respect to the latter, the result of non-assertiveness was that staff would invariably ignore the students' learning needs.

Amy's diary: *"At times the responsibility I was given was too much and I felt out of my depth. It was left up to me to ask for help no matter how incompetent I felt or looked. This made me more assertive as I realised I was accountable for my actions and wasn't prepared to do something that could be wrong."*

Louise was amongst the students who were aware that their assertiveness skills were lacking. Consequently they felt disempowered and their self-esteem was low.

Louise's diary: *"I'm going to have to say something about this to one of the charge nurses since I'm beginning to feel rather unsupported by what seems to be an unsystematic and opportunistic approach to teaching. My delay in doing this is my acute sense of lack of practical competence in the ward, which I think has the effect of making me behave as if I am incompetent at expressing my learning needs as well. Part of it is just timidity - I'm not very good at voicing even constructive criticism."*

According to Parahoo (1992c) the assertiveness of students has its limits because of the pressures inherent in the ward to conform. However more promising findings have been identified in Project 2000 students. Project 2000 students exert their assertiveness particularly in relation to patient advocacy and voicing their concerns regarding inexperience or unhappiness in performing aspects of care (Jowett et al 1994; Clark et al 1996b). Students in this study were functioning as their counterparts in England. They believed that their development was very positive and certainly a step in the right direction. This comforting realisation seemed to confirm that they were evolving as a student and moving away from being a 'glorified auxiliary.'

Claire: *"The further I go on, the more I realise there is still such a lot I still don't know and yet I feel I have built a lot on what I do know and its been a gradual insidious change."*

Another aspect of development that a few students mentioned during this third round of interviews was intuition, and from the students' descriptions it was linked to their development in viewing patient care holistically.

Claire: *"I have become more fluid I suppose, the fluidity of my practices with patients and my ability to talk to them and to recognise when they don't want to talk to you perhaps and when they are perhaps not giving you the full picture. I don't know what it is. Your intuition improves and you can pick on their psychological states and read between the lines as to what they are saying and to know that there is something not quite right..."*

Amy: *"I experienced that (intuition) with the chap with the aneurysm. I thought all day he wasn't well and I had taken him to the bathroom in the morning and there was just something about him and I asked him if he was feeling ok. He said 'yes' but he was a wee bit dizzy and I told him that he should just take it easy. I said to the staff that there is something wrong, I don't know what. I never thought I would be able to have that. You always hear from staff nurses that there is something wrong there and I have always wondered about it."*

Morag: *"Where do you think it comes from?"*

Amy: *"Knowing your patients and being allocated patients so that you are working with them a whole shift and maybe three or four shifts in a week so you know them as a character and not just as a number and you know what they are usually like. I think it comes from that although I don't exactly know."*

Having reached level four in Maslow's Hierarchy, students were now beginning to reach self-actualisation and become intuitive. Benner (1984) is renowned for her text 'From Novice to Expert' in which she asserts that intuition is the province of expert practitioners. How then can these students' experiences fit in with Benner's model? The model was investigated to answer this question.

Benner uses the Dreyfus Model of Skill Acquisition as a basis for her research. Stuart Dreyfus, a mathematician and systems analyst and Hubert Dreyfus, a philosopher originally developed their model as a result of studying the performance of pilots in emergency situations and chess players (Benner 1984). The Dreyfus model consists of five stages through which an individual passes as they acquire and develop skills, namely: novice, advanced beginner, competent practitioner, proficient practitioner and expert practitioner.

Benner (1984) aimed to study the applicability of the Dreyfus model to nursing. Using a critical incident technique, she sampled 21 pairs of nurses. Each pair consisted of a newly qualified practitioner and an expert nurse. In addition she sampled 51 experienced nurses, 11 newly qualified nurses and five senior nursing students. Despite only a token number of student nurses (n=5) in the sample, many nurse education institutions have adopted Benner's model as though her results were generalisable in relation to nursing students. Benner's data collection methods involved interviews and participant observation. Heideggerian Phenomenology is used to identify meaning and content. The following description of the results is heavily drawn from Benner (1984).

Novice Practitioners

Novice practitioners come into nursing without prior experience or knowledge. To function, they must follow rules and procedures to an extent that they cannot adapt their techniques to suit individual clients because they have to function in a context free manner (Benner 1984; Lahiff 1990). They require a high level of supervision and contact with more experienced practitioners and learn through demonstration and supervised practice. They tend to concentrate on a single issue at a time and spend lengthy periods with irrelevant information (Tabak et al 1996). The novice part of the model very much 'fits' with students in this study wanting to learn tasks, yet in Benner's model, novices are newly qualified nurses.

Advanced Beginner

Advanced beginners have gained sufficient experience to be able to notice recurring aspects of a situation. They are adept enough in 'real' situations to be able to identify meaningful components but require assistance in aspect recognition (Macleod 1996). Advanced beginners learn by working within broad guidelines and require supervision to learn to prioritise and consolidate their skills but at a level tailored to their specific needs (Benner 1984).

Benner (1984) notes that advanced beginners 'demonstrate marginally acceptable performance' and that new graduates usually are in this category. However in this study, this part of the model equated with students who knew the routine and were happy to perform basic skills tasks unsupervised but required help and assistance with more technical skills.

Competent Practitioner

According to Benner (1984) individuals who fall into this category function at a more analytical level. They can identify problems and prioritise care required. Supervision is more distant at this stage. According to Sloan and D'A Slevin (1991) a competent practitioner is the limit of the pre-registration course. Benner (1984) asserts that competent practitioners do not possess enough experience to perform care holistically and are unable to differentiate between the importance of variety of aspects. However they do exhibit considerable and deliberate planning skills. She also contends that competent practitioners are nurses who have been in the same or similar job for two to three years. However, this is the level in the UK that we expect students to achieve. A competent practitioner is aware of their actions and experiences a feeling of mastery but is said by Benner (1984) to lack the flexibility and speed of a proficient practitioner. This part of the model 'fits' with students in this study taking on their allocation of patients and assessing, planning, implementing and evaluating the care given.

Proficient Practitioner

A proficient practitioner is able to view situations holistically. They use problem solving skills (Meerabeau 1992) and anticipate and acknowledge that certain events will occur in certain situations. This is based on their intuitive grasp which is a product of their deep involvement and ability to recognise similar patterns through experience (Benner 1984; Macleod 1996). They can therefore recognise when a normal picture does not materialise (Benner 1984).

"It is the proficient performer who is most frequently able to recognise deterioration or patient problems prior to explicit changes in vital signs - that skill called the early warning signal" (Benner 1984, p31). Benner offers three to five years as an estimate before a practitioner becomes proficient.

Intuition

Proficient practitioners display intuition. According to Dreyfus and Dreyfus (1996) intuition is a central component of practical knowledge and is essential to expert judgement. Roberts and Burke (1989, p37) believe that intuition is "at work when something occurs to you suddenly and in a nearly complete form. It is a fundamental part of creativity." Recent debate has concluded that intuition is a difficult concept to define (Burnard 1989; McCormack 1993; Kenny 1994). One definition that is often quoted is that "intuition refers to the immediate awareness of past, present and future events without the conscious use of linear reasoning ..." (Miller and Rew 1989, p85). However, the very fact that it bypasses linear reasoning makes it difficult to explain (Easen and Wilcockson 1996).

It is argued that since intuition is seen as lacking an empirical base, it is viewed as something 'soft'. It is often 'whispered' about and usually accompanied by expressions of self-doubt (Burnard 1989; McCormack 1993). The negative connotations surrounding intuition causes experienced nurses not to discuss it, other than with an open-minded colleague (Correnti 1992; Easen and Wilcockson 1996; Miller and Babcock 1996).

The existence of intuition is difficult to prove. Burnard (1989), Correnti (1992), Rubenfeld and Scheffer (1995) warn that intuition cannot and should not be ignored as it is one of the fundamental qualities of a nurse and a valuable part of clinical judgement (Miller and Babcock 1996). "Intuition combined with objective verifiable approaches enables nurses to deliver holistic care ...and is a dimension of the state of the art of nursing" (Correnti 1992, p91-92).

Dreyfus and Dreyfus (1996) believe intuition relies on perceptual capacity based on previous experiences. They state that it is only accessible where there is a deep understanding of the situation and sufficient experience to differentiate between similarities and dissimilarities. They define intuition as understanding without rationale and state that it is characterised by six key aspects: pattern recognition; similarity recognition; common-sense understanding; a sense of salience; skilled know-how; and deliberate rationality. These aspects will now be discussed.

Pattern recognition

Pattern recognition means that the individual is able to perceive relationships within situations without pre-specifying the components of the situation. Through experience, nurses begin to learn patterns of responses exhibited by patients in certain situations (Benner and Tanner 1987). It is proposed that Amy was exhibiting pattern recognition when she stated earlier that:

Amy: *"Knowing your patients and being allocated patients so that you are working with them a whole shift and maybe three or four shifts in a week so you know them as a character and not just as a number and you know what they are usually like. I think it comes from that although I don't exactly know."*

Similarity recognition

Here nurses pursue lines of inquiry to identify problems in what may be highly ambiguous situations (Benner and Tanner 1987). In other words problem solving skills are used to clarify the situation.

Common-sense understanding

In using common-sense understanding the nurse is connecting with the patient/client on a deeper level. The nurse has a good understanding of culture and language so they can understand diverse situations. S(he) moves from seeing the patient/client as someone with a disease to someone who is experiencing illness due to a specific disease (Benner and Tanner 1987). It is argued, that in this study, this equated with the ability to move from task orientated learning to learning holistic care giving.

Sense of salience

This is when an expert nurse displays the ability to differentiate between what is relevant and pertinent to a situation and which aspects can be safely ignored (Benner and Tanner 1987). This ability is taken for granted by those who possess it (Benner 1984).

Skilled know-how

According to Benner and Tanner (1987) skilled know-how is based on embodied intelligence. It involves visualisation and the ability to think skills through from almost an internal perspective. Benner and Tanner (1987, p26) give the example of "when inserting an intravenous catheter, for example, the experienced nurse probes with the catheter tip as if it were an extension of her fingers, not an unwieldy foreign object."

Deliberate rationality

This is the ability to elucidate one's prevailing perspective by considering how that perspective would change if the situation was interpreted differently (Benner and Tanner 1987).

It is argued that some students in this study, were beginning to develop intuition by displaying two out of six Dreyfus and Dreyfus's (1996) key aspects: pattern recognition and common-sense understanding. Although Benner claims that intuition is the sole prerogative of expert nurses, there must be a developmental phase. It is postulated that some students are exhibiting early indications of the developmental phase of intuition.

Expert Practitioner

According to Benner (1984) this is characterised by intuitive practice. The practitioner has a holistic view which develops from experience. According to Meerabeau (1992) their knowledge is embedded within their practice. She refers to Polanyi's (1958; 1967) tacit knowledge which is "when we know something only by relying on our awareness of it for attending to a second activity" (Meerabeau 1992, p109). Thus the expert nurse functions intuitively and is able to grasp, analyse and make decisions based on intuition (Benner 1984; Benner and Tanner 1987; Thomson 1992; Macleod 1996). Jasper (1994) suggests that experts develop 'rules of thumb' that allows them to function as they do. Dreyfus and Dreyfus (1996) insist that expertise does not inevitably apply to a whole skill domain, but applies to at least to some significant part.

Rubenfeld and Scheffer (1995) and Paley (1996) state that intuition is not the sole prerogative of expert nurses; beginners possess it in varying degrees. It is generally accepted that intuition is acquired through experience with patients (Pyles and Stern 1983; Paul and Heaslip 1995) with students using reflective practice to enhance their understanding of the total patient care situation (Correnti 1992; Paul and Heaslip 1995). The more the student experiences caring for patients with similar conditions, the more they will develop and use intuition to guide their reasoning and decision making (Pyles and Stern 1983; McCormack 1993; Paul and Heaslip 1995). Crow and Spicer (1995) believe the learning of signs and symptoms associated with particular conditions forms the basis of intuition in medical students. The same could be said of the development of intuition in Project 2000 students who experience looking after patients with similar conditions, particularly now that wards are increasingly specialist based.

Paley (1996) asks the question - why do some nurses acquire intuition while others who ostensibly have the same experience, do not? Many reasons exist why this may be so. It could be argued that since intuition is often accompanied by negative remarks, there is a tendency to deny its existence.

Alternatively, the difficulty in defining and measuring intuition could have a bearing since if we cannot measure it, it could be argued that it cannot exist. It could also be that some individuals are more able to think more intuitively that others and can experience the six characteristics specified by Dreyfus and Dreyfus (1996). Correnti (1992) outlines the attributes that facilitate intuitive thinking: direct patient contact and nursing experience; openness; desire to 'tune-in'; energy; self-confidence; and a caring nurse patient relationship.

Benner extended her 1984 study by conducting a six year study with a sample of 130 critical care nurses, the majority of whom had a Baccalaureate degree. Benner et al (1996) used a narrative approach and interpretative phenomenology to access the every day practice of critical care nurses. Only trained nurses working in specialist areas were used. There were no student nurses included in the sample. The nurses ranged from having less than one year's experience to over five years. Some 44 nurses were deemed to be expert nurses and 26 experienced but not expert.

Benner et al (1996) report that the proficiency stage is the transitional stage to expert. Advanced beginners, presumably (not defined) were those with less than one year's experience. According to Benner et al advanced beginners are frustrated because they cannot not function as competent practitioners who can see the 'big picture.' They are anxious about their lack of expertise and consequently are very attentive to their patients and are not afraid to voice their own inadequacies. The environment is important for their learning as they function best in the safety of a routine, where they have role models and the opportunity to ask questions. Advanced beginners are able to prioritise care but on the basis of what they feel able to accomplish and often psychosocial care is neglected. As noted earlier, Project 2000 students, including those in this study, have been described to function similarly in the early stages of the branch programme.

With experience, advanced beginners become aware of the increasing number of situations they can cope with independently but Benner et al (1996) emphasise they still require emotional support from experienced nurses.

Competent practitioners were one and a half to two years into practice. In relation to advanced beginners, competent practitioners' understanding is increased and they are able to see the 'big picture'. Their technical skills, organisational ability and ability to anticipate likely course of events are also much improved. This is linked to their ability to 'see the big picture'. These nurses experience a 'conscious repersonalisation' of patient and family and in so doing can offer psychosocial support. These findings are in contrast to those of Benner's 1984 study where she stated that competent practitioners were likely to have been in the same or similar job for two to three years.

In 1984, Benner asserts that competent practitioners do not possess enough experience to perform holistically. However, Benner et al (1996) report that competent nurses can indeed perform holistically. Certainly in this study, by the end of the course, students developed to the level of competency and were able to provide holistic care. The development of intuition will be explored further in chapter VIII and X.

Problems with models

According to Macleod (1996) there are problems with both the Dreyfus model and Benner's (1984) model. MacLeod's arguments are theoretical rather than empirically based. According to MacLeod, the Dreyfus model fails to explain how people move from one level to the other. Macleod (1996) states that it seems that movement happens through amassing an extensive collection of discernible situations formulated through experience. She further elucidates that people seem to make a qualitative jump between levels as opposed to making a liner progression. This supports the earlier argument that there must be a developmental phase in acquiring intuition. MacLeod asserts that the problem with Benner's (1984) model is that it concentrates on the decision making aspect of performance and rejects any other areas of performance and their development. In addition, Benner does not fully explore the nature of learning.

It is argued that Benner's (1984) findings cannot be generalised to student nurses as her sample contained only five senior student nurses, with the remainder comprising trained nurses from critical care areas. Her model is primarily directed towards trained degree level nurses who work in intensive care. The method of nurse education in the USA is different to that in Britain. Benner's premise is that individuals develop from novice to expert through experience. Baccalaureate student nurses tend to have a preceptor allocated in their final semester whereas Project 2000 students have a 'mentor' for the whole three years. Thus their experiences are likely to be markedly different from Baccalaureate students. It is not surprising therefore that the Benner model does not fit the development of skills in student nurses in Britain. It should be noted, that Benner (1984) never intended that her model should be used with student nurses. Perhaps that is the reason why her replication study omitted student nurses.

It is postulated that Project 2000 students have a very different practice experience from their American counterparts and perhaps this explains why they appear to progress further along the novice - expert continuum prior to completing their basic course. The increased use of reflection in and on practice in Project 2000 courses may also enhance this process as students learn actively from their experience (Correnti 1992; Paul and Heaslip 1995). This argument is supported by Benner (1984, p36) as she states that experience "does not refer to the mere passage of time or longevity. Rather it's the refinement of perceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory."

6.6 What makes a good placement?

By the end of term eight, students were more focused and able to offer the factors that contributed to making a placement a good or bad learning experience. It was noticeable, that the students were describing the fuller picture of a good experience as opposed to having a good mentor. This links with their development to view the patient holistically.

Invariably good placements were areas where the staff and their mentor were considered to be excellent; worked as a cohesive and effective team; were approachable, knowledgeable, enthusiastic, supportive and engendered confidence in the student. There was a feeling that it was the ward staff that made the placement good and not the particular speciality. As Claire stated: *"The more and more I have come to realise it perhaps is not the type of nursing or the ward or the area of nursing, the speciality or branch or whatever, it is more the team that you are working with that makes a good placement."* This is in contrast to Smith (1987) who included the ward speciality along with working relationships as crucial variables that affected the learning environment.

In this study, the working relationship with their mentor and other staff was facilitated by the relaxed but efficient student-friendly atmosphere, the positive attitude towards student learning and the staff's realistic ideas regarding what students could do at certain stages of their course.

Elizabeth: *"They knew the level that you were at and they were prepared to let ...you take enough responsibility to let you feel as though you were working independently but also within the team. They never let you feel that you couldn't cope with it. There was a good balance. It was a really good placement."*

Sarah: *"If there was something happening that I hadn't done, well it was look come and see it and the next time it happens you can do it."*

In good placements, students' learning was seen by trained staff as very important and was facilitated in a number of ways; clear explanations, willingness to answer questions even when they were busy and providing good role models for the students. Teaching programmes and learning materials were available. The staff's teaching skills were appreciated and particular mention was made of staff supporting them while they learnt new skills. It was evident that the staff were committed to teaching students.

Having a good placement had a positive effect upon the students. Students described development in their self-esteem and that they felt wanted and valued. One student in particular who had written about how difficult she found being assertive, experienced a different feeling when she was in what she felt was a good placement.

Louise's diary: *"I suspect that part of the reason for this 'student-friendly' atmosphere is the high level of dependency of patients in the post operative area.... I have felt it much easier in this atmosphere to be assertive about articulating my learning needs .... I felt comfortable today about asking a staff nurse already armed with a syringe if I could give the injection, whereas I suspect that in other placements I would have just kicked myself that I had not asked in time."*

A good placement was one where students felt safe to learn, where they were supported and nurtured and where there was a genuine interest for them as an individual with particular learning needs. Inevitably when the end of their placement arrived, the students found it difficult to cope with leaving.

Sarah: *"Overall the placement was absolutely brilliant, heart wrenching to leave...The whole atmosphere was just perfect for students. We were made to feel like a valued member of the team. Every member of staff was brilliant, they all acted as a mentor but the designated mentor was absolutely fantastic - I'll miss her!".*

6.7 What makes a poor placement?

Students could describe equally what they felt was a poor placement. It had certain characteristics; negative ward atmosphere, lack of nurture, poor teaching, and gave students a feeling of being used. The ward environment was unwelcoming and indeed students talked about being ignored. Students felt a visitor rather than a member of the team. They felt undervalued and at times they felt disowned by the trained staff.

Sarah: *"I think the staff that were there were very close knit, ... and I felt as a student you are the visitor. You are only there for five weeks therefore they get very impersonal with you."*

Mary: *"...myself and the other student would cover the ward with an auxiliary and they would go for their tea together and then they would let us go for our tea together so it wasn't as if they were treating us as a member of the team or trying to include us."*

The negative ward atmosphere had a profound effect on the students and obviously affected their learning on the ward. The lack of nurture was related to the negative ward atmosphere and lack of encouragement. Students felt staff were either too busy to bother about them or lacked trust in their abilities.

Kirsty's diary: *"A bad start to this placement. I did not have contact with my mentor at the beginning of the week. When I started on Monday I was left to work without supervision, although there was not a lot to do. I got the distinct impression either the staff did not like Project 2000 students or did not like students of any kind!"*

Claire: *"When we got there, the first thing I asked was had a mentor been allocated. It was a busy ward and no they hadn't. Nothing, they would let us know soon. We started on the Monday, there were two of us there and by the Friday we still hadn't been issued a mentor. When we were allocated mentors it was a matter of nobody has picked you up, we might as well."*

Elizabeth: *"It wasn't that anybody turned round to me and said that I was incompetent or a bad nurse but I just didn't get the encouragement that I needed and it has left me feeling quite unsure."*

Not surprisingly, students stated that poor placement areas also had poor teaching and learning opportunities. The lack of nurture and interest in the student was reflected in the staff's poor attitude to facilitating the students' learning. Students described barriers being put in the way of their learning and complained that the staff were not knowledgeable about their course. Students' learning was seen as having a low priority and important aspects such as their assessments were invariably late.

Laura: *"The next day the Sister was on and she was just screaming and shouting at everyone in the ward. She said to me that I would need to get more than three patients up before half past eight. I didn't even know the patients. I was like sorry but if you want me to assess patients, get them washed properly, assess their pressure areas and everything I am sorry but I cannot get three patients up in about half an hour. I thought it was a bad place for students to be. They were not good role models. They were not interested in the students at all."*

Claire: *"You felt as though you couldn't settle and nobody really wanted to take the onus of showing you because it was a really busy ward and unless you asked or somebody knew you wanted to see it, it was very difficult. You had to have sort of radar ears and eyes as to know what was going on to be able to get the learning experiences."*

According to Parahoo (1992a;b;c) the extent to which students feel used impinges on their morale and their ability to learn. As discussed before, students in this study, did not seem to mind being a pair of hands as long as they felt they were being treated fairly and were actually learning. However in poor placements where little learning took place, students commonly expressed how demoralising it was to be used as pairs of hands.

As Sarah stated:

Sarah: *"The more I think about it, I was dying to say look what if I wasn't here? You wouldn't have me so don't look on me like that. I really feel that they were taking advantage of me as a pair of hands."*

Students described how they felt they were being used as cheap labour to cover weekends and being asked to cover unsocial hours. This caused obvious resentment but invariably the students blamed it on the poor economics prevailing in the health service.

Having a poor placement caused students frustration, anger and resentment. They complained of the wasted opportunities and longed for their next placement which they hoped would be a good one.

Jayne: *"As I said I just hated that placement and wished four weeks of my life away. I couldn't wait to get out. It was such a relief when my final day came! I had said to her (mentor) that I had three weeks holiday at the end of it and I had to work the Saturday - you know it was just badness. I went into community and I loved it. That sort of made up for that bad experience."*

The students coped with poor placements either by putting on a brave face or being more proactive. Amy's diary read:

"I decided to shut up and get on with it....I'll need to just grit my teeth and get on with it." Amy then shared what had happened to a peer who had complained: *"The other P2000 student discussed with the Clinical Tutor, the lack of mentorship and unavailability of observing and participating with the staff nurses. The Tutor then informed the Sister who gave the student the most appalling shifts and was really nasty to her by being 'off-hand.' I felt bad as the Tutor obviously hadn't mentioned that I had voiced the same opinions as my shifts remained the same.... The Sister marked the other student's assessment book with mainly 1's, 2's and C's. A staff nurse did mine and marked me at mostly B's with some C's. I felt that the other student was at the same level as me which demonstrates why the booklets do not give an accurate guide as it wholly depends upon who is marking them."*

Only students who had particularly poor placements seemed to have experienced stigma on the wards. This finding relates to Elkan et al's (1993c) study who report that hostility and stigma diminished over time once staff became more informed about the course. It may have been that the fear accompanying change had gone.

Elizabeth: *"They would rather have knocked you down at any opportunity. It was all these stupid petty Project 2000 remarks and it really winds me up. I don't see why they don't utilise that time they are given with us more, instead of just standing there slagging us off all the time. Why don't they say come and look, come and see this and come and do this with me and give you more encouragement. I have got the feeling that they think we are just playing at being student nurses, we are not real student nurses."*

Lynne shared a blatant example of how one staff nurse felt about the HE Diploma course:

"...one of the staff nurses on my last ward did say to me that she was a trained midwife and she said she was expecting a baby and if she went in and it was a Project 2000 trained midwife she would ask for somebody else. 'No offence to you as you are not doing midwifery.' She said they hadn't done any normal general nursing and they don't know about blood pressure or signs of illness but I said they are obviously getting taught about mother and baby, it's not just the baby. They have done three years. She said 'I don't care' and that she would want a 'traditionally trained' midwife."

6.8 What makes a good mentor?

As the students' impressions of good placements had emerged, their views of what made a good mentor became even more focused. Having a good mentor remained associated with luck. The same was said of having a good placement and usually the two coincided.

The need to work with their mentor on their first day continued to be seen by some students as important, and for others it became vital.

Claire: *"I really think that they need to be prepared for you. I have always found that the best time to go in on your very first day is a backshift because they are usually not so busy. Sometimes you get the feeling that if you come in on the morning you are just going to be used as a pair of hands on your first day. Whereas, if staff roster you on a backshift they are more willing to give you time for a proper orientation. They have got their act together and you know that you are not really going to be used a extra labour."*

There is a summary of the characteristics of a good mentor encompassing the students' views from the first three interviews and diaries in Table 15, p181.

6.9 What makes a poor mentor?

Students were equally clear about what made a poor mentor. Students complained that a poor mentor invariably used them by making them work harder than themselves by delegating their unwanted jobs to them. This often resulted in the students feeling resentment towards their mentor. Students also noted that poor mentors often disliked their job and/or students and might in fact be disliked by other members of the ward team.

Lynne's diary: *"There is also quite a bit of friction in the ward as the G grade (my mentor) is not very popular and I am told by many that her care of patients is not good. She's interested in the look of the ward only! I feel so awkward when I am on a break and they sit and talk about her. As usual I just sit and say nothing. I will make up my own mind."*

Mary: *"My mentor was very busy herself and she - when I first went in - it was the first time that I had ever felt any hostility from a mentor. I went in and introduced myself. I am here as a student and I asked 'Who is my mentor?' She looked in a book and said 'Oh I am' (grudgingly) like this (rolling eyes.)"*

By the time of the third interview, about a third of the students had experienced what Darling (1985b) called the fourth type of toxic mentor: Underminer or Belittler. Students usually coped by keeping a low profile.

Sarah's diary: *"I can't say I really took to her (mentor), she didn't really seem interested in doing any mentor-student activities. I felt a bit overwhelmed by her as she didn't really explain the procedure that we were doing yet expected me to know exactly what I was doing. I felt quite intimidated by this so I didn't approach her again with regards to learning opportunities."*

Lynne's diary: *"The last shift I worked with her (mentor) she actually shouted at another student for not knowing where some equipment was - I decided on that shift not to ask her anything unnecessary as I wouldn't like her attitude or answer."*

Another coping mechanism seemed to blame a personality clash.

Jayne: *"But she was just horrible. I don't know if it was a clash of personalities. I don't think she liked me and I didn't like her."*

Generally, students coped with poor mentors by taking a philosophical stance. They either reported to the charge nurse at the end of their placement or more commonly engineered their off duty so that they did not need to work with their mentor. In Table 18 (p195) there is a summary of characteristics of a poor mentor encompassing the students' views from the second and third interviews and diaries. It should be noted that students were deliberately not asked for their pre-placement expectations of a poor mentor as it was considered to be unfair as it might have increased their already high anxiety levels.

6.10 Mentor or no mentor?

By the end of Term eight, students continued to state that having a mentor was worthwhile. However, there was usually a qualifying statement such as only if they are good or you do not need them as much as when you were in the CFP.

Mary: *"I think for the early placements it was good to have a mentor when you were completely unsure about what you were doing. I think now you need somebody the first couple of days, to show you the ropes and guide you as to what you should be doing and the routines and whatever. After then you get to know the other members of staff and I feel most people would be willing to ask anybody, any member of staff for information rather than just relying on their mentor. So I think in the Branch, I don't think that a mentor is as important."*

Students provided a theory as to why they required their mentor less now that they were in their branch programme. Mary's explanation was typical:

Mary: *"I think you have developed and that is why you don't need your mentor. Sometimes it just makes it a wee bit more awkward as your mentor occasionally will want to work with you, because you can organise your day - you feel you can organise your day maybe better if they weren't there because they will have their way of how they would organise their day and you are at the stage where you can organise your own day and get on with things so you don't really need your mentor for a lot of the time. It's good that they are there and they are available if you have a problem or if you need something."*

However those students who actually experienced not having a mentor during Term 8 did not like it at all.

Kirsty's diary: *"I didn't have a mentor on this ward. I don't like not having a mentor as I feel I don't have anyone to turn to if I have a problem. Depending on what staff I worked with, depended on what I learned. Some staff are willing to teach you or allow you to do things, but other staff think we are there to do an auxiliary's job, they forget we are there to learn! I asked a staff nurse if he minded if I did the drugs with him - he said he did mind as he would be quicker doing them himself."*

6.11 Summary

The transition from supernumerary status to rostered service was one of surprise and challenge. Students were totally unprepared for the changing expectations of staff. Suddenly they were expected to be able to function as independently as possible with their own allocation of patients. This added responsibility caused students' to experience a huge learning curve. Although students believed that they had learnt a great deal in the process, most considered it to have been extremely stressful and that they had to become accustomed to the 'real world' very quickly.

Perhaps because the students were allocated their own patients, they were forced to look beyond the practical tasks involved in patient care. Alternatively, perhaps because they had learnt and felt competent about performing basic skills tasks, they were now ready to progress beyond learning practical tasks. Whatever the reason, students had moved away from thinking about nursing care as a series of tasks to think more holistically. Some students experienced the early development of intuition.

The transition to thinking more holistically was accompanied by a desire to learn more technical skills and aspects of care which staff nurses delivered. Students realised that they were functioning as 'glorified auxiliaries' and in order to learn beyond that, they began to assert themselves.

Students believed that they were more confident in their abilities and progressing in the right direction - away from task centred to holistic care and away from 'glorified auxiliary' towards the role of staff nurse. However, the progression towards their end goal was not always smooth.

The ability to view patient care more holistically, was accompanied by an ability to see the ward from a wider perspective. Students were able to see beyond what made a good or poor mentor, to viewing the context in which they learnt.

See Tables 18 and 19 for summaries of the characteristics of good and poor mentors.

Table 18 **Summary of characteristics of a good mentor encompassing the students' views from the first three interviews and diaries**

Perceptions of what is a good mentor (From pre-placement interview)	Views of what is a good mentor (From second interview)	Views of what is a good mentor (From third interview)
Nice	Enthusiastic and friendly	Enthusiastic and friendly
Approachable	Approachable	Approachable. Open and helpful
Understanding	Patient and understanding	Patient and understanding
Respected by others	Good working relationships with staff and respected by peers	Good working relationships with staff and respected by peers. Loves job.
Good role model	Good role model, professional, organised, caring, confident in own ability	Good role model, knowledgeable about own area of speciality
	Possess sense of humour	
Good communicator	Good communicator	Good communicator
	Knowledgeable about course and has realistic expectations	Knowledgeable about course and has realistic expectations
	Be an ally and speak up for them	Supportive
	Involve student in activities	Make them feel at home
	Good teacher	Facilitates learning. Good explanations.
	Gradually withdraw supervision	Gradually withdraw supervision
	Make effort to spend time with student	Willingly spend time with them
	Genuinely concerned and interested in student	Actively involved in their learning
	Confident and trust in student's ability	Confident and trust in student's ability
	Allow use of initiative	Allow use of initiative
	Pace teaching and steadily move along continuum from observer to participant	
	Incorporated feedback in their teaching	Incorporated feedback in their teaching

Table 19 **Summary of characteristics of a poor mentor encompassing the students' views from the second and third interviews and diaries**

Views of what is a poor mentor (From second interview)	Views of what is a poor mentor (From third interview)
Less friendly and less supportive than good mentor	Less friendly and less supportive than good mentor
Unapproachable	Unapproachable
	Often disliked job and/or disliked by other members of team
Lack of expertise, poor role model	Lack of expertise, poor role model
Lack of knowledge about the course. Unrealistic expectations	Lack of knowledge about the course. Unrealistic expectations
Ignored student	Ignored student both physically and psychologically
Poor teaching skills, not given the opportunity to learn	Often intimidated student
Tendency to allow student to observe only and not participate in care	Used student by delegating them their unwanted jobs
Not valued either as a colleague or individual. Made aware of how much of a nuisance they were. Seen as a threat to ward routine.	Failed to make them feel welcome
Tendency to over protect and not clear in student's capabilities	not interested in student learning
No structure in their teaching, chopping and changing their minds about things	Poor teaching skills
Unlikely to give feedback	Unlikely to give feedback

CHAPTER VII

TOTAL SURRENDER OF SUPERNUMERARY STATUS

7.0 Introduction

The fourth interview and diary data collection occurred after the students had been in their second period of rostered service (appendix 4). They were now fully on rostered service duties apart from their community experience. Data were subjected to a constant comparison method of analysis as before and 14 codes were identified. These were further analysed and condensed into 6 sub-categories: learning environment; mentor - gatekeeper of learning; gradual distancing; problems with mentor; lack of practical skills; and intuition. These were subsumed into one category: total surrender of supernumerary status.

Saturated sub-categories or categories are indicated by using students or all students, while sub-categories or categories which were not completely saturated are indicated by the use of most, majority or some. Once initial analysis was completed, the literature was searched to add data to the analysis and to search for negative cases.

Students continued to mourn the loss of their supernumerary status. In reality, the two concepts; supernumerary status and rostered service were incompatible unless the students were allocated to Community, Accident and Emergency or an Intensive Care Unit. In these areas, students worked full shifts but the specialist nature of nursing care precluded them from working independently and therefore, de facto supernumerary status existed. According to students, staffing levels in those areas seemed adequate to cope with supernumerary status. However in the wards, it was an altogether different picture.

Students were aware they were nearing the end of their course and resented being used as cheap pairs of hands and working as 'glorified auxiliaries.' Students in Jowett et al's (1994) study also complained of being exploited.

Labelled as rostered service, students in this study were very much seen as part of the work force and expected to take their fair share of work. This too was evident in studies by (Orton et al 1993; Jowett et al 1994; Clark et al 1996b). Indeed Clark et al (1996b) ascribe the term 'working role' to students during their rostered service.

Students compared themselves to third year 'traditional' students. There was a belief that traditional students had a greater opportunity to learn and practice more complicated tasks, such as being in charge of one side of the ward, giving reports and going on ward rounds. Students believed that their development was arrested because they were confined to performing basic nursing care which was no different to that provided by auxiliaries. The only aspect which differed appeared to be that students also made observations (obs).

Karen: *"In terms of rostered service and supernumerary I felt it was just a nightmare. All I did was work as an auxiliary nurse for four weeks. They couldn't roster you as a non-supernumerary. They rostered you as an auxiliary because you weren't a trained member of staff. You couldn't take the place of a staff nurse. I did the work of an auxiliary but was unfortunate that I could do the obs as well because you ended up doing the obs for half to three quarters of the ward."*

Davies and Atkinson (1991) note that within nursing 'doing the obs' has become routinised and is viewed as the sole province of the nurse. They suggest that 'doing the obs' is part of the socialisation process. Taking the 'obs' is viewed as a low level task. Students considered this to be a poor example of the difference between an auxiliary and themselves. They felt that there must be a greater differentiation between themselves and the auxiliaries and wanted to strive to make that so.

Sarah: *"It was a nightmare of nine weeks, it really was. There was absolutely no support whatever. Supernumerary status went out the window. You were counted in the numbers but you weren't part of the team. You weren't allowed to go on any ward rounds, social meetings, you weren't allowed to be involved in the multidisciplinary team whatsoever. You were very much a pair of hands. The first three or four weeks I was just an auxiliary. I came in, I washed, I bed bathed. The nice things I got to do were the care plans. That was it. You were just literally a pair of hands. You were just a skivvie, which I really felt was an abuse of a term 10 student."*

In agreement with other studies, students felt strongly that as a result of being on rostered service their learning suffered (Orton et al 1993; Clark, et al 1996b). This was the key cause of the upset in fully surrendering their supernumerary status.

Amy's diary: *"Missed out on some important learning skills as we were understaffed and busy. Remained to be called away from interesting things to do escorts."*

Eventually students became resigned to losing their supernumerary status but the feeling of being treated unfairly remained. Their anxiety levels rose when they considered their own capabilities vis a vis fulfilling a staff nurse's role at the end of the course. The more they were expected to act as a 'glorified auxiliary', the fewer opportunities there were to learn and practise new skills. This phenomenon has been documented previously in studies using 'traditional students' (Melia 1982;1987; Peirce 1991; Seed 1991). Some more assertive students tried to rectify the situation in which they found themselves but often to no avail.

Karen: *"Anyway I sort of said at this stage in my course, 'I feel I really need to get an insight into your job (staff nurse) as well. I need to build up the skills that I have got. I think they made a little more of a point then of including me more in some of the things, depending on which staff nurses were on. Other staff nurses said it is not that we don't want to do things with you. It's just that we are so busy we forget that you are there'. Even with the staff nurses who did want you to being doing things, you still ended up looking after your eight patients which left very little time to be doing much else I can tell you. Because I wanted to do other things as well I felt myself completely chasing my tail from the time I went in in the morning until the time that I went home at night because I was trying to do two things. I felt it was the only way I would ever learn anything."*

Amy's diary: *"I have serious considerations about whether I want to nurse when I'm qualified. Only a small part of me doesn't want to - the rest of the reason is that I do not think I am capable and have the necessary skills to do so. I really feel that I would be endangering my patients, as there is so much that I have not experienced, i.e. nursing interventions, interventions to try if others don't work, or are not suitable for a particular person, types of dressing to use etc."*

Students almost never directed blame towards members of the ward staff for the lack of learning opportunities. Rather, students took a more abstract view blaming understaffing in general or the fact that they themselves were not assertive enough.

According to students, since their last placement experiences, they had noticed that most staff seemed to have accepted supernumerary status now for more junior students. Could it be that the students on rostered service were amongst the staff who paid for the luxury of the junior students being supernumerary?

The only benefit identified, albeit grudgingly, by students of not being supernumerary was that they were more likely to be seen as part of the team but the disadvantages outweighed this advantage. Students in other studies have also reported that being on rostered service made them feel part of the team (Orton et al 1993; Jowett et al 1994; Clark et al 1996b).

7.1 Learning environment

It was noticeable that over the two periods of rostered service in the branch that students had become more aware of the importance of the ward, how it was run and how this in turn affected their learning. Students were able to differentiate between a positive learning environment and a negative one. Returning to Benner et al's (1996) model it could be argued that the students were now becoming competent practitioners because they were beginning to see the wider picture.

According to Fretwell (1982) the ward learning environment is not a static concept but a dynamic outcome of the inter-relationships of a variety of elements that are ever changing. She differentiates between a working environment and a learning environment by stating that in the latter, skill, knowledge and attitudes are transmitted to the student. From her research in 1983, she states that an optimum workload and staffing levels are pre-requisites to establishing a good learning environment but did not ensure its occurrence.

Research completed in the 1980's highlighted the ward sister's pivotal role in creating the learning environment (Orton 1981; Fretwell 1982; Marson 1982; Ogier 1982; Jacka and Lewin 1987; Ogier 1989). The ward sister was the key to team style and the emotional climate (Hyland, et al 1988 and French 1992).

Smith (1987) points out that although the ward sister is a key person, she alone does not create the learning environment. She requires good relationships with staff and patients to create a good learning environment. However studies using Project 2000 students all agreed that since the introduction of the ward manager role the pivotal role now belongs to the mentor/practice supervisor and placement staff (Orton et al 1993; Macaskill 1994; MacKenzie 1994; Nicklin and Kenworthy 1995). Evidence from this study supports that finding.

7.1.1 Good learning environment

In this study, a positive learning environment was characterised by a number of features. It was well organised, staff shared the same philosophy of care, students felt that the standard of care was high and staff were enthusiastic. The ward was considered student-friendly as staff were approachable, supportive, interested in teaching them, respected them as individuals, made them feel useful and a part of the team. Students explained that they did not feel abused or compelled to work unsocial hours to suit staff. A key feature was that the staff trusted and allowed students to participate in care independently.

Many students observed that wards with positive learning environments were also likely to have supernumerary post-registration students. However this may have been more to do with the numbers of staff in those areas than anything intrinsic in the environment. As mentioned above, Fretwell (1983) notes that an optimum workload and staffing levels are pre-requisites to establishing a good learning environment. Wilson-Barnett et al (1995) report that areas where staff experience periods of supernumerary learning themselves are more likely to be viewed as excellent by students, give appropriate guidance and act as good role models despite having heavy workloads. The following quotation from Lynne's diary is a good example of a ward with a positive learning environment. She is referring to an intensive care unit (ICU) where she should be supernumerary.

Lynne's diary: *"You really are supernumerary there. Everyday I work with a staff nurse for the whole shift. The staff are really great and they are well aware that it can be a scary place for students at first! I have had the opportunity to see and do a variety of things. The ward also have printed sheets with learning objectives for a student in ICU which gives me a good idea of the things to see and do in the short time of four weeks. One thing all the staff have in common is that they see me as being supernumerary and believe I should not miss out on doing and seeing things, even if the ward is really busy. The ward is so well organised and the standard of care is second to none."*

Table 20 illustrates what students in this study considered to be features of a good learning environment compared with those studies previously conducted.

Table 20 Characteristics of a good learning environment compared with those reported in previous studies

Findings from this study	Findings from other studies
Well organised ward	Degree of structure, planning and organisation (Ogier 1982)
Staff share same philosophy of care	Staff worked together (Orton 1981; Wilson-Barnett et al 1995)
High standard of care	Caring environment (Smith 1987). Good standard of care (Orton 1981; Fretwell 1982; Wilson-Barnett et al 1995)
Enthusiastic staff who are student friendly	Motivated, positive attitudes to nursing (Wilson-Barnett et al 1995). Friendly (Orton et al 1993, May et al 1997)
Approachable staff	Learning most effective when doubts in the mind of learner can be voiced spontaneously Revans (1964 cited in Ogier 1984) Allow questions to be asked (Orton et al 1993) Approachable (Fretwell 1982, May et al 1997)
Supportive staff	Gave support to students (Fretwell 1982)
Interested in teaching students	Keen to share knowledge (Wilson-Barnett et al 1995, May et al 1997) Make time for student (Orton et al 1993) Teaching programmes (Orton 1981)
Respect students as individuals	Respected (Orton et al 1993)
Students feel valued	Valued (Orton et al 1993)
Students feel part of the team	Included in team (Fretwell 1982; Orton et al 1993, May et al 1997)
Mutual trust	Staff trust students (Ogier 1989)
Students allowed to work independently	Freedom of expression (Knowles 1990)
Supervision	Supervised (Wilson-Barnett et al 1995)
Adequate staffing levels	Adequate staffing levels (Jacka and Lewin 1987; Orton et al 1993)

Marriott (1991) makes an interesting observation about supervision in a good learning environment. She states that there is no empirical evidence to suggest that students receive more supervision in a good learning environment as opposed to a poor one. She believes students report more supervision because they feel happy about approaching staff for help and guidance in a good learning environment.

7.1.2 Poor learning environment

According to students in this study, a negative learning environment also had clear characteristics. Invariably poor practice and inappropriate attitudes towards patients were associated with these areas. Staff did not work as a cohesive team. Nor did they follow the same philosophy of care. Staff treated students as an encumbrance and were generally unwelcoming.

Staff in poor learning environments appeared to have little or no interest in students as individuals with individual learning needs. Rather than allocate patients requiring care relevant to the students' abilities and stage in their course, there was an overwhelming routine of using them as 'glorified auxiliaries.' Students continued to believe that they were abused and that they were shown little respect. They complained that in poor learning environments, high levels of stress and workload gave little time for teaching and learning even though their mentor had the potential of being good. The following excerpts from Amy's diary and Sarah's interview capture how they felt about a negative learning environment.

Amy's diary: *"First day. Orientated by night staff. Quick orientation of emergencies, treatment room, layout etc. Doesn't appear to be any cohesiveness amongst staff. The patients aren't too happy either which I feel reflects the nursing practice. Mentor not on so I was allocated to an E grade. She made me feel awkward as she kept informing me about how busy she was, i.e. I was a hindrance. I did not feel at all welcomed but have gone past the stage of caring as I'm there to learn and not to worry about staff attitudes. I can't wait to get my patient allocation so I can just get on with things myself...."*

Sarah: *"I had a really bad time in that ward. There was no recognition of a term 10 student at all and when they did recognise that I was term 10, they didn't recognise my individual capabilities. I was told on one occasion I wasn't even allowed to use the phone. I think what they wanted me to lack confidence and be totally dependent on them. They couldn't cope that I wasn't like that."*

Table 21 illustrates what students considered to be features of a poor learning environment compared with those reported in previous studies.

Table 21 Students' descriptions of the characteristics of a poor learning environment compared with those reported in previous studies

Findings from this study	Findings from other studies
Staff not interested in students' progress	Disinterest in students (French 1992; Baillie 1993)
Students not seen as individuals	Little regard for individual learning needs (Orton 1981)
No account taken of their stage in programme	No teaching programme (Orton 1981)
Used as 'glorified auxiliaries'	
Not given appropriate responsibility for their abilities	
Abused as students	Left to 'get on with it' (Fretwell 1982) Just a pair of hands (Orton 1981)
Students given little respect	Unfriendly, uncaring (Orton 1981)
Unwelcoming staff	Unhappy staff (Wilson-Barnett et al 1995) Low staff morale (Orton et al 1993)
Students made to feel they are a nuisance/hindrance	Students seen as nuisance (Wilson-Barnett et al 1995) Discouraged from asking questions (Orton et al 1993) Not valued or wanted (Orton 1981)
Standard of care poor	Poor nursing practices (French 1992)
Inappropriate attitudes to patients observed	Poor nursing practices (French 1992)
Staff do not work together well nor follow same philosophy of care	Poor working relationships (French 1992) Lack of team work (Orton 1981)
High levels of stress and workload mitigates against teaching	Inadequate teaching, workload and stress (French 1992) Overburdened staff (Wilson-Barnett et al 1995) Pressure of work; lack of time to spend with students (Orton et al 1993)
Students not made part of team	Discouraged from feeling part of team (Orton et al 1993)

Orton (1981) notes that students in poor learning environments are treated as workers and little attention if any is given to their need to learn. This reflects closely how the students in this study felt.

7.2 Learning needs of students

Students were now more focused about their learning needs. They wanted to practice those skills they were not yet proficient in and to learn skills related to being a staff nurse. Examples of the latter were giving report, dispensing medicines and taking charge of a group of patients for a shift. This endorses earlier research related to the desire to learn technical skills (Fretwell 1982; Jowett et al 1992; Melia 1982; MacKenzie 1994; Koh 1996).

A recurring and important aspect to students was the need for their mentor on their first day to agree the students' learning outcomes for the duration of their placement. Students in Orton's (1993) and MacKenzie's (1994) studies also expected their practice supervisor to be there on their first day. Project 2000 students in Orton et al's (1993) study believed the manner in which students were made to feel welcome on their first day set the tone for the whole placement. This was endorsed by students in this study.

7.3 Mentor - the gate keeper of learning

Whilst students continued to distance themselves from their mentor, all were adamant it was vital to continue having a mentor. The role of the mentor was not redundant, just different. Students stated the mentors' main roles, in term 10, were giving crucial constructive criticism and teaching. The students felt strongly that if they did not have a mentor, their learning experience would undoubtedly suffer. Their mentor was seen as the gate keeper of learning. It was they who would, or would not, let students do and see things. It was they who allowed or refused independence and the use of initiative.

Those students who were unfortunate enough not to have a mentor, very much felt the loss. Elizabeth worked in an out patient department and her 'mentor' worked mainly on another site:

Elizabeth: *" I don't think I actually worked with her. She had no idea as to what my capabilities were at all. She didn't even know me. When she did my end of term assessment we she sat down to do it and she asked me my name to fill it into my book! I just thought how in God's name have you any idea what I am like as a nurse when you can't even remember my name! I just thought it was ridiculous. My assessment from there meant absolutely nothing."*

7.4 Gradual distancing

Students discussed the gradual distancing of themselves from their mentor. This movement was related to confidence in their own abilities and their familiarity with ward routines. There was a definite reduction in reliance upon their mentor.

Morag: *"Do you feel that you need a mentor as much in term 10 as you did in term eight?"*

Karen: *"I suppose if you are talking about a mentor as someone to follow around all day then no you don't. You don't need as intense help. But I think it is useful to have a mentor just to give your placement a wee bit of purpose. It is useful for you to have somebody you can go to and say well I worked with you last week and I have worked with you this week, what do you think? Are there any areas I should be practising?"*

Claire: *"...you are more prepared perhaps not to dote on your mentor as much. I think you start to realise and understand it perhaps. You suss them out more. You know, this person is more of a specialist in this area and you can get this type of information from this one. Perhaps even people that you feel that you can work better with or are more approachable."*

The idea that students are selective in what they imitate from chosen role models is well documented (Kramer 1974; Shapiro, et al 1978; Deane and Campbell 1985; White et al 1993; Campbell et al 1994; du Toit 1995). Role models are essentially passive (Shapiro, et al 1978; Yoder 1990) and possess the attributes of professional competence, a humanistic approach and power (Baillie 1993). Role modelling need not necessarily be associated with the role of the mentor. According to (Yoder 1990) learning from a role model does not need to involve a personal relationship.

In Benner's (1984) model the supervisor in the stage of the competent practitioner is described as being at arm's length. In this study, students described a gradual distancing from their mentor.

As Sloan and D'A Slevin (1991) point out, the competent practitioner stage is what should be expected of a pre-registration student. With gradual distancing, it could be argued that students are beginning to make the transition from advanced beginner to competent practitioner. This is obviously in conflict with Benner et al's (1996) interpretation of their model as they state that competent practitioners have usually been in the same or similar job for 1.5 to 2 years. However it is agreed that in the UK we cannot interpret Benner's model in the same way as our own students are generally more competent given the nature of their clinical experience.

7.5 Good mentoring experiences

Students continued to have the same opinions and beliefs as to what made a good mentor. No additional characteristics were noted and thus the category remained saturated. The description of the good mentoring experience was more perceptive that had been in previous interviews and diaries.

Claire: *"Probably in that area I felt I had more of a mentorship almost going with a student of October 92 (now a staff nurse of 5/6 months). He was excellent. He seemed to know about our style of training, things we need to see. He was always, constantly perhaps, looking out for you if he knew things were going on within the area. It was very easy to cut yourself off from what was going on in all the cubicles (in A & E). Sometimes it was difficult to know what was happening. He was brilliant. He would come and seek you out."*

7.6 Poor mentoring experiences

The students' impressions of poor mentors did not alter and this category too remained saturated.

Laura: *"...the way my mentor taught me was go away and do it yourself and I will correct your mistakes. It almost felt like she was putting me down all the time. It was always like I was getting my mistakes corrected and I was never getting any information beforehand to help me prevent making mistakes. So that was quite demoralising. I just thought it wasn't really the best way to do it. I did mention to the Sister before I went away but there had been problems before with that same mentor."*

The threatening aspect of the relationship was particularly interesting because the students had worked out a rationale for the staff nurses' behaviour.

Mary: "*I think that some mentors feel threatened by you. Perhaps it is the course or it's possibly with me being a wee bit older as well - I am often older than my mentor. I do find mentors who have either done the PS11(post-basic) course or have done their degree are far less threatened by us. They seem to accept us more and they are willing to give you that wee bit more. I think it's because they have just recently been in further education themselves. They know what you are sort of looking for and they don't seem so threatened....*"

It is argued that those mentors who feel the need to exert excessive control over their students may be inexperienced themselves in their own role. They may not feel capable of coping with the additional responsibility of a student working independently, for fear of the potential consequences. Further research is required to investigate this further.

7.7 Problems with mentoring

Off duty rota

It was almost as though the distancing of themselves from their mentors allowed the students to appreciate an additional two factors that impinged upon mentors. Students were often frustrated by the off duty rota. Either they were rostered on different shifts from their mentor which resulted in not seeing them for weeks at a time; or twelve hours shifts which meant that their mentor was less available to them as students only worked eight hour shifts.

Pressure of work and staff shortages

Students were very much aware of the effect of the pressure of work and lack of time and staff. They felt that there was a solution to the off duty problem and, with more attention, a better system could have been produced. However workload and lack of staff were not seen as the province of the ward staff and the students' anger and frustration were directed to those in higher authority.

7.8 Lack of practical skills?

As the students entered term 10, there was increasing criticism voiced by qualified nurses about HE Diploma in Nursing students; that is that they were less skilled than their more traditionally trained counterparts. Whilst a few students may have agreed with this, most felt strongly that it was only a transient problem that would be rectified either by the end of their course or in their first staff nurse post, in line with findings from Clark et al's (1996b) study.

Students had several rationales for why they were labelled as lacking practical skills. They realised that their course did not contain the same percentage of practice time as the 'traditional' course; the placements were shorter and fewer, and consequently it was difficult to consolidate their skills; and finally the opportunities to observe and practice new skills were diminished. Students also perceived that they were not given as much responsibility as 'traditional' students. When asked which skills they were deficient in, students invariably answered that it depended very much on the type of placements they had. Commonly there was only one skill identified; catheterisation.

Mary: *"Everything I have seen I feel that I am quite confident in doing but I don't think that I have seen as much as an old course third year student would have seen. I think I possibly learn practical skills just as quickly as they would. They would have given far more injections and set up many more I.V's that I would have at this stage."*

Sarah: "*Yes I have heard that said about our skills but I think a lot of it has to do with placements. If you are not going to get somewhere that isn't acute or isn't high dependency, then you are not going to be able to develop acute skills. That was the good thing that I valued about A & E."*

A number of students explained that many of their practical skills were not learnt until they were in the branch programme. This too may have contributed to trained staffs' perception of their skill level. In the past they had been used to students coming into the second stage of training being skilled in basic techniques and the HE Diploma students did not live up to the same expectation.

Laura: *"There are some basic things I think I still have not done. I performed my first catheter insertion when I was in community. I think - but there are some of us that still haven't done it. Same with injections. I had never done an injection until I came into term 7."*

Other students did not agree with the criticism of lacking practical skills. They believed that their skills were just as good as the previously trained students but they did accept that they were probably slower and offered this as an explanation for the criticism.

Karen: *"Well it annoys me intensely when I hear it being said. I have nothing to compare it with because I do not know what the practical skills of the other students were like but I have asked a lot of people and they do seem to have been very skilled in things like, routine stuff. Yes they can make beds quicker than us. They can but that's not to say that we can't make beds. I don't think after talking to a lot of people that the other programme turned out super nurses at the end of three years and I don't think ours does either. But I don't think practical skills is a terribly good thing to make comparisons about. Practical skills you can pick up. It's not that we don't know how to do things. We are maybe a bit slower. I think it's a handy little peg to hang their hang ups about the course on. You know we don't do things as repetitiously as they do which is probably why we are slower at priming a drip. I have great hopes that once you are in a job, in an area, for more than four weeks that your motor skills and things like that will speed up and you will pick up the skills pertinent to that area."*

The literature is replete with references to the perceived lack of practical skills in Project 2000 students (Jowett 1992; Jowett et al 1992; Elkan and Robinson 1993b;c; Greenwood 1993; White et al 1993; Jowett et al 1994; Bowman 1995; Clark et al 1996b; Parker and Carlisle 1996; White 1996). Many authors mention the anxiety this perceived skill deficit causes students, particularly in the transition from CFP to the branch (Bradby and Soothill 1993; Orton et al 1993; Hamill 1995). O'Neill et al (1993) state that it was the primary concern of students in their study. Orton et al (1993) report that 89% of Project 2000 students (n=195) in their study worried about their lack of practical skills and 83% (n=182) were worried that it would persist after they qualified.

Orton et al (1993) attribute the perceived lack of skills to qualified staff making comparisons between traditional students and Project 2000 students. Students in this study certainly complained of this phenomenon. In a quantitative study using a questionnaire, Cuthbertson (1996) reports that of those qualified staff surveyed, over 90% underestimate the actual time spent by Project 2000 students in the practice area; 65.3% (n=117) believe that students spend insufficient time in the practice area and 65.9% (n=118) feel that students qualify with insufficient practical skills.

Cuthbertson (1996, p41) concludes by stating that as qualified staff underestimate the actual time students spend in practice, "the results call into question the validity of attitudes to the local P2000 course and it seems that those opinions are based on a faulty knowledge base."

In the past, undergraduate nursing students experienced being labelled as having insufficient practical skills as it was felt that there was an inverse relationship between intellectual ability and practical skills (Luker 1984). This is reinforced by Robinson (1991b) who asserts that resistance by trained staff to the 'new' course causes similar feelings to be expressed, as found by Luker (1984). She continues to state that resistance is a strategy "to control the tide of change while the profession collectively takes time to re-assess the system by which it makes sense of its practices, values and beliefs" (Robinson 1991b, p823).

Skill development has been debated in both traditionally trained and Project 2000 trained students. As far back as 1974, Kramer argued that students' lack of confidence in their skill development was transmitted to them by their clinical instructors. This has the inherent danger of students developing a self-fulfilling prophecy and abandoning attempts to improve themselves (Bircumshaw and Chapman 1988). Bircumshaw and Chapman (1988) predict that since Project 2000 students have similar experiences to undergraduate students, the same could apply to them. The perceived lack of skills may have such an effect on students because they are convinced that they and their course are assessed on their level of skill acquisition (Orton et al 1993). Watts (1992) predicts that although the learning curve for skill acquisition in Project 2000 students is at least one year slower than in traditional students, eventually it should climb steeply to match the height of traditional students by the end of their course. Castledine (1994), aware that the same comments were made 20 years ago about the first nursing graduates, adds that due to the increased pressures, lack of time and staff, the concern currently expressed may in fact have substance. However recent research suggests that the lack of practical skills in Project 2000 students is only an initial deficit once qualified (National Audit Office 1992; Clark et al 1996b; Murray 1996).

It is noteworthy that supernumerary students in the Glasgow Experiment (1961) were found to be slow and lacking in initiative in the final phase of their training. This was attributed to the delay in participating in care as a full time team member (Department of Health for Scotland 1961). Martin (1996) proposes that the format of the CFP delays the development of skills until later in the branch programme. This seemed to be the case in this study with students reporting tasks that they were unable to develop skills whilst in the CFP because of the type of experience available in their placements.

7.9 Evolving as a student nurse

Students believed that their confidence levels had increased particularly now they had had experience of working with critically ill patients. Their assertiveness and communication skills had also improved. They were now working more independently, were more self-reliant, able to use their initiative and accept more responsibility. Students could see things coming together now and believed that this was central to their development.

Lynne: *"I was more independent and I was thinking that it is not long until I finish. The more I take responsibility and not keep going and asking people to do things, the more I do that now, the easier it will be when you are suddenly left on your own with the keys (laughs)."*

7.10 Intuition

The concept of intuition was explored again to establish whether there were any changes since term eight. Although the category remained unsaturated, more students perceived themselves to be acting more 'intuitively' although they rarely used this term to describe it. They believed that it was a skill they had developed unconsciously and that it was derived from getting to know their patients better, being more observant and picking up cues when patients' conditions changed. There are links here with the notion of developing as a competent practitioner who is able to see the wider picture. Karen described the phenomenon well.

Karen: *"It's getting more observant and noticing things because you are not so worried about the technical or practical aspects of the job, you can devote more time to other parts of the job. Whether you call it intuition - I don't think we have enough experience to be intuitive about anything really. It's like driving. Once you have forgotten about the controls, you have more time to spend on doing other things. I think we are like that too. I wouldn't say it's intuitive really."*

7.11 Summary

Students had completely surrendered their supernumerary status by the end of their second set of placements in rostered service. More emphasis was placed on learning the skills required to be a staff nurse. However, this often proved more difficult because students were still expected to function as 'glorified auxiliaries.' This caused obvious concern and unhappiness in students who sensed the end of their course approaching and having to fulfil a role which prevented them from learning the skills required of a staff nurse.

Students became even more aware of their learning milieu and easily differentiated between a positive and negative learning environment. By this stage in their course, there was evidence of students thinking more abstractly; not just in terms of the wider context in which they learnt but also in regard to their relationship with their mentor.

Students reported a gradual distancing from their mentor as they evolved in their own role but emphasised that it remained vital to have a mentor. The main roles of their mentor were now teaching and constructive feedback. Problems associated with mentorship were identified as staffing levels and off duty.

Students were aware of comments being made about HE Diploma in Nursing students lacking practical skills. Some students agreed with this assertion whilst others dismissed it. The general feeling was that they would quickly learn any new skills required of them in their new staff nurse post. The students continued to feel that they were gaining in confidence and more students reported using intuition in the care of patients. Table 22 summarises the developmental progression of students between the third and fourth data collection points.

Table 22 Evolving as a student nurse as reported by students between the third and fourth data collection points.

Third interview and diaries	Fourth interview and diaries
Confidence rising	Even more confident - probably gained through nursing critically ill patients
Need less guidance	Working more independently
Rely on mentor less	Gradual distancing from mentor
More self reliant	More capable of accepting responsibility
Increasing confidence in their use of communication skills	Communication skills further improved
Increase in their ability to use assertiveness skills	Assertiveness skills further improved
Some students report developing intuition	Some more students report being aware of intuition

7.12 Findings from member and outside validation

As discussed in Chapter III, member validation is at the heart of establishing credibility and is advocated by (Schatzman and Strauss 1973; Lincoln and Guba 1985; Stern 1985; Patton 1990; Ely 1991; Webb 1993; Koch 1994). Member validation involves participants reading the research findings and indicating whether the findings are true to their experience (Holloway and Wheeler 1996; Clifford 1997). If participants endorse the findings, this validates the researcher's interpretation (Stern 1991; Dickson 1995), increases confidence in the data (Walker 1989; Pidgeon 1996), and verifies the information (Burns and Grove 1993). Stern (1991) asserts that since the ultimate experts are the participants, their judgement should not be over-ruled.

Member validation in this study was not performed until after the final interviews. In this way the fear of influencing participants and thus altering their future behaviour was avoided (Huberman and Myles 1994).

Outside validation was accomplished by readers who had had similar experiences to the research participants. Burns and Grove (1993) believe the findings can be intuitively verified in this manner.

Following the final interviews in this study, a diary of a HE Diploma in Nursing student was written by the 'researcher' from the findings (see appendix 5). At the end of each sentence or group of sentences a square box was inserted. The anonymity of participants was protected by writing the diary in the first person. Participants' permission was obtained to use the 'researcher's diary for member and outside validation.

All students were given the following guidelines. "Please read the following diary entries of a student who is nearing completion of their Adult Branch in the Diploma programme of nurse education (Project 2000). As you read, place a ✓ or a ✖ in the box provided. If you can recognise yourself or a colleague in what you read place a ✓ in the box. If you cannot recognise yourself or a colleague in what you read place a ✖ in the box. As you read it is important to reflect back to the time indicated in the diary. There are no right or wrong answers. What I am interested in is whether you can identify with the experiences and thoughts that this student has had during training".

Since the final interviews were conducted in the last three to four weeks prior to the end of the course there was insufficient time to analyse these data and to include these findings into the diary. The diary therefore contained findings from the first four interviews. In other words, the diary covered the span from commencement of the course to the end of Term 10; that is, 30 months. It therefore seemed appropriate that the findings from member and outside validation be presented here in context with the material discussed thus far. In reality, the analysis of the member and outside validation responses did not occur until after the final interviews had been analysed and the core category established.

Member validation

The 'researcher's diary was distributed to the participants and the remainder of their cohort at the same time. This was to prevent the possible bias that may have occurred if participants had been given the prepared diary earlier than the rest of their peer group.

There were 53 diaries distributed and all were returned giving a 100% response rate. This is probably attributed to the fact that students were asked to complete the diary, independently, in class time. It was emphasised that there was no obligation to participate. Those not wishing to participate were free to leave the classroom. Informed consent was assumed to have been given if the completed diary was returned.

Outside validation

The same diary, with minor modifications made to reflect their own specific course terminology, was distributed to other HE in Nursing Diploma students in another institution. These students were at the same point in their course as the participants' group. Fifty-five diaries were distributed and a 100% response rate was achieved. The is probably attributed to the fact that students were asked to complete the diary, independently, in class time. Again there was no obligation to participate. Those not wishing to participate were free to leave the classroom. Informed consent was assumed to have been given if the completed diary was returned.

As Fuller and Petch (1995) warn analysis and reporting of the results of member validation did prove difficult. Despite a lengthy literature search, no similarly validated qualitative studies could be found. There was therefore no guidance available regarding how data should be analysed. The data were categorised using the same sub-categories and categories as in the main study and Microsoft Excel was used to calculate the percentage agreement of responses with the diary. Overall there was a 83% agreement with the diary from participants and their peer group, i.e., member validation. There was an overall 77% agreement obtained from students in the other College of Nursing & Midwifery, i.e., outside validation.

As the diary was devised in the same chronological order as the data were presented in the study, the opportunity to display the emerging sub-categories and categories was presented (see Tables 23 and 24).

Table 23 **Member and outside validation responses in relation to categories emerging during the CFP**

	Member validation	Outside validation
Anticipatory anxiety		
Fear of unknown	82%	75%
Stigma	80%	76%
Rumours	76%	91%
Role of mentor	88%	84%
Reality hits home		
Stigma	84%	82%
Settling into placement	99%	90%
Past experience as auxiliary	95%	95%
Transition placement to placement	88%	89%
Mental handicap placement	78%	75%
Mental health placement	63%	36%
Task V's Holistic care	96%	93%
Supernumerary status used as compromise	94%	96%
Part of team	98%	87%
Mucking in	94%	85%
Mentor has competing priorities	78%	84%
Need a mentor	80%	67%
Luck of the draw	94%	91%
Qualities of good mentor	95%	87%
Description of poor mentor	60%	64%
Important that mentor is there day 1 of placement	86%	89%
Fear of rocking the boat	98%	87%
Role of other staff nurses	94%	80%
Support from peers	73%	69%
Easier to ask peers questions	86%	76%
Pleased with own progress	94%	93%
Caught up with those who had prior experience	63%	67%
Cannot wait to start branch programme	95%	96%

Table 24 **Member and outside validation responses in relation to categories emerging during the Adult Branch**

	Member validation	Outside validation
Becoming a branch student		
Supernumerary Status does not work	80%	91%
RSC - changing staff expectations	71%	78%
RSC - frightening due to increased responsibility	78%	82%
RSC - expected to work as 2nd year traditional student	84%	89%
RSC - really stressful due to increased expectations and responsibility	90%	89%
RSC - terrified forget to do something	90%	84%
Important to learn technical tasks	92%	76%
Last thing you want to be is a glorified auxiliary	100%	91%
Now thinking holistically	98%	95%
Difficulties arise when excluded from information	96%	89%
More confident in abilities	84%	82%
Can cope with increased responsibility	80%	87%
Not so reliant on mentor	96%	91%
Picking up cues from patients, notice more things	94%	95%
Characteristics of good placement	98%	93%
Characteristics of poor placement	85%	86%
Total surrender of supernumerary status		
Continue to mourn loss of supernumerary status	94%	93%
Characteristics of positive learning environment	76%	73%
Trusted to work independently	96%	82%
Not abused	98%	87%
PS II students have positive attitude and help you learn	84%	76%
Characteristics of negative learning environment	53%	54%
Gradual distancing from mentor	57%	62%
Poor skill development	93%	86%
Skill development depends on the placements you get	98%	82%
Agree not as efficient or as quick as traditional students because there is not so much practice in our course	96%	91%
Once in first staff post, our practice will be as good as others	92%	75%
More confident especially after working with critically ill patients	90%	85%
More self-reliant, happy to use initiative and take more responsibility	83%	93%
More observant, notice things more quickly (beginnings of intuition)	94%	93%

Students were invited to make their own written comments at the end of the diary. The following quotations are divided into those from the member validation group and those from the outside validation group.

Comments from member validation group

"I have found that in some of the other type of courses students often had the practical skills and confidence we sometimes lack but overlook other aspects of care such as dignity, confidentiality, effective infection control, often taking short cuts."

"Although I have worked as an auxiliary, it was not in a hospital setting, and was very different. Reading this diary was like reading your own diary!"

"An excellent account of life as a P2000 student, which I could relate to."

"This was too long winded and not very clear!"

"Who found my diary! - pretty well representative"

"Very accurate. I can relate to almost all of these situations. Being an auxiliary first gave me confidence in my first placements because I was never left loitering around. I would just do auxiliary jobs, e.g. flowers, cleaning, clothes etc. Whilst it kept me busy it also helped to build a friendly relationship with staff."

Comments from outside validation group

Again students were asked to make their own comments in the space provided at the end of the diary. None of these students took this opportunity but they did write in the margins of the diary to emphasise the point they were either agreeing or disagreeing with. Unsolicited verbal feedback was very positive, with students agreeing that the diary was a good representation of the life of a HE Diploma in Nursing student. A few remarked that it felt as if someone had been looking at their personal diary.

It can be seen from Tables 23 and 24 that there were four distinct aspects which neither group of student scored higher than 65% agreement.

- Mental health placement. In the actual study, this category was never saturated. The mental health placement caused about half of the students concern and difficulty. The responses from the outside respondents reflect this finding.

- Characteristics of a poor mentor. The reduced agreement here may have been attributed to the students' reticence in criticising a poor mentor whom they considered otherwise to be a good professional.
- Characteristics of a negative learning environment. Reduced agreement here could be attributed to a lack of experience of negative learning environments to make informed comments, or reticence in apportioning blame on ward staff for poor learning environment.
- Gradual distancing from mentor. The reduced agreement here could reflect the students' continued need for a mentor and perhaps reflected their anxiety of their impending role change.

In conclusion, the overall member validation was 83% whilst the overall outside validation was 77%. From these findings it is argued that credibility of these findings has been established (Ely 1991).

CHAPTER VIII
THE END IS NIGH

8.0 Introduction

The final data were collected in the students' last four weeks of their course. Data were subjected to a constant comparison method of analysis as before and 14 codes were identified. These were further analysed and condensed into five sub-categories: management experience; learning environment; role of ward sister; future mentoring; and students' development. These five sub-categories were brought together in one category: the end is nigh.

Saturated sub-categories or categories are indicated by using students or all students, while sub-categories or categories which were not completely saturated are indicated by the use of most, majority or some. Once initial analysis was completed, the literature was searched to add data to the analysis and to search for negative cases.

The data collection period covered the students' six week elective and four week management placements. The elective experience was related to adult health and located either locally or abroad and was one which students looked forward with eagerness. The majority of the students in the study chose to go to an area of speciality such as oncology, cardio-thoracic, HIV/AIDS unit, Burns and Plastics, High Dependency and Theatre. A few chose medical or surgical units. They all reported their elective placement as interesting and extremely worthwhile since they felt they had learned so much. They also mentioned that if they had not chosen that particular area they would have missed out on the special experience that was afforded them.

Lynne: *"It was really, really good. I picked oncology but then before I went I didn't know if I was going to like it, you know, that's why I picked it because I had trouble dealing with oncology patients...."*

Morag: *"Do you think it was worthwhile?"*

Lynne: *"Yes I do because I wouldn't have got an oncology placement otherwise. I learnt so much there. I don't know lots but I learnt so much more....just the experience I had from the staff and learning from the patients too, I felt really helped me. I was really glad that I picked there. I was glad I went."*

Lynne had the strength of character and confidence (like many of the students) to apply herself to a situation where she knew she had had difficulty in the past. Lynne believed that her increasing confidence with oncology patients freed her from the almost paralysing anxiety she had and allowed her to move on to reflecting on nursing practice.

8.1 Management experience

On the whole, the students' experiences in their management placement were also positive. All students commented on how, as Term 12 students, they were treated differently and felt they were given more respect. They stated that they felt valued and that their opinions counted. Students who returned to areas where they had previously been, believed that this was advantageous since they already knew the staff and the ward routine.

Students experienced being supernumerary for part of this placement and being on rostered service for the remainder. In their elective placement, the students were supernumerary and they all took advantage of this to enhance their learning by visiting other areas associated with their chosen placement. However, in their final placement, they were on rostered service with the express objective of gaining management experience.

Since the students were nearing the end of their course, they were asked to reflect upon the value or otherwise of both supernumerary status and rostered service in their education. Generally they felt being on rostered service helped them learn more and become used to working shifts.

Students reflected back to times when they were supernumerary and not being allowed to practise things because their mentor or other staff nurses believed it was quicker if they did it themselves. Whilst on rostered service, students felt more part of the team and were given more responsibility.

The main disadvantage of being on rostered service was the lack of opportunity to leave the ward to observe care and treatments in other areas. However by the time they reached their management placement, students could see that it was more valuable to stay on the ward and learn how the team worked. In respect to supernumerary status most of the students expressed the view it was good to have it at the beginning of their course. Being supernumerary helped them to find their feet. However once they ward became busy, they had to abandon their supernumerary status and 'muck in.'

Students also reflected that in CFP they were addressed as either the student or the supernumerary whilst they were more likely to be called by their first name on rostered service. By term 8, most students felt they were beginning to adapt to losing their supernumerary status. However, they were aware that some of their peers felt unprepared for this and wanted to prolong their time as a supernumerary student. By term 10, they all felt happy to be on rostered service. Lynne sums up this feeling well.

Lynne: *"I think it was good you had the shorter hours (when supernumerary) because it sort of breaks you in gently. When you go on rostered service those extra 2 hours seemed like an eternity but it was good to see the whole shift. I felt there were times when things were going on that would be a learning experience for me but they couldn't spare me on the ward. I thought we weren't going to be used as the traditional students were but it didn't always work that way. There were times when I would get to but when you came back you knew they just couldn't cope without you. You got the feeling that if you hadn't gone down to watch something it wouldn't have been so bad. But when I speak to staff nurses just now, there are so many things they didn't get the chance to see and they say make sure that you get to see as much as possible. It was good to be rostered service because the only way that you can learn is just getting in there and doing it all."*

Students concentrated on learning as much as possible of the staff nurses' role in their management experience. Many were pleasantly surprised that were now doing things that in the past, had filled them with awe.

Karen: *"Somebody else said to me over coffee the other day - 'I used to think that the ward sisters were great or the nurse in charge. She used to know all the patients in the ward and what was going on with them and all the rest of it. What a skill that is - how do you pick that up'? Then he said 'I know it's not that difficult now because when I was in charge for four shifts during my management experience everybody comes to and reports to you about everything that is going on'. As a student, you don't get all the information but I suppose as the person in charge all the information channels through you a lot of the time."*

According to Melia (1981) students complain that trained staff do not give them sufficient information about patients that they are nursing. Melia calls this 'Nursing in the Dark.' From Karen's comments, it seems that the phenomenon of nursing in the dark still persists.

Much of the students' confidence stemmed from knowing that they could function as a staff nurse in the future. Mary: *"I really felt that I was managing and organising the care. It was good."*

Laura: *"The first week she (mentor) let me settle in which was nice. Then she said, 'right change roles, I am the student and you are the staff nurse. That's it for the next three weeks' and she stuck to it. She really did."*

Claire: *"If you were allocated a bay of patients it was great because it was up to you to manage their care, to prioritise your work and delegate work to others. In that respect it was quite good management experience."*

The realisation that they were about to embark upon their future career as a staff nurse was welcomed by some of the students and feared by others. Some were more than ready to fulfil the role of staff nurse, whilst a small number feared the loss of their student role. The latter is best expressed by Elizabeth herself who felt this most acutely.

Elizabeth: *"I don't know. I am beginning to look back on my three years and think I wish I had done that and I wish I had done this. I am the first person to admit that I am not the most studious person and I really do have to push myself into studying. But I have probably done more studying in the last month off my own back, than I have in the last three years because of the panic. I know it's not true but I feel I don't know enough. I feel that I don't have enough experience and enough confidence. I just wish that there was just something in between being a student and a staff nurse. It just seems like such a huge step to take."*

Elizabeth had never been the most confident of students and freely admitted that she was a worrier. Her anxiety seemed to be related to the number of poor placements she had experienced and that her last placement had also been poor. It was therefore hardly surprising that her confidence was at a low ebb.

Elizabeth: *"I feel completely unprepared but I think that it is just a sense of panic because when I was on the ward, I wasn't doing the work of a staff nurse, I wasn't getting the responsibility of a staff nurses but a lot of the time that was frustrating me. It wasn't like oh thank goodness. I don't know whether it is just me but you hear people saying oh everyone feels like this and you will be fine. But I am not convinced."*

The majority of the other students felt quietly confident about their impending role change.

Karen: *"Well I am happy that I am standing on the edge of the diving board, ready to jump in, if that is a good analogy (both laugh). You know how you think oh well I can't put this off any longer. Obviously it is going to depend what areas you are sent into but I think when you get majorly frustrated in wards, at certain things, it's a sign that you are really wanting to take on the responsibility and do it. I am not saying that I won't be scared stiff."*

Lynne: *"I wouldn't have said 'yes' before my management placement but I think doing that and with it being such a busy ward and managing, you know making mistakes but seeing them and learning and still managing at the end of the day, made me think, well I suppose I can do it. I know that there is more to learn and I am still willing and wanting to learn so much. I think I am ready. Even if I had another 10 placements I wouldn't feel anymore confident. I feel that I am ready. Any more time as a student wouldn't really benefit me. I would rather be a staff nurse and start learning a whole new role."*

Mary: *"I feel ready in as much as I won't hurt anybody (both laugh). I think that I can go and do the job. Anything I don't know I will be able to look up or find out. I know that I don't know half of it and I have an awful lot to learn. I know from what I do know, that I won't do anybody any harm, I don't think. I could monitor anybody or look after anybody and if there is a problem, I can let the proper people know that there is a problem. I am keen to start working as a staff nurse now."*

Sarah: *"I am looking forward to it. Obviously I am apprehensive. It is a hell of a big jump. I feel because I got so much good management that I could handle it. I am very much looking forward to it. There is no point in being scared about it because it is inevitable now. I am ready for it now. I am glad I had such a good placement because I feel some of the others haven't. They weren't getting as much management as they could."*

When questioned about their skill level, the students consistently stated that this was very much related to where they had been lucky or unlucky enough to be allocated during their course. Students commented on how the acquisition of a good level of skills can be accomplished. It required the combination of a good mentor, a good learning environment and a student who was assertive enough in ensuring that she learned.

All the students, except Elizabeth, felt competent in their skills base and that nothing would unduly concern them. This finding is in contrast to Robinson et al (1992b) who predicted that students about to complete their programmes would probably feel less confident in emergency situations. The students in this study had had learning opportunities in intensive care units, accident and emergency or theatre that would have potentially afforded them the opportunity to be involved in emergency situations. There was no reference made to any doubts regarding their ability to cope in emergency situations, so perhaps they felt competent in this area. Alternatively, it could also have been that students were unaware of lacking any emergency skills.

Catheterisation continued to be the only skill that most students mentioned that they had not practised. Catheterisation was one of the skills identified by students in Jowett et al's (1994) study as requiring more practice. Elizabeth felt she was lacking in her technical skills because she had not had a placement in Accident and Emergency or theatre. Most students were philosophical about their skill level. They believed that anything they felt they could not do was because there had been little or no opportunity to see and or practise it and not because they were incapable of doing it.

Claire: *"Sometimes things have happened when you have been there but because the ward is busy or a member of staff has forgotten and you haven't seen it. I will just learn when I am on the ward. You just can't worry about not having everything under your belt or not having done everything ten times. As long as you know what you feel competent in doing and if you are unconfident in doing something you are just going to have to ask another staff member to supervise what you are doing."*

Lynne pondered on her skill acquisition during her education and explored how she developed from simply performing skills to using a holistic approach to nursing.

Lynne: *"In term three if you were doing a bed bath, you would do your bed bath and be chatting away and that would be it. Whereas now if you were doing a bed bath, you'd be assessing the patient, you would be thinking about their breathing, their skin, you would be doing all that. Whereas before you were just thinking, right, bed bath, clean the patient and that was it. Whereas now you are bringing so much more into it and you are thinking much more widely. You are not just looking at, I mean doing a dressing, before you would be just so focused on your aseptic technique that you weren't thinking about the patient. You were just making sure that you didn't touch the wrong forceps whereas you can do that but you are also looking at the patient and seeing if they are in pain whereas before I would be too busy concentrating, I wouldn't be taking in anything else. But now you are no much more experienced and you look at things differently."*

Lynne's quotation is an example of the development of students from concentrating on the accomplishment of tasks to the ability to see the wider picture and provide holistic care of patients. Using Benner's (1984) model, these students had achieved the level of competence as opposed to nursing students educated by the Amercian system who only seem to achieve the level of advanced practitioner on qualification. There are undoubtedly complex reasons why this may be so and this is another area for further research.

8.2 Learning environment

In the latter part of their course, students were able to reflect more on the actual learning as opposed to classing the placement as good or bad. This ability seemed to mirror their ability to see the provision of care in a wider context.

8.2.1 Good learning environment

This category was quickly saturated. A good learning environment was essentially made by the ward staff. It was the staff who made their experience interesting and enjoyable as opposed to the speciality of the placement. Students were able to describe the components which they felt determined whether there was a good learning environment.

Students were made to feel welcome and staff were genuinely interested in them. The staff worked together as a cohesive team sharing the same philosophy of care that invariably was of a good standard.

The staff were geared up for students in terms of teaching materials and their teaching strategies. Students commented that in a good learning environment staff were patient and paced the teaching/learning for the student according to their individual needs. They made time to teach students and gave them at least the occasional tutorial. Perhaps most importantly, the staff demonstrated their confidence and trust in the student by allowing them to practice some aspects of care independently. Table 25 illustrates the characteristics of a good learning environment as perceived by students over time compared with characteristics found in other studies.

Table 25 Characteristics of a good learning environment as perceived by students over time compared with characteristics found in other studies.

Findings from term 10	Findings from term 12	Findings from other studies
Well organised ward	Well organised ward	Degree of structure, planning and organisation (Ogier 1982)
Staff share same philosophy of care	Staff share same philosophy of care. Worked as a cohesive team	Staff worked together (Orton 1981; Wilson-Barnett et al 1995)
Standard of care was high	Standard of care was high	Caring environment (Smith 1987). Good standard of care (Orton 1981; Fretwell 1982; Wilson-Barnett et al 1995)
Enthusiastic staff	Enthusiastic staff	Motivated, positive attitudes to nursing (Wilson-Barnett et al 1995) Friendly (Orton et al 1993)
Approachable staff	Approachable staff	Learning most effective when doubts in the mind of learner can be voiced spontaneously Revans (1964) cited in Ogier (1984). Allows questions to be asked (Orton et al 1993) Approachable (Fretwell 1982)
Supportive staff	Supportive staff	Gave support (Fretwell 1982)
Interested in teaching them	Genuine interest in them as individuals. Geared up for teaching students; teaching materials and strategies used.	Keen to share knowledge (Wilson-Barnett et al 1995) Makes time for student (Orton et al 1993) Teaching programmes (Orton 1981)
	Good teaching skills - patient, paced teaching/learning according to student's needs. Gives occasional tutorial	
Respect students as individuals	Respects students as individuals	Respected (Orton et al 1993)
Make students feel useful	Made to feel welcome	Valued (Orton et al 1993)
Make students feel part of the team	Makes students feel part of the team	Included in team (Fretwell 1982; Orton et al 1993)
No abuse of students working unsocial hours to suit staff		
Staff trust students	Demonstrates confidence and trust by allowing students to practise independently	Mutual trust (Ogier 1989)
Staff allow students to work independently	Demonstrates confidence and trust by allowing students to practise independently	Freedom of expression (Knowles 1990)
Supervision		Supervised (Wilson-Barnett et al 1995)
Adequate staffing levels	Adequate staffing levels	Adequate staffing levels (Jacka and Lewin 1987; Orton et al 1993)

It can be seen in Table 25, that many of the findings from term 10 and term 12 confirm previous work. However there are slight differences in the students' perceptions of a good learning environment between terms 10 and 12. Students in term 12 rated teaching skills in the equation as well as the need for a cohesive team. The characteristic of a cohesive team in a good learning environment has been mentioned in previous studies (Orton 1981; Wilson-Barnett et al 1995). The students' belief that in a good learning environment staff pace their teaching according to the students' needs, has not been noted elsewhere.

Supervision was no longer mentioned by students in term 12, probably because these students were for the most part, working independently with little supervision. This is in contrast to findings from Wilson-Barnett et al (1995). This may reflect the differing nature of the present study to other Project 2000 studies. In common with the majority of research into Project 2000, Wilson-Barnett et al's (1995) study was broad ranging whereas in this study there was a more specific focus and it was possible to note changes over time.

Another omission in term 12 was the abuse of students by making them work unsocial hours to suit trained staff. It is possible that the students were now socialised to an extent that they see the necessity of this strategy. Alternatively, students no longer viewed working shifts as suiting trained staff. Rather, working shifts was regarded as part of the working life of a staff nurse and therefore part of their learning. This aspect requires further research.

8.2.2 Poor learning environment

All students admitted that they had experienced a poor learning environment at some point in their course. They often communicated their views of a poor learning environment with a degree of bitterness. They believed it did not have to have been that way and that it was a wasted opportunity in a course where they felt they got little enough time in the clinical areas. This category quickly became saturated.

The characteristics of a poor learning environment were as follows: staff were not interested in them; staff worked independently and there was little of evidence of team spirit; students did not learn anything and were in the most part unhappy.

Some students had the impression that patient care seemed to be of a poorer standard in a poor learning environment and that patients seemed less happy too. A consistent feature of poor learning environments was poor staffing levels. Table 26 (p251) illustrates the characteristics of a poor learning environment as perceived by students over time compared with characteristics found in other studies.

As can be seen from Table 26, the issue of being used as a 'glorified auxiliary' is not reflected in other studies. Students no longer complained about being treated as 'glorified auxiliaries.' Perhaps this was because they had acquired most of the technical skills required and felt reasonably confident in their ability to perform them. It is noted that in term 12 students no longer mentioned being made to feel a nuisance or complained that they were not given the appropriate responsibility. Since students were now more than likely to be functioning almost independently. They were more likely to feel part of the team rather than a nuisance or hindrance. They were also more likely to accept, take and assertively demand responsibility.

Students in this study identified characteristics of a poor learning environment which are not noted elsewhere; being used as 'glorified auxiliaries' and not given appropriate responsibility for their abilities. As noted previously, this may reflect the differing nature of the present study to other Project 2000 studies. However despite one of the aims of Orton et al's (1993) study being 'to assess the quality of the learning environment for Project 2000 students' and 'to conduct a small scale replication of Orton's (1981) study,' the aforementioned findings of the present study were not evident in Orton et al's (1993) work. This might be attributable to the longitudinal and qualitative nature of this study since data were detailed and well described.

Table 26 Characteristics of a poor learning environment as perceived by students over time compared with characteristics found in other studies.

Findings from term 10 of this study	Findings from term 12 of this study	Findings from other studies
Staff not interested in students' progress	Staff not interested in students' progress	Disinterest in students (French 1992; Baillie 1993)
Students not seen as individuals	Students not seen as individuals	Little regard for individual learning needs (Orton 1981)
No account taken of their stage in programme	No account taken of their stage in programme	No teaching programme (Orton 1981)
Used as 'glorified auxiliaries'		
Not given appropriate responsibility for their abilities		
Abused as students	Students most unhappy	Left to 'get on with it' (Fretwell 1982) Just a pair of hands (Orton 1981)
Students given little respect	Students given little respect	Unfriendly, uncaring (Orton 1981)
Unwelcoming staff	Little team spirit	Unhappy staff (Wilson-Barnett et al 1995) Low staff morale (Orton et al 1993)
Students made to feel they are a nuisance/hindrance		Students seen as nuisance (Wilson-Barnett et al 1995) Discouraged from asking questions (Orton et al 1993) Not valued or wanted (Orton 1981)
Standard of care invariably poor	Standard of care invariably poor	Poor nursing practices (French 1992)
Inappropriate attitudes to patients observed	Patients often unhappier than those in good learning environment	Poor nursing practices (French 1992)
Staff do not work together well nor follow same philosophy of care	Staff worked independently	Poor working relationships (French 1992) Lack of team work (Orton 1981)
High levels of stress and workload mitigates against teaching	Poor staffing levels Did not learn	Inadequate teaching, workload and stress (French 1992) Overburdened staff (Wilson-Barnett et al 1995) Pressure of work; lack of time to spend with students (Orton et al 1993)
Students do not feel part of team		Discouraged from feeling part of team (Orton et al 1993)

Sarah: *"You see her (sister) as a higher mentor if you know what I mean. You know you have your mentor who is possibly a D or an E but then in most wards you only have one sister per ward. I don't know, I think I see her as a higher mentor and if she is very good that is the type of role model that you want to take on for the future. Whereas if you get on very well with your lower grade mentor, if you know what I mean, that's something you want to see yourself in the immediate future."*

Karen was more critical in her view of the ward sister's role.

Karen: *"I would say really on the whole, that they are not any driving force at all. In fact if they are the people who make up the off duty - you would think it would be common sense and it's not and I think that is a real problem. One of the key problems is that you work shifts with your mentor and it is just not happening in a lot of cases. The other girl ... with me, it was a week and a half before we were given a mentor and her mentor was going off on 3 weeks annual leave in 2 days time! How stupid can you get! It just isn't thought through. I wonder if that it is because the wards don't perceive the role of the mentor as being critically important?"*

Karen's suggestion of ensuring that off duty was planned more effectively so that mentor and student could be on the same shift is also proposed by Omerod and Murphy (1994). However, as Eraut et al (1995) point out just because both student and mentor are on duty together, does not guarantee that feedback, advice or even discussion between the two parties will occur.

There has been considerable research conducted on the role of the ward sister in the past. These studies were executed using wards where traditional training of students was taking place. They established that the ward sister is the key person responsible for creating the learning environment (Orton 1981; Fretwell 1982;1983; Gott 1984). Sisters are also crucial in determining the attitudes of the ward team towards students (Ashworth and Morrison 1989). According to Smith (1988; 1992) the ward sister's attitude is vital in terms of the happiness of patients, staff and students.

In creating the learning environment, the ward sister is expected to have a role in teaching. Many of the studies referred to above found that although many sisters wanted to teach there was insufficient time to do so (Lewin, 1982; Fretwell, 1982; Revans, 1964 cited in Ogier 1982). The solution as Lamond (1974) perceives it is for the ward sister to delegate teaching responsibility to staff nurses.

8.3 Staffing levels

If staffing levels were good it made a positive difference to their learning which invariably was labelled as excellent. If the staffing numbers were good, students felt that there was always someone they could go to if they required guidance or help. When staffing levels were poor, students learnt 'on their feet' which they described as 'being scary.' They recognised that staff were under considerable pressure so it was normally a case of 'just getting on with your job and do not ask too much.' Some students noted that when staffing levels were poor, nursing care tended to become task orientated. This latter finding replicates evidence in previous studies by (Orton 1981; Fretwell 1982). Gerrish (1990b) stated that task orientated care stifled learning whilst individualised care through patient allocation was favourable to learning.

Mary: *"Well it is definitely to do with the numbers on the ward. You have to have the staff to make it a good learning experience because I have learnt on wards where it has been really really busy but I wouldn't say it was a good learning experience. I had to learn, I had to learn on my feet and it was scary sometimes. If you know that you always have someone there that you can rely on, that you could go and ask - I knew that I didn't have that in poorer learning environments. I didn't feel that I had the support of anybody. The good wards, like oncology, were really good because you knew they had the staff. They were fairly well staffed so if you had a problem, there was normally somebody there that you could ask if you had something that you needed answered."*

8.4 Role of ward sister/charge nurse

Throughout the study, students focused on staff nurses as the most important people to their learning. The question was posed: 'What role does the ward sister have in your learning?' All students replied that the ward sister had no role whatsoever. They perceived that students were not seen as one of her priorities and that her role was an administrative one. They had very little or no contact with the sister. Sister was seen as having no impact on the learning environment and seen as remote. Since it was the staff nurses who impinged on their learning every day, it was they who were seen as the key players. The role of the sister was something they might aspire to. This supported by the work of Burns (1994).

Amongst other changes, such delegation according to Jolley and Allen (1989) has devalued the ward sister role over the last two decades. With the adoption of patient centred care and primary nursing, the hierarchical structure in the ward has been flattened (Gerrish 1990b; Northcott 1994) with the ward sister becoming advisor rather than supervisor (Gerrish 1990b).

A replication of Ogier's (1982) study was conducted by Ogier and Barnett (1986). They added two aspects to the original study: role of the staff nurse in relation to the ward sister and students; and the sister's leadership style and ability to implement concepts of individualised care. Data collection involved the use of questionnaires: Ogier's Learners Perception of Ward Climate (LPWC) and Fleishman's Leadership Opinion Questionnaire. The sample consisted of 24 sisters, 42 staff nurses and 209 students in two hospitals. Questionnaires were collated to allow investigation of each ward.

Questionnaires from the ward sister, staff nurses and students were compared. Ogier and Barnett (1986) found that regardless of their stage in training, over half the students rated the staff nurse higher on the LPWC. When they looked at the student responses, depending on their stage of training, they noted that as students became more senior there is an increasing trend in the level of preference for the sister. As in this study, they found that the type of ward does not affect the student's perceptions of the ward sister or staff nurses.

Since the introduction of 'Project 2000' several studies have included the role of the ward sister in their research. Orton et al (1993) encountered similar findings to Ogier and Barnett (1986). Orton et al report that 68% - 76% of all groups sampled (n= 482) perceived that staff nurses are the key people in terms of student learning on the wards. They attribute this to the establishment of the mentor role for staff nurses. They state that "the majority of diploma students (77%, n=169), qualified staff (85%, n=61) and teachers (90%, n=18) felt that the students' mentor was crucial for a beneficial ward experience" (Orton et al 1993, p47). Davis et al (1994) report that having a mentor increased the likelihood of having a planned and meaningful practice experience.

These points reflect the finding in this study where students were of the opinion that their mentor was the linchpin to their learning in the practice placement. It also suggests why these students view the ward sister as more remote to their learning.

Davies et al (1994) also report that competing pressures on the ward sister cause her to delegate responsibility for the teaching of students to staff nurses. This therefore could be cited as the reason why students in this study perceived the staff nurse as having the sole role in their learning. It could also be argued that students, even those nearing completion of their programme, cannot yet see the overarching role of the ward sister. They therefore dismiss the sister as having no direct role in their learning. They fail to see the much wider organisational framework created by the ward sister. In White et al's (1993) study, sisters themselves describe their role as co-ordinating the students' experience on their wards as opposed to having a teaching function.

8.5 Students own future mentoring role

The students continued to differentiate between good and poor mentors and this sub-category remained saturated. As well as contemplating their future role as a staff nurse the students had thought about how they would perform as future mentors. They had made some promises to themselves as to how they would perform the role. These are listed below. A good mentor would:

- support the student rather than breathe down their neck;
- show confidence in the student's abilities and trust them to do things unsupervised;
- allow and encourage them to do things and to form a relaxed relationship;
- take time every day to let the student do or observe something and not assume that because they were in a certain term they would have already seen or done it;
- regardless of the student's stage, have an initial discussion, preferably on the first day, to determine what the student's present abilities were and their intended learning outcomes for the placement;
- refamiliarise themselves with their placement profile booklet and ascertain what the student required as an individual to meet the desired learning outcomes;

- clarify ground on both sides and discuss the opportunities available to meet the student's competencies;
- keep the student in mind if there was anything interesting happening on the ward;
- allow the student some independence by giving more guidance at the beginning of the placement, encourage, help and assist the student. Then they would stand back and let the student show initiative and self motivation;
- make arrangements with other members of staff to 'look out for them' if they were going to be off duty when the student was on duty rather than have the student feel abandoned;
- encourage and allow involvement and participation in patient care rather than just observation;
- think very carefully about the duty rota in terms of arranging shifts to allow student and mentor to work together at some point each week.

Mary: *"So hopefully I will show that I am confident and that I trust them to do it. So that I give them confidence in themselves because I think it's the mentors who are too protective destroy some of your confidence because you don't want to make the decision yourself, you want to check with them that it is ok first before making the decision."*

Laura: *"Just to let people have a chance to do things. I know it is not always possible due to time limits but trying to make time each day to do something or if there is something maybe out of the ordinary always ask them have you done this? And not just assume that because you are in term eight or term ten that you have done something. Everybody has had a wide and varied experience and some people haven't had the chance to do things. I never did an injection until term seven which frightened me to death. I thought they are going to think that I am really stupid not being able to do this but if you just give people the opportunity I think that's best."*

Claire: *"It has made me very interested in being a mentor myself. It keeps you up to date, keeps reinforcing your practice, enhancing your teaching skills and backs up your knowledge behind the practice. It forces you to keep up to date with research and new changes. I think it is a very useful thing to do."*

The list of how students' would perform their future role incorporates all the important points they made regarding their mentoring during the course of this study. In essence the list reflects the attributes of a good mentor from the students', as consumer, perspective.

8.6 Students' development

The students discussed how they felt now that they were on the brink of becoming staff nurses. They all felt positive about their development over the last two placements. As with all other placements, students reported an increase in their confidence both in themselves and their skills. This is supported by the work of Jowett et al (1994), Clark et al (1996b) and Maben and Clark (1996). By developing self-confidence, it could be argued that students had at least reached the self-esteem level in Maslow's Hierarchy of Needs.

Cotanach (1981) conducted a quantitative study to investigate if a change in personal levels of self actualisation is associated with the process of professional socialisation. Shostrom's Personal Orientation Inventory (POI) and Clinical Student perception Questionnaire (CSPQ) were used as data collection instruments. The POI was constructed by Shostrom in consultation with Maslow. Reliability and validity of the instruments are established.

In total, the sample comprised 48 instructors and 280 students. Students were classified as junior students (n=142) and senior students (n=138). Since the sampling technique was not discussed, it is difficult to ascertain if the sample was biased. Data were subjected to descriptive and inferential statistical analysis. Cotanach (1981, p13) states that one of her hypotheses is supported. "It appears that a change in self-confidence, self-acceptance, and self-actualisation is part of professional socialisation which is likely to occur as students become familiar with expectations demanded by their profession." Cotonach claims a relationship between the students' professional socialisation and Maslow's Hierarchy of Needs.

Students in this study believed they were better organised and had the ability to assess, plan, implement and evaluate care from a holistic perspective. This perspective included relatives as well as patients. They reported an increase in the effectiveness of their communication skills and an expansion in their assertiveness. The latter they attributed to the shortness of their placements.

A consequence of short placements and low staffing levels was that students felt compelled to maximise their learning opportunities by reminding staff that they were there to learn. Some students were spurned into being more assertive because they felt up until now they had not exercised their assertiveness skills to the full.

Elizabeth: *"It was literally a ward where the students, unless they said something, they were there to fetch commodes and do the obs and that was what they spent their time doing. Whereas I was not prepared to use up my last four weeks as a student doing things like that. I felt this was my last chance to really get a grip of things so I just had to march up to them and say excuse me, can I do...? They were fine. Sometimes they said no."*

Claire: *"It really took from probably term nine when I felt more confident in my skills within ward placements. I then started to think I have only got a few weeks left in my placement and if I don't start being more assertive or asserting myself in what I want to do and see and learn from this placement I am not going to have much time to do it. So take the bull by the horns!"*

However, the students' appraisal of their development was not all positive. Most students complained that they had difficulty in delegating and in admitting that they did not know something. They took solace in discussing their lack of knowledge with fellow students on the wards rather than asking a trained member of staff for fear of being labelled negatively. The reluctance to ask staff may relate to how they perceived how the trained staff felt about their lack of skills. The thought that they did not know everything was a great source of concern for the students. They envisaged as a staff nurse having to ask for help and guidance in performing particular skills. What would they think of them? How would they react? Would they be supportive?

Jayne offered an explanation for this continued development:

Jayne: *"I think you get more confidence because you are getting more complex things to do and at first it is a bit daunting because you think they are expecting me to know this and I don't know. But then once you try and think about it, well I do know. And you are getting more responsibility. I think confidence wise, yes very much so because you think I will never be able to do that. When I was in term 8, there was a term 12 student doing her management and she put the fear of death into me because I thought there is no way I will be able to do that. But that was a year ago and now I look back and I think I can do it. I have got there."*

Table 27 summarises the students' development as reported during the Adult Branch of the course.

Table 27 Summary of the students' development as reported during the Adult Branch of the course.

Term 8	Term 10	Term 12
Confidence rising	Even more confident - probably gained through nursing critically ill patients	Even more confidence in self and in skills
Needs less guidance	Working more independently	Better organised
Rely on mentor less	Gradual distancing from mentor	Working independently
More self-reliant	More capable of accepting responsibility	More capable of accepting responsibility but difficulty in delegating and admitting that they are unable to admit they do not know something
Increasing confidence in their use of communication skills	Communication skills further improved	Increased effectiveness in communication skills
Increase in their ability to use assertiveness skills	Assertiveness skills further improved	Expansion of assertiveness skills
Some students report developing intuition	Some more students report being aware of intuition	Ability to assess, plan, implement and evaluate care from a holistic perspective - for both patients and their relatives

A number of the findings in Table 27 confirm those found in previous work. The increasing confidence reported by students is supported by Bradby and Soothill (1993), White et al (1993), Jowett et al (1994), Clark et al (1996b), Hallett et al (1996), and Parker and Carlisle (1996). Clark et al (1996b) and Jowett et al (1994) note the increasing use of assertiveness in Project 2000 students, whilst Jowett et al (1994) note the students' increasing self-reliance. The students' gradual distancing from their mentor and the early development of intuition are not identified elsewhere.

8.7 Summary

The end was nigh because students were a few weeks from qualification and registration as general nurses. All students had gained a great deal from their elective placement, particularly those who had chosen to go to areas which would provide a challenge and the opportunity to learn more technical skills and 'specialist' care. In their final placement students endeavoured to maximise their learning of management skills. As Term 12 students they felt they were treated differently than before and believed that they were respected and valued, which in turn, enhanced their self-esteem. The majority of students felt ready to take on the staff nurse role although they were fully aware that they still had a lot to learn. The reader is directed to Table 16 (p171), where the readiness to take on the staff nurse role is noted in the application of Maslow's Hierarchy of Needs to student learning.

The students' developed their capacity to view the learning environment from a wider perspective and continued to evaluate the learning environment as good or bad and the characteristics they identified were supported by previous research.

A good learning environment could exist in busy areas with limited staff. The key was the manner in which the staff worked in a cohesive team sharing the same philosophy of care. Staff enjoyed having students and were keen that they should learn and extend their skills.

A poor learning environment essentially had the opposite characteristics of a good learning environment. In poor learning environment areas, students invariably used their assertive skills in an attempt to gain the necessary experience. Those who had previously been reticent in being assertive, found an impetus in realising that the end of their course was nigh and if they were not assertive now it would be too late.

Students were of the opinion that the ward sister had no role to play in their learning nor in creating the learning environment. Perhaps this was because they had not yet achieved the experience necessary to observe the ward sister's overarching role and may have been unable to see this until in the staff nurse role.

To the students, their mentor remained the linchpin of their learning whilst in practice. Students could relate to the staff nurses and aspire to their level. Ward sisters or charge nurses were seen as somewhat distant and aloof.

As students were nearing the end of their course they reflected upon their experiences of mentoring and produced a list of characteristics and functions which they would follow in order to be good mentors to future students.

The analysis of data collected in terms eight and 10, led to the development of the core category. The immersion of the 'researcher' in the data combined with the use of the constant comparative method of analysis and incorporation of previous research lead to the emergence of a conceptual theme which could be traced through the entire study. Eventually the core category was established.

CHAPTER IX

A THEORY OF PROFESSIONAL SOCIALISATION OF HE DIPLOMA IN NURSING STUDENTS

9.0 Development of the theory

The goal of grounded theory is the generation of a theory that occurs around a central or core category (Glaser and Strauss 1967; Glaser 1978; Corbin 1986; Strauss 1987; Strauss and Corbin 1990; Glaser 1992). Unless the core category is established, the "effort of grounded theory will drift in relevancy and workability" (Glaser 1978, p93; Glaser 1992, p75). Once categories have been created, compared and contrasted, links are made in an attempt to pull the theory together around a core category (Corbin 1986; Glaser 1992). Since the emergence of the core category usually follows the creation of categories, often the researcher does not uncover it until nearer the end of the research (Corbin 1986; Holloway and Wheeler 1996). This was the case in this study. As Glaser (1992) warns, the discovery of the core category is not automatic. The 'researcher' found the establishment of the core category was not a passive process, but rather an active process of constant comparison and abstract thinking.

Glaser (1978; 1992) argues that most of the variation in behaviour can be accounted by the core category. When a core category describes a process of more than two stages occurring over time, Glaser (1978;1992) states that it can also be known as a Basic Social-psychological Process (BSP). The core category of this study emerged as the professional socialisation of HE Diploma in Nursing student nurses and is known as a BSP as five clear stages were identified.

As the analysis progressed, the 'researcher' became more immersed in the data and became more theoretically sensitive to 'wider picture.' It could be argued that the 'researcher' was able to conceptualise and think more abstractly and consequently able to view the data from a wider more analytical perspective.

Through this critical process, in which relevant literature was also reviewed, the core category emerged.

As the aims of this study had been to:

1. To explore the effects of supernumerary status on student nurses undertaking a three year higher education diploma course in adult nursing.
2. To explore the effects of mentorship on student nurses undertaking a three year higher education diploma course in adult nursing.
3. To generate either substantive or formal theory in relation to the above two aims.

the process of meeting these aims led to the development of the theory.

By the first placement in the branch programme (18 months), it was evident that students were experiencing a definite transition as they learned within the practice area. Despite the multi-faceted nature of the transition, all students developed similarly. It became obvious that the key areas of the study, supernumerary status and mentorship, had an overwhelming influence on how students made the transition from lay person to qualified nurse. In other words, how students were socialised into the nursing profession.

During data analysis the five categories emerged: anticipatory anxiety; reality hits home; becoming a branch student; total surrender of supernumerary status; and the end is nigh. These were compared and contrasted to establish a focus through which all could be linked together. Professional socialisation involves role clarification and role modelling (Olsson and Gullberg 1988; Davies 1993), both of which can be attributed to the role of the mentor. Indeed an effective mentorship programme is said to be one of the key features in the socialisation process of student nurses (Fitzpatrick et al 1996). The development of self is also said to be inherent in professional socialisation (Fitzpatrick et al 1996). The impact of the learning environment upon the socialisation of students has been well established in this and other studies (Melia 1981; Ogier 1982; Fretwell 1982). The core category of professional socialisation includes all these aspects and links all categories.

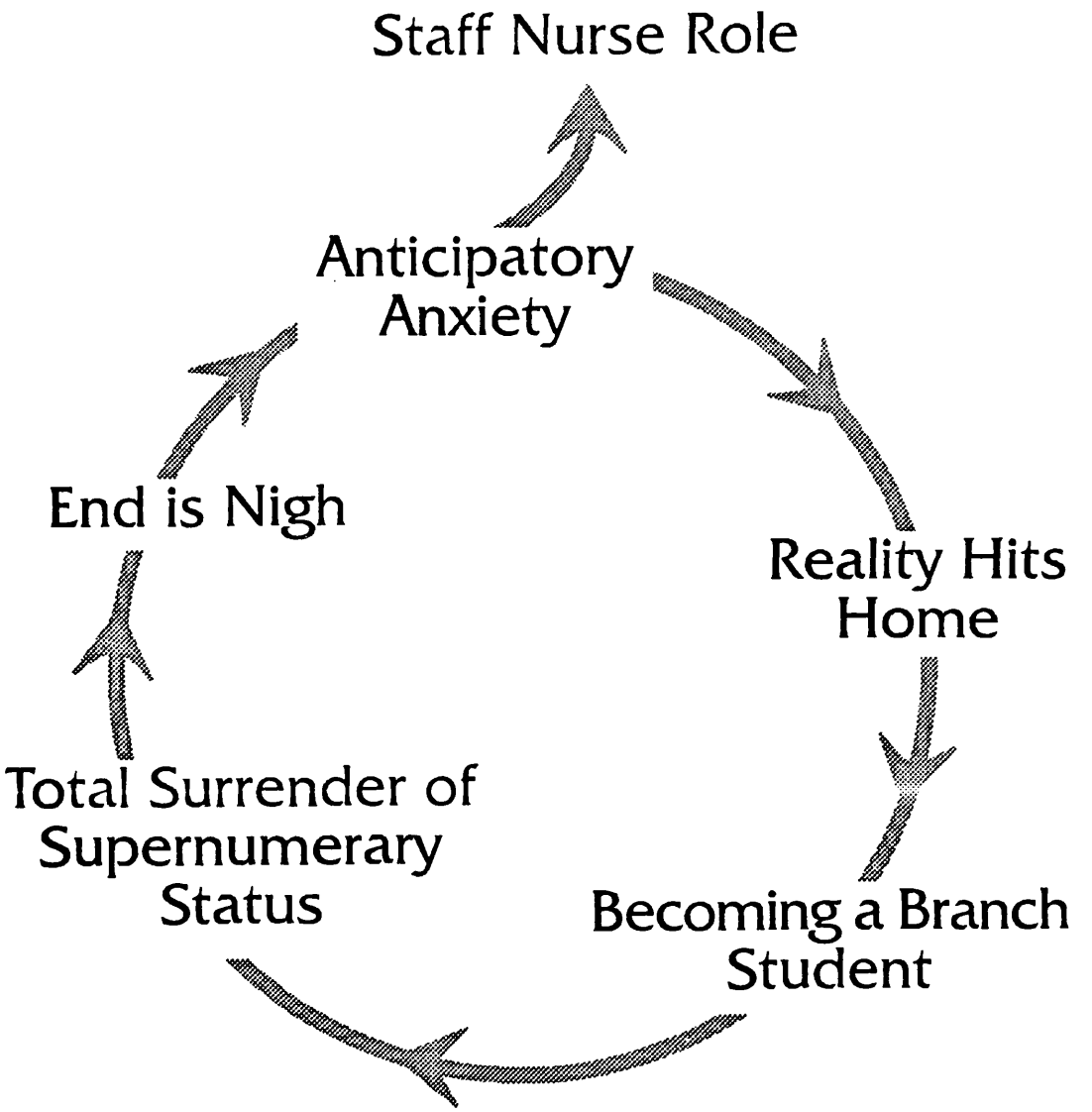
9.1 A Theory of Professional Socialisation of HE Diploma in Nursing students

Professional socialisation has been defined as the process by which the individual learns the culture of the nursing profession (White and Ewan 1991). By learning the culture, students acquire the values, attitudes and practices that make the profession distinct (Smith 1976; White and Ewan 1991; Ouellet 1993). The process is an active one that requires students to be motivated and self-directed (Deane and Campbell 1985; Ouellet 1993). White and Ewan (1991, p190) stress the active nature of the process by commenting that students "are not blank pages waiting to be imprinted with a professional persona."

The reader is reminded that literature pertaining to professional socialisation can be found in Chapter II. Other researchers have presented theories of how student nurses are socialised but these have related to nursing degree students (Davis 1975; Simpson 1979) or students following the 'traditional' RGN programme, 1982 syllabus, (Bradby 1989; Melia 1981; O'Neill et al 1993). O'Neill et al (1993) conducted the only study designed to specifically investigate professional socialisation of Project 2000 students however only focused on the CFP part of the programme.

The present study is unique in proposing a theory of professional socialisation of Project 2000 students using data obtained throughout their three year course. Interviewing students at key points during their course permitted a detailed picture of the processes involved in the transition from lay person into a member of the nursing profession. Although the processes involved have been discussed in some detail in Chapters IV, V, VI, VII, and VIII it is appropriate that this Chapter is dedicated to providing a comprehensive account of the theory of how HE Diploma in Nursing students are socialised into the profession. The theory is presented using the five categories developed from the constant comparative analysis of the data. The process of professional socialisation consists of five successive phases: anticipatory anxiety; reality hits home; becoming a branch student; total surrender of supernumerary status; and the end is nigh. The reader is advised to refer to Diagram 1 for a visual representation of the theory.

Diagram 1: The professional socialisation of HE Diploma in Nursing students



9.1.1 PHASE 1 ANTICIPATORY ANXIETY

Going to the wards after spending six months in College without seeing a patient is viewed by students as a momentous event. Students express a mixture of feelings in the weeks leading up to their first practice placement; excitement and pleasure are accompanied by ambivalence. Students are able to discuss their hopes and fears of what lies ahead but struggle to determine the cause of their concerns. They are about to embark on one of the most important aspects of their course without knowing what to expect. The anticipatory anxiety felt by students is attributed to fear of the unknown. This finding is in agreement with Bradby (1989); Kleehamer et al (1990); Jowett et al (1992); Davis et al (1994); and MacKenzie (1994).

The perceptions students have regarding supernumerary status and mentorship tend to be used as coping mechanisms in this phase. The prospect of having a mentor is perceived positively. Their mentor is there exclusively for them and can be disturbed at any time. They believe that the label of 'their mentor' means they have tacit permission to disturb their mentor at anytime since they are there specifically for the student. The opposite is applied to other staff nurses who students are hesitant to disturb.

According to students, as well as guiding and supervising them, their mentor will provide them with support, advice and sort out any problems, anxieties or worries they have. Their mentor is seen as an ally and as a friend. Indeed, some students see the support being in terms of 'being nurtured.' The anticipatory anxiety is somewhat mitigated by the students' belief that their mentor will be there for them. Students' believe that their mentor will be the linch pin of their practice placement and as such invest faith in their future mentors to support and to help them learn. The mentor is viewed as someone who will support, guide, assess and supervise students and for many, this is a great comfort.

Students also gain comfort from the thought that they will be supernumerary and that it is acceptable to acknowledge ignorance and uncertainty when on the wards. Since they will be seen as students who are there to learn, they will be able to learn at their own pace. They will have the opportunity to observe something from beginning to end and to choose what they would like to learn and practice.

Students perceive that since they will be supernumerary they will not be part of the ward team and as such will not be used as a pair of hands or forced to work certain hours. Rather they are there to learn the skills required of being a nurse. Whilst taking comfort from their supernumerary status, they are concerned that it may allow them to stand back and observe for too long and delay their progress. Generally students wish for a balance between the opportunity to observe and to practice and see their mentor as playing a leading role in creating this balance.

It is only during this phase that a difference is noted between students who have prior hospital experience and those who have none. Those who have prior experience of working in a hospital have already experienced anticipatory anxiety and are secure in their knowledge of the ward routine and their previous contact with patients. Students who have no prior hospital experience express more anticipatory anxiety. Moreover they feel that they are at a distinct disadvantage to the other students. However, students who have prior experience are anxious of adopting an auxiliary role rather than a student role when in their practice placement.

As the commencement of their first placement approaches, students express considerable trepidation and apprehension regarding the vital relationship between themselves and their mentor. Students, aware of the frailty of human interaction, are fearful that personality clashes could occur. In addition to the eagerness of beginning to learn to be a 'real' nurse, there is worry and concern regarding the stigma students perceive surrounding the Project 2000 course. Rumours spreading through an effective grapevine serve to heighten fears and concerns.

9.1.2 PHASE 2 REALITY HITS HOME

Early in their first placement students realise that their pre-placement expectations do not reflect reality. Students with no pre-existing 'nursing' experience, encounter shock when their lay conceptions of nursing meet the realities of being on a ward for the very first time. Not only do these students need to learn the 'rules' associated with working in placement areas, they are faced with an environment which is alien to them. Students with previous 'nursing' experience have the advantage of having some insight into how things work on the wards, which seems to mitigate the effects of the fear of the unknown.

The main foci of this phase are the students' pre-placement perceptions of supernumerary status and their mentor which are incongruent with what they experience in actual practice. Having experienced the anticipatory anxiety phase, students remain faced with many unfamiliar aspects of hospital life.

The duration of this phase is the remainder of the CFP during which students learn about hospital culture and the significance of quickly 'fitting-in' and learning the ward routine. Students discuss learning routines but since their mentor is their linchpin, they learn their mentor's preferences as opposed to the ward sister's. In this way students learn to conform in order to cope with the reality of becoming a nurse and to create a smooth path towards their final goal. In essence, they are learning survival skills.

The rewards for conforming to the prevailing norms are identified as; increasing the potential for experiencing a good placement, feeling part of the team and feeling like a nurse, pleasing their mentor, receiving a good practical assessment and reducing stigma. 'Learning the routine,' 'fitting-in,' and 'mucking-in' are ways in which conformity is manifested. The students' description of 'mucking-in' equates with that of 'traditional' students 'pulling their weight' in Melia's (1981) study. It is vital to HE Diploma in Nursing students that they are accepted by their colleagues as this facilitates the loss of the 'outsider' role and the associated stigma.

Once accepted as an individual, students learn the routine and 'muck-in' and become useful by doing their share of the work. This is usually enough to dissipate the stigma attached to being a Project 2000 student. Seed (1991) observed 'traditional' students being similarly useful and attributed this to students responding to what they perceived to be the ward staff's expectations. The HE Diploma in Nursing students may also have been responding in this manner but the emphasis on 'mucking-in' and being useful is on a need to belong combined with a desire to jettison the stigma attatched to them as quickly as possible. HE Diploma in Nursing students in May and Domokos (1993) study behave similarly to students in this study. Phillips et al (1996) add that being useful is very important to students, particularly in the CFP, as it was a means of coping and fitting into the ward team more quickly than would otherwise be the case if they were observers only.

Melia (1981) and Seed (1991) both conducted studies focusing on 'traditional' students experiences of their training. A number of similar findings occurred in both studies including an emphasis on students not just on 'pulling their weight' but getting through the work as quickly as possible. The issue of speed of working was never mentioned by the HE Diploma in Nursing students in this study.

During 'reality hits home' phase, students report that supernumerary status does not work because of lack of ward staff and the pressure of work. Students consider supernumerary status as being valuable because it helps them 'to find their feet.' However once the ward becomes busy, they have to abandon their supernumerary status and 'muck-in.' Students suffer dissonance as the expectations of College staff for students to exert their supernumerary status and the pressure to conform causes tension. Dissonance can be defined as a lack of harmony between students' expectations and reality that produces tension and frustration and a desire to find a way to reduce the dissonance (Day et al 1995). The feeling of dissonance is managed by adopting a 'middle of the road' approach. Students 'muck-in' when required but expect to be allowed to exert their supernumerary status when learning opportunities arise. This middle of the road approach is referred to by Parahoo (1992c) as accepting a 'token form of supernumerary status.'

A second source of dissonance for students comes from a realisation that their initial view of nursing was idealistic and perhaps even naive and does not match reality. This is felt particularly by students who have poor mentors or are in poor learning environments. Students cope by ascribing the allocation of a good mentor as involving luck and believing that the next placement would undoubtedly be better. Students who have good mentors do not seem to have the same feeling of dissonance as those who have poor mentors. This is attributed to the support good mentors give students and undoubtedly this helps to reduce the dissonance experienced.

Much of the professional socialisation of students occurs through interaction with others in practice situations. The vital role of the mentor in facilitating the students' learning cannot be stressed enough. Indeed, O'Neill (1993) and Phillips et al (1996) view the mentor role of providing emotional support and guidance as crucial to the students' well-being and learning potential.

HE Diploma in Nursing students have great faith in their mentor who is seen as the linchpin of their placement. A good mentor will act as student advocate to allow students to be supernumerary when specific learning opportunities occur. It is also part of their mentor's role to move them along the observer - participant continuum in line with their individual capabilities. Having a poor mentor in their first placement can be catastrophic for some students. The mentor has such a profound effect upon the student that having a poor mentor may lead to students concluding that they are not suitable for nursing.

The shortness of placements causes students to realise quickly that early contact with their mentor is vitally important. Ideally they expect to meet their mentor on their first day but realise that this is not always possible. If the initial meeting is delayed beyond a couple of days, the quality of the relationship is invariably reduced. In attempting to identify expectations and how best to meet them, students very quickly realise the importance of negotiating learning objectives at the beginning of the placement with their mentor.

Early negotiation means that both parties have a clear idea of what is expected from one another and the means of achieving learning outcomes are agreed from the outset. When this negotiation does not occur, students exhibit frustration and anger, and invariably both the mentor and placement are described as poor.

In their study of Project 2000 students, Davis et al (1994) found that having a mentor was more likely to be associated with having a planned and meaningful placement. Students in this study relate that the manner in which this is achieved is by having early negotiation between themselves and their mentor and planned sessions when feedback on performance can be given. The importance of students meeting with their mentor either on the first day or early in the placement is also documented by Orton et al (1993); White et al (1993) and MacKenzie (1994).

Students are clearly aware of both positive and negative role models and learn from both. They quickly realise the potential effects that a good or poor mentor can have on their learning. However, having access to role models alone is insufficient. Students require supervision and feedback on their performance from their mentor. They insist that feedback on performance is one of the key aspects of their learning since feedback is vital to developing skill and competence.

Clinical practice plays a crucial role in the socialisation process (Bucher and Stelling 1977; Melia 1987; Perry 1988). HE Diploma in Nursing students begin by learning physical care tasks. These physical tasks appear the most straightforward to learn and students are pre-occupied by the practicalities of mastering these tasks correctly. In this way they can function independently, be a useful team member and gain satisfaction from delivering aspects of basic nursing care. The more students 'muck-in,' the more routine these particular tasks become and the more proficient they become.

Students' practical learning is dominated by the need to accomplish proficiency in physical tasks. Hallett et al (1996) state that students are exhibiting the earliest stages of their learning career by 'having a go.' They concur with the assertion that students have a drive to acquire some competence in practical procedures at this stage.

At this juncture, students are unable to practice holistically. The patient is viewed as someone who requires a particular task to be performed. Students are almost obsessed by ticking off a mental checklist of skills to be mastered before they finish their CFP. Students, especially those who consider they lacked feedback from their mentor, gauge their own progress by the accomplishment of tasks.

It is important to students that they enter their branch programme with competency in the basic nursing skills. Those who fail to attain this level of proficiency are worried about how they are going to cope in the branch and how their lack of skills will be perceived by the ward staff. Concerns about the lack of clinical experience towards the end of CFP are raised by other Project 2000 students (Bradby and Soothill 1993; O'Neill et al 1993; Hamill 1995). Orton et al (1993) relate that students in their study, were terrified at the end of their CFP because of their perceived lack of skill and competence. Most students in this study did not express the same level of concern as students in Orton et al's study.

Clark et al (1996) state that Project 2000 students are only beginning to see themselves as nurses by the end of their CFP. An alternative view is expressed in this theory. During the CFP, students have concentrated on learning tasks and how to fit in and developing survival skills to cope with working in a hospital environment. It is only once they reach this stage in their development that they begin to change their perception of the nurse's role. Up until now they believe they are learning the skills of nursing and it is only once they have learnt 'basic' nursing skills that they realise that what they have learnt are in fact the skills required of an auxiliary. They then turn their attention to learning to be a student nurse who will become a staff nurse.

The students' ability to differentiate between good and poor role models continues to be refined during this phase. Students are aware of choosing to adopt practices of different members of staff as opposed to relying entirely on their mentor. This is most evident when students encounter poor mentors.

As students near completion of their CFP, they realise that they have, for the most part, learnt about hospital culture, routines, and trained staff and mentor pleasing strategies. Collectively these make up the students' survival skills. Students feel they have gained in confidence and improved their communication skills. When self-confidence is evident, it reflects a comfort felt in the role and that progress is being made. The fostering of the students' self-confidence is an important aspect of the mentoring role.

9.1.3 PHASE 3 BECOMING A BRANCH STUDENT

Great excitement is expressed by students as they enter their branch programme as for many students the 'real' learning would now start. Glaser and Strauss (1971) would refer to the transition from CFP to branch as a status transition. The move from CFP to the Adult branch programme holds surprises, changes and challenges for students.

The transition from supernumerary status to rostered service causes most students significant upset and brings unexpected pressures. The extra hours to be worked cause students to feel tired and they realise quickly that they are now experiencing the 'real world.' The overwhelming nature of the transition is supported by previous studies. Bradby and Soothill (1993), White et al (1993) and Jowett et al (1994) comment on how Project 2000 students feel unprepared for the increasing responsibility placed upon them as a branch student.

Students begin to mourn the loss of their supernumerary status and experience a sense of loss as they pass through into rostered service. It is almost as though they do not fully appreciate the worth of supernumerary status until they have lost it. The main disadvantage of being on rostered service is the lack of opportunity to leave the ward to observe care and treatment elsewhere. Students find it difficult to reconcile the loss of learning opportunities supernumerary status afforded them with the staff's attitudes towards their learning now they are on rostered service. Students are now expected to plan and manage the care of allocated patients with minimum support, to work independently and give total nursing care to their patients.

This expectation comes as a shock to many students and causes them emotional turmoil and at times stress. Feeling daunted by the transition, students worry greatly about whether they have the necessary skills or knowledge to fulfil the role expected of them. Their worst fear is of not doing things correctly or forgetting to do something vital. Students have to learn quickly planning and organisational skills as well as developing the ability to think more holistically about their patients. It is however difficult for them to adjust as quickly as expected by ward staff. This was also the case with 'traditional' students who felt that trained staff expected them to become efficient workers in a very short space of time (Melia 1987).

The effect of the transition leads to development and changes in the students' ability to provide care. In essence the move from the relatively protective label of supernumerary student to rostered service makes students more active in their learning and forces them to develop at a faster rate than ever before. The survival skills learnt in the CFP form the basis of their coping strategies during the transition. Students remark on the huge learning curve they experience during their first rostered service placement. They learn more by working complete shifts, being a team member and being allocated their own patients. Despite feeling unhappy with the added responsibility, most students acknowledge that they have learnt a great deal. The elation of realising that they had grown through the experience is evident. Jowett et al (1994) comment that students in their study valued their rostered service placements as a means of easing them into the employee role.

Students aware of the finite time available have an overwhelming desire to learn as much as possible. Instead of viewing nursing care as a series of tasks, the students are now aware that they have to develop a more holistic approach. It is as though they had to go through the process of learning tasks that focused on physical care before they could progress to thinking about meeting their patients' psycho-sociological and spiritual needs. Clark et al (1996) also note that as students progress in their course, they develop a more holistic approach to patient care. Only once students become competent in basic nursing care tasks, do they view basic nursing care as something anyone could do and thus equate it with 'auxiliary' work.

The transition to thinking more holistically is accompanied by a desire to learn more technical skills and aspects of care which only staff nurses deliver. The emphasis is on learning skills that distinguishes them from auxiliaries and brings them closer to their goal of becoming a staff nurse. Students realise that they need to assert themselves if they are to progress. Students continue to complain about the lack of time their mentors can spend with them. Staff-shortages mean that learning opportunities are often missed because hard-pressed staff forget to include students. This leads students to adopt a pro-active approach by persistently asking to be involved.

Accompanying the recognition that they are now able to think holistically about their patients, is the realisation that they are beginning to mature in their role as a student nurse. Students report a rise in their self-esteem and self-confidence that is related to coping successfully with the responsibility of determining and delivering care for their allocated patients. Students also begin to gradually distance themselves from their mentor. They do not require the same amount of support and guidance they once did and this too signals their development towards becoming more independent. However they acknowledge that it is comforting having their mentor around so they can ask questions or discuss issues with them.

Students continue to 'muck-in' and perform all work allocated to them whilst continually being aware of any learning opportunities which may occur during their shift. An inherent danger of the rostered service role is to be treated as an auxiliary as opposed to a student nurse. If they are given similar tasks to an auxiliary they require less supervision and guidance and therefore are less time-consuming to the trained staff. Students resent being treated in this manner and usually complain bitterly to their peers as they are reluctant to complain to their mentor for fear of reprisal.

In this phase, students are becoming more confident in their abilities and progressing in the right direction - away from a task centred approach to holistic care and away from 'glorified auxiliary' towards the role of staff nurse. There is also an increase in their assertiveness skills which students describe as necessary to fulfil the role of patient advocate and to achieve their learning outcomes. Students believe that their development is very positive and certainly a step in the right direction.

This comforting realisation seems to confirm that they are indeed evolving as a nurse and moving away from being a 'glorified auxiliary.'

By this phase in their socialisation, students have a much clearer concept of what 'being a nurse' involves. Students begin to adopt a reality-based image of a 'real nurse' and take a more lateral view of the world of work. Once the students accomplish learning basic nursing care tasks, they are somehow 'freed up' to view not just the patient, but also their work environment, more holistically.

Macaskill (1994) found that staff attitudes characterised good and poor placements. The design of this study facilitated the capture of students' in-depth accounts of the characteristics of good and poor placements. Invariably good placements are areas where the staff and their mentor are considered to be excellent; work as a cohesive and effective team; are approachable, knowledgeable, enthusiastic, supportive and engender confidence in the student. Students believe that it is the ward staff that makes a placement good and not the particular speciality. The working relationship with their mentor and other staff is facilitated by the relaxed but efficient student-friendly atmosphere, the positive attitude towards student learning and the staff's realistic ideas regarding what students can do at certain stages of their course. Having a good placement has a positive effect upon the students. There is development in the students'self-esteem and they describe feeling wanted and valued. A good placement is one where students feel safe to learn, where they are supported and nurtured and where there is a genuine interest for them as an individual with particular learning needs.

Students describe a poor placement as having certain characteristics; negative ward atmosphere, lack of nurture, poor teaching, and using students as 'glorified auxiliaries.' The ward environment is unwelcoming to the extent that some students complain of being ignored. Students feel a visitor rather than a member of the team. They feel undervalued and at times they feel disowned by the trained staff. A negative ward atmosphere has a profound effect on the students and obviously affects their learning on the ward.

The lack of nurture is related to the negative ward atmosphere and lack of encouragement. Students feel staff are either too busy to bother about them or lack trust in their abilities.

Not surprisingly, students state that poor placement areas also have poor teaching and learning opportunities. The lack of nurture and interest in the student is reflected in the staff's poor attitude to facilitating the students' learning. Students describe barriers being put in the way of their learning and complain that the staff are not knowledgeable about their course. Students' learning is seen as having a low priority and important aspects such as their assessments are invariably late. Having a poor placement causes students frustration, anger and resentment. They complain of the wasted opportunities and long for their next placement which they hope will be a good one. The students cope with poor placements either by putting on a brave face or being more proactive.

As the students' impressions of good placements emerge, their views of what makes a good mentor become more focused. Having a good mentor remains associated with being lucky. The same is said of having a good placement and usually the two coincide. The need to work with their mentor on their first day continues to be seen by some students as important, and for others it becomes vital.

Students are equally clear about what makes a poor mentor. Students complain that a poor mentor invariably uses them by making them work harder than themselves by delegating their unwanted jobs to them. This often results in the students feeling resentment towards their mentor. Students also note that poor mentors often dislike their job and/or students and might in fact be disliked by other members of the ward team. Students cope with poor mentors either by keeping a low profile or blaming the poor relationship on a personality clash. Generally, students cope with poor mentors by taking a philosophical stance. They either report to the charge nurse at the end of their placement or more commonly engineer their off duty so that they do not need to work with their mentor.

By the end of their first rostered service placement, students reflect that in the CFP they are addressed as either the student or the supernumerary whilst they are more likely to be called by their name on rostered service. This reflects the transition from being supernumerary and not part of the team to being on rostered service and a full working member of the team. This parallels findings from Melia (1987) and O'Neill et al (1993).

9.1.4 PHASE 4 TOTAL SURRENDER OF SUPERNUMERARY STATUS

Once students have experienced their first rostered service placement, they realise that it is neither possible nor desirable to cling to their supernumerary status. They therefore totally surrender all thoughts of being allowed to participate in learning opportunities regardless of the needs of patients. Labelled as rostered service, students are very much seen as part of the work force and expected to take their fair share of work. This however has its own benefits as students realise that it is more valuable to stay on the ward and learn how the team works.

During this phase, students begin to adopt a reality-based image of a 'real nurse.' Students increasingly identify with particular mentors whom they consider to be good role models. Students internalise this as their professional model and continue to strive to become a professional nurse. Students are willing to accept the responsibility of caring for their allocated patients in a holistic and independent manner.

As senior students they compare themselves to third year 'traditional' students. They believe that traditional students have a greater opportunity to learn and practice more complicated tasks, such as being in charge of one side of the ward, giving reports and going on ward rounds. Students believe that their development is arrested because they are often confined to performing basic nursing care that is no different to that provided by auxiliaries. The only aspect that differs appears to be that students also perform observations (obs). Taking the 'obs' is viewed as a low level task which students consider to be a poor example of the difference between an auxiliary and themselves.

Students feel that there must be a greater differentiation between themselves and the auxiliaries and strive to make this so. Their anxiety levels rise when they consider their own capabilities vis a vis fulfilling a staff nurse's role at the end of the course. The more they are expected to act as a 'glorified auxiliary,' the fewer opportunities there are to learn and practise new skills. Some more assertive students try to rectify the situation in which they find themselves but often to no avail.

Students find themselves caught between wanting to learn more technical skills and acknowledging the reality of workload and staffing levels. If staffing levels are good it makes a positive difference to their learning which invariably is labelled as excellent. If the staffing numbers are good, students feel that there is always someone they can go to if they require guidance or help. When staffing levels are poor, students learn 'on their feet' which they describe as 'being scary.' They recognise that staff are under considerable pressure so it is normally a case of 'just getting on with your job and do not ask too much.' Students almost never direct blame towards members of the ward staff for the lack of learning opportunities. Rather, students take a more abstract view blaming understaffing in general or the fact that they themselves are not assertive enough.

While students continue to distance themselves from their mentor, they are adamant that it is vital to continue having a mentor. The role of the mentor is not redundant, just different. In the latter stages of the course, the mentor's main roles are giving crucial constructive criticism and teaching. The students feel strongly that if they do not have a mentor, their learning experience undoubtedly suffers. Their mentor is seen as the gate keeper of learning. It is they who will, or will not, let students do and see things. It is they who allow or refuse independence and the use of initiative. A recurring and important aspect to students was the need for their mentor on their first day to agree the students' learning outcomes for the duration of their placement. The manner in which students are made to feel welcome on their first day sets the tone for the whole placement.

The mentoring process experienced by HE Diploma in Nursing students, in conjunction with experiences derived from practice, facilitates the development of intuition. Some students become aware of their ability to consider the patient's condition and intuitively know that something unusual has, or is about to occur. They believe that it is a skill they have developed unconsciously and that it is derived from getting to know their patients better, being more observant and picking up cues when patients' conditions change. For some students, the development of intuition appears at the end of their second year. For others, it does not manifest itself until midway through their third year. Some students do not develop it at all during their course.

Seed (1991) notes the development in 'traditional' students' abilities in their second and third years. She states that they are able to consider factors which may underlie the patient's behaviour, rather than labelling the patient as unco-operative. This reflects a similar move towards holistic nursing as opposed to being task-orientated. Seed refers to this development as students moving from seeing individuals as patients to seeing them as people. Neither Melia (1987) or Seed (1991) identify the development of intuition in 'traditional' students. There is however some evidence that 'traditionally' trained students do experience intuitive feelings (McCormack 1993).

McCormack (1993) conducted a qualitative study to examine the role of intuitive decision making in nursing practice. McCormack's opportunistic sample comprised of ten 'traditional' student nurses who had completed the first 18 months of their training. Students were asked to keep a diary for three weeks and then attend a group semi-structured interview. The diaries were analysed using Young's (1987) intuitive knowledge scale. Data from the group interview were subjected to content analysis. McCormack found that although students thought intuitively, they lacked appreciation of the holistic nature of intuitive knowledge, however they were able to care holistically for patients. As in this study, students in McCormack's study, attributed their intuitive thinking to getting to know their patients well.

The development of a holistic perspective and intuition in HE Diploma in Nursing students is viewed as a natural progression along a learning continuum. The education of nurses has changed drastically with the introduction of 'Project 2000.' The HE Diploma in Nursing curriculum is one which is education led, research and practice based (NBS 1989). HE Diploma in Nursing students are taught, particularly in the branch programme, using principles of care as opposed to a medically orientated model of care which many institutions used prior to Project 2000. According to Gott (1984, p81) principles are abstract and necessitate the use of higher cognitive skills and that the "learning of principles is more meaningful than the learning of procedures." In addition, HE Diploma in Nursing students are encouraged to foster a spirit of independent thinking and enquiry.

It is acknowledged in Chapter 11 that one of the changes is that 'Project 2000' students have less time in practice placements than their traditional counterparts. Since clinical experience is fundamental to the development of intuition (Pyles and Stern 1983; Young 1987; Benner et al 1996) it is logical to suggest that traditionally trained student nurses would demonstrate more intuition than their 'Project 2000' trained colleagues. It is proposed in this thoery, that there is a multiplicity of factors which HE Diploma in Nursing students experience during their course which facilitate the development of intuition. These factors will now be discussed.

It is argued that HE Diploma in Nursing students are facilitated through their educational programme to move from the learning of tasks to developing the ability to think and care holistically about the needs of patients and their relatives. Furthermore, this theory proposes that the changing philosophy and educational techniques employed in 'Project 2000' programmes facilitate the development of holistic thinking and thereby the development of intuition. 'Project 2000' students are actively enouraged to reflect in and on practice, an ability which has been found to improve nurses' intuitive judgement (Young 1987).

As mentioned previously, some HE Diploma in Nursing students develop the beginnings of intution by the end of their second year, while for others it emerges in their third year. Some students do not appear to develop intition at all. As an explanation for the diversity in the timing of, or lack of, developing intition attention is paid to the work of Young (1987). Young notes that intuition is facilitated by direct patient contact, self-receptivity, experience, energy and self confidence. Perhaps the differences noted in HE Diploma in Nursing students are due to the differing degrees of self-receptivity, experience, energy and self confidence which students experience during their programme.

In her seminal text, Novice to Expert, Benner (1992) asserts that intuition is the province of the expert nurse. It is intended to apply this study's theory to Benner's (1982) model of novice to expert in an attempt to differentiate between the theory proposed here which is based on the students' own perceptions with Benner's model which, as has been argued previously in Chapter 6, is relevant only to trained nurses despite being commonly used in pre-registration courses throughout the U.K. This theory proposes that students develop from learning tasks and gaining competency in basic tasks to learning technical skills, to giving competent holistic care and to developing intuition.

HE Diploma in Nursing students begin by learning tasks, the ward routine and how to fit in to an unknown environment. During the CFP they develop, for the most part, competency in basic skills. White et al (1993) note that Project 2000 students prefer to observe a procedure once or twice before attempting to practice it themselves under supervision. Thereafter they practice the task at their own pace until they develop proficiency. The same sequence of events is noted in students in this study. This phase of basic task competency can be equated to Benner's novice stage. The novice is taught rules and procedures and has a high level of contact with their supervisor. At this point students are unable to think holistically.

HE Diploma in Nursing students then progress to learning technical skills. Fretwell (1982) is of the opinion that students are socialised into believing that technical skills are more important than basic care skills. This theory proposes that students realise that only performing basic skills equates them with auxiliaries as opposed to staff nurses and they therefore wish to learn skills which differentiate them from auxiliaries. At this time, students' responsibility is increased with the allocation of their own group of patients to care for. As a result they begin to develop the ability to think holistically. This level of development in HE Diploma in Nursing students is equivalent to Benner's (1982) advanced beginner. The advanced beginner has sufficient experience to recognise recurring aspects of situations and they are able to work within broad guidelines. Mcleod (1996), commenting on Benner's model, asserts that advanced beginners are unable to prioritise care in complex situations. The same can be said of HE Diploma in Nursing students.

The development of the HE Diploma in Nursing students to providing holistic care is seen as a natural progression as students move towards the end of their course. Sloan and D'A Slevin (1991) state that Benner's (1982) level of competent practitioner is the limit that can be expected of a pre-registration student. By the end of their course, the HE Diploma in Nursing students state they feel competent and ready for their staff nurse role. Benner's competent practitioner is able to plan and solve problems , as can HE Diploma in Nursing students at this stage. Benner notes that supervision is at arms length which reflects HE Diploma in Nursing students distancing from their mentor. The ability to give holistic care develops with experience and maturity (Seed 1991). Ramprogus (1995, p101) believes that the ability "evolves over time through the creative use of experiences."

The ability to give holistic care develops with experience and maturity (Seed 1991). Ramprogus (1995, p101) believes that the ability "evolves over time through the creative use of experiences." In the period when HE Diploma in Nursing students are developing their holistic perspective of caring for patients and their relatives, some of the students are also developing intuition. This is in direct conflict with Benner's (1982) model which views intuition as the sole province of the expert nurse.

Benner's proficient practitioner is at post-registration level and has the ability to recognise the whole situation. How then is this different to HE Diploma in Nursing students developing a holistic perspective? The key is the level at which HE Diploma in Nursing students are operating in terms of their holistic care and intuition. Benner (1982) asserts that the expert nurse possesses deep understanding and a high level of perceptual ability. How deep is deep and how high is high? Like Dreyfus and Dreyfus's (1996) model on which Benner bases her model, the key issue of how nurses move from one level of skill to another is not clearly delineated. It is suggested that with experience, nurses move from level to level.

Since the experiences of HE Diploma in Nursing students are varied depending on their placements, this could be a rationale as to why some students develop intuition whilst others do not. "Experience is anything lived or undergone. It is the inner perception that a person has of events in which he participates. It consists of the 'felt relations' - the connections which a person feels concerning an event - or the inferences he draws" (Peplau 1957, p884). It could be that some students are better at making connections and inferences from experience and become more intuitive as a result.

Dreyfus and Dreyfus (1996) state that there are six key aspects of intuitive judgement. The reader is reminded that these were discussed at length in Chapter six. It is useful to note here that HE Diploma in Nursing students exhibit possession of the first three aspects, namely; pattern recognition; similarity recognition and common-sense understanding. As Jasper (1994) writes, intuition seems to be intangible and immeasurable. As such it is therefore difficult to make assertions regarding the level of intuition HE Diploma in Nursing students possess. However it is clear that many begin to develop intuition prior to the completion of their pre-registration course. Perhaps some enlightenment can be drawn from Benner et al's (1994) work. They state that a proficient practitioner "is most frequently able to recognise deterioration or patient problems prior to explicit changes in vital signs - that skill being called the early warning signal" (p31).

It is suggested that the ability to recognise 'early warning signals' which students in this study claim to have experienced, is in fact an earlier stage in the development of intuition.

As the students enter their penultimate placement, there is an increasing criticism voiced by qualified nurses that HE Diploma in Nursing students are less skilled than their more traditionally trained counterparts (White et al 1993; Watson and Kiger 1994;; Ramprogus 1995). While a few students may agree with this, most feel strongly that it is only a transient problem that will be rectified either by the end of their course or in their first staff nurse post. Students have several rationales for why they are labelled as lacking practical skills.

Students realise that their course does not contain the same percentage of practice time as the 'traditional' course; the placements are shorter and fewer, and consequently it is difficult to consolidate their skills; and finally the opportunities to observe and practise new skills are diminished. They also perceive that they are not given as much responsibility as 'traditional' students. When asked which skills they are deficient in, students invariably answer that it depends very much on the type of placements they have had. Generally, catheterisation is the skill most commonly cited.

Students report that their confidence levels increase particularly once they have had experience of working with critically ill patients. Their assertiveness and communication skills also improve. They work more independently, are more self-reliant, use their initiative and accept more responsibility. Students can see the wider picture and believe that this is central to their development. Orton et al (1993) also note that students' assertiveness skills develop and they offer the need to make the most from every learning opportunity as an explanation.

9.1.5 PHASE 5 THE END IS NIGH

On the whole, the students' experiences in their final management placement are positive. All students comment on how they are treated differently. They feel valued, feel they are given more respect and that their opinions are acknowledged. Seed (1991) notes that 'traditional' students make similar comments. She asserts that as the near completion of their course, trained staff see them as individuals but that their 'worker' identity remains only partially hidden.

The realisation that they are about to embark upon their future career as a staff nurse is welcomed by some HE Diploma in Nursing students and feared by others. Some are more than ready to fulfil the role of staff nurse, whilst a small number fear the loss of their student role. The majority of the other students feel quietly confident about their impending role change. This final placement invariably motivates both students and staff in facilitating the maximum learning opportunities possible. Students consistently state that their skill level is very much related to where they have been lucky or unlucky enough to be allocated during their course. The acquisition of a good level of skills requires the combination of a good mentor, a good learning environment and a student who is assertive enough to ensure that she learns. Students continue to concentrate on learning as much as possible about the staff nurse's role in their management experience. Many are pleasantly surprised that they are now doing things that in the past filled them with awe.

Students no longer complain about being treated as 'glorified auxiliaries.' Perhaps this is because they have acquired most of the technical skills required and feel reasonably confident in their ability to perform them. Since students are now more than likely to be functioning almost independently, they are more likely to feel part of the team rather than a nuisance or hindrance. They are also more likely to accept, take and assertively demand responsibility.

On the brink of becoming staff nurses, students feel positive about their development particullarly over their last two placements. As with all other placements, students report an increase in their confidence both in themselves and their skills. Students believe they are better organised and have the ability to assess, plan, implement and evaluatte care from a holistic perspective. This perspective includes relatives as well as patientts. They report an increase in the effectiveness of their communication skills and an expansion in their assertiveness. The latter they attribute to the shortness of their placements. A consequence of short placements and low staffing levels is that students feel compelled to maximise their learning opportunities by reminding staff that they are there tto learn. Some students are spurred into being more assertive in their final placement because they feel that they have not exercised their assertiveness skills to the full.

The sttudents' appraisal of their development is not all positive. Most students complain that they have difficulty in delegating. At this stage they take solace in discussing their lack of knowledge with fellow students on the wards rather than sharing their concerns with their mentor for fear of being labelled negatively. The reluctance to ask staff relates to how they perceive how the trained staff feel about their lack of skills and the importance of their final assessment.

In this final phase the principal roles of the mentor are teaching of technical skills and providing feedback on performance. Students no longer mention supervision because for the most part they are working independently. As students near the end of their course,, although experiencing a 'natural' anxiety, most students feel ready to adopt the role of a staff nurse. The thought that they do not know everything is a great source of concern for the students.

Students envisage as a staff nurse having to ask for help and guidance in performing particular skills. What will the other trained staff think of them? How will the trained staff react? Will the trained staff be supportive? However students have internalised the 'learning for life' concept and are willing to learn more in their new role.

Students reflect on the practice placements they have had during their course with all admitting that they have experienced and survived at least one poor learning environment. They often feel a degree of bitterness particularly when they believe it was a wasted opportunity in a course in which they have little enough time in the practice areas.

Throughout their course, students focus on staff nurses as the most important people in their learning. Despite the students' holistic approach to patient care, and their ability to view the ward environment from a wider perspective, at this juncture, they are unable to perceive the role the ward sister had in their learning. Since they have little or no contact with her, it is perceived that students are not seen as one of her priorities and that her role is very much an administrative one. Since it is the staff nurses who impinge on their learning every day, it is the staff nurses who are seen as the key players. As mentioned earlier, students learn their mentor's likes and dislikes, unlike "traditional' students who learn Sister's ways of running the ward (Melia 1987). In her account of occupational socialisation, Melia (1981; 1987) argues that students learn to be student nurses during their training, rather than learning to be staff nurses. She states that the "main transition that the student nurse must make on becoming a staff nurse, is from a worker undertaking allocated tasks to a qualified member of staff allocating work" (p172). Seed's (1991) findings concur with Melia's. Seed states that 'traditional' students in her study believed they were ill-prepared for their staff nurse role and that they had spent much of their training completing a physical workload rather than learning the skills required to give holistic care.

In this study, HE Diploma in Nursing students begin providing holistic care by the end of their first rostered service placement. The majority of these students felt ready to assume the role of staff nurse although they acknowledge that they lack delegation skills. As well as contemplating their future role as a staff nurse, the HE Diploma in Nursing students consider how they might perform themselves as future mentors. They make some promises to themselves as to how they will perform this role. Their list of characteristics of a good mentor serves as a valuable insight into how students feel the role of mentor should be performed.

As a mentor they would:

- support the student rather than breathe down their neck;
- show confidence in the student's abilities and trust them to do things unsupervised;
- allow and encourage them to do things and to form a relaxed relationship;
- take time every day to let the student do or observe something and not assume that because they were in a certain term they would have already seen or done it;
- regardless of the student's stage, have an initial discussion, preferably on the first day, to determine what the student's present abilities were and their intended learning outcomes for the placement;
- refamiliarise themselves with their placement profile booklet and ascertain what the student required as an individual to meet the desired learning outcomes;
- clarify ground on both sides and discuss the opportunities available to meet the student's competencies;
- keep the student in mind if there was anything interesting happening on the ward;
- allow the student some independence by giving more guidance at the beginning of the placement, encourage, help and assist the student. Then they would stand back and let the student show initiative and self motivation;
- make arrangements with other members of staff to 'look out for them' if they were going to be off duty when the student was on duty rather than have the student feel abandoned;
- encourage and allow involvement and participation in patient care rather than just observation;
- think very carefully about the duty rota in terms of arranging shifts to allow student and mentor to work together at some point each week.

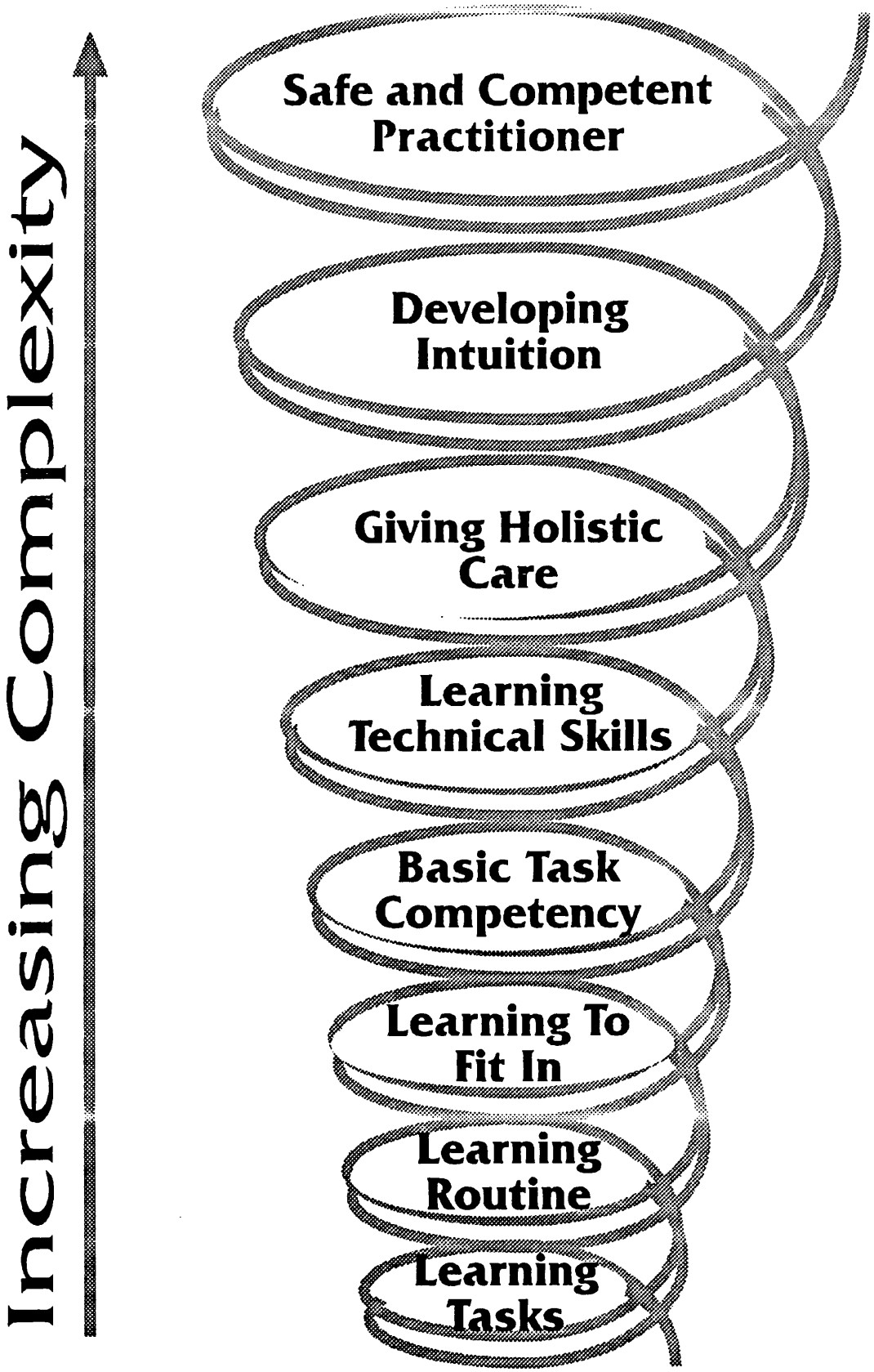
9.2 Summary

A theory of the professional socialisation of HE Diploma in Nursing students, which emerged from the constant comparison of data derived from this longitudinal study, has been presented. The development of students involves the cognitive, psychomotor and affective domains.

The progression through the hierarchical and sequential process is accompanied by a developmental process that is reflected in the categories presented in this study (see Diagram 2). The students experience anticipatory anxiety before their first practice placement that is soon replaced by 'culture shock' as reality of the workplace hits home. Students cope with reality by learning the routine and fitting-in. Becoming a branch student is a milestone which signals, for many students, the beginning of feeling like a nurse. The transition from the CFP to branch is stressful and a time when students have to adapt and change to another reality - this time moving from being supernumerary to giving rostered service. Students work through this by accepting more responsibility, developing a more holistic approach to care which allows them to assess, plan, implement and evaluate care for their own allocation of patients. This development marks the total surrender of their supernumerary status. In the latter stages of their course whilst all students contemplate yet another transition (student to staff nurse) some students begin to develop intuition. Those students who do begin to develop intuition appear to be more confident in their abilities to take on the role of staff nurse. All students aware that the end of the course is nigh view the next step in their development with anticipatory anxiety.

The role of the mentor is crucial to the professional socialisation of the HE Diploma in Nursing students. The mentor is the linch-pin of Project 2000 courses rather than supernumerary status. This assertion has obvious implications for practice and education as it is incumbent on the profession to provide quality mentorship for students.

Diagram 2: The development of HE Diploma in Nursing students



CHAPTER X

FUIRTHER DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

10.0 Introduction

An acccount of the process of professional socialisation from the perspective of studentts undergoing the HE Diploma in Nursing course has been provided. This is uniquee as previous longitudinal studies have either focused on traditional students (Simpssom 1967; Seed 1991; Wilson and Startup 1991) or degree students (Davis 1975; Day ett all 1995) or have failed to follow Project 2000 students throughout their course (Bradboy and Soothill 1993; O'Neill et al 1993). Other Project 2000 research studies have hhacd such broad research aims that detailed investigation of the socialisation processs has been sacrificed (Robinson 1991a;b; Robinson et al 1992; Orton et al 1993; Robinssom 1993; White et al 1993; Jowett et al 1994; May et al 1995;1997).

Apart ffrom professional socialisation of HE Diploma in Nursing students, a number of other aareas have been highlighted in this study that have not been reported elsewhere. These aare the transition from task centred caring to holistic caring; discovering the phenommenon of the 'glorified auxiliary'; development of intuition in HE Diploma in Nursing students; and what constitutes good mentoring from the students' perspective with thhe incorporation of a time dimension. The chronological longitudinal framework allowecd the process of being a supernumerary student nurse who has a mentor to be describbecd. This will serve as a basis for further research in the field of HE Diploma in Nursing courses.

10.1 The aims of the study

1. To explore the effects of supernumerary status on student nurses undertaking a three year higher education diploma course in adult nursing.

2. To explore the effects of mentorship on student nurses undertaking a three year higher education diploma course in adult nursing.

3. To generate either substantive or formal theory in relation to the above two aims.

The aims of the study were met. Through the exploration, a vast amount of data were generated. The aims were achieved through the use of grounded theory.

A substantive theory is defined as a theory that is developed "for a substantive, or empirical, area of sociological inquiry, such as patient care, race relations, professional education, delinquency and research organizations.... A formal theory is ... developed for a formal, or conceptual area of sociological inquiry, such as stigma, deviant behaviour, formal organization, socialization, status congruency, authority and power, reward systems, or social mobility. Both types of theory may be considered as 'middle-range.' That is, they fall between the 'minor working hypotheses' of everyday life and the 'all-inclusive' grand theories" (Glaser and Strauss 1967, p32). According to these definitions, a formal theory, relating to the professional socialisation of HE Diploma in Nursing students was developed.

The theory presented will now be compared with previous work to emphasis its uniqueness.

10.2 Student experiences of professional socialisation

Of the three models of professional socialisation presented in Chapter II, Davis' (1975) model is the most appropriate to use as a comparison for the theory presented in Chapter IX as the research which underpins the model was longitudinal following students throughout their three year course.

Davis's (1975) model involves six sequential phases; initial innocence; labelled recognition of incongruity; psyching out; role simulation; provisional internalisation and stable internalisation. The initial innocence phase can be compared with Gray's (1997) 'anticipatory anxiety' phase. Davis notes that students have a lay conception of nursing; are eager to practice skills and keep their feelings of worry, frustration and disappointment private. HE Diploma in Nursing students voice their feelings of concern and worry. This may be attributed to students having faith in their mentor who will support, guide, supervise and assess them. HE Diploma in Nursing students have the added worry and concern regarding the stigma of being on the 'Project 2000' course.

In Davis"s labelled recognition of incongruity phase, students become aware that their lay conception is inaccurate and begin to share their feelings with their peers. Students are often afraid of being asked to take on more responsibility than they feel capable of. Davis omits any detail regarding the learning of skills. This phase can be contrasted with Gray's 'reality hits home' phase. The HE Diploma in Nursing students embark upon task orientated learning of skills. They have great faith in their mentor moving them along the observer-participant continuum in line with their individual capabilities. Students who have poor mentors or are in poor learning environments are most likely to complain of lacking the ability to function as desired by ward staff.

In Davis"s psyching out phase, students are described as establishing what is expected of them and how to achieve it. They select role models who will be useful in meeting their goals but are uneasy about delivering care, stating that they are 'putting on a front.' In Gray's 'reality hits home' phase, HE Diploma in Nursing students strive to negotiate their learning objectives and how they can be achieved with their mentor within the first few days of each placement. This strategy remains consistent throughout their course. Like Davis's students, HE Diploma in Nursing students select role models but the predominant role model in this phase is their mentor. Should students have a poor mentor they will select a role model from one of the other staff nurses in the placement.

The mentor however is the linch-pin of the placement for the student for it is they who will organise the students' participation or otherwise in care, supervise and provide feedback for the student.

The fourth phase of Davis's model, role simulation, sees students highly conscious of being able to perform tasks successfully and feeling more comfortable in their role. The more practice and positive feedback the student receives, the more the student begins to internalise the role and lose the feeling that they are 'putting on a front.'

The role stimulation phase can be compared to the 'reality hits home' phase. While Davis' model furnishes little detail of this phase, the theory presented in this thesis provides a detailed account of how HE Diploma in Nursing students develop during this phase.. HE Diploma in Nursing students view their progress in terms of the accomplishment of various tasks which they perform for patients. The students' hold the attainment of competence in basic nursing skills in high regard and strive to gain competence in as many skills as possible before the end of their CFP. It is as though they have a mental checklist of tasks which require to be performed and practised. Students are unable to practice holistically at this time.

Students have a overwhelming need to be part of the ward team and to accomplish this they 'muck-in' where they can so that they can be useful and contribute to care. This also helps reduce the stigma of being a 'Project 2000' student. The learning of the hospital culture, ward routine and their mentor's likes and dislikes are an important adjunct to feeling part of the team. As the student progress through their placements in CFP their views change about certain aspects of nursing. For example they become more open minded regarding mentally ill and learning disability patients. They are also able to diffferentiate between good and poor role models and mentors. These added abilities manifest in an improvement in students' communication skills and an increase in their comfidence.

It should be noted that the first four phases of Davis's model take 12 months to occur whilst the corresponding first two phases of Gray's theory take 18 months for students to move through. This is attributed to the shorter placements which afford students less opportunities to observe and practice nursing care.

The fifth phase in Davis's model is provisional internalisation where students experience a fluctuation between their lay conception of nursing and the internalising an image of their role. At this time, students increasingly identify with their role models. The corresponding phase for HE Diploma in Nursing students is 'becoming a branch student'. In this phase students recognise that if they only perform 'basic nursing care' they are acting as 'glorified auxiliaries.' They begin to question the differentiation between student nurses and auxiliaries. The only difference noted by students is that in addition to performing the same care as auxiliaries, they can perform routine observations on patients. Performing the observations is equated with low level tasks and as such is not seen as sufficient to differentiate themselves from auxiliaries. Instead they identify that the difference is the technical aspects of care which staff nurses perform. The attainment of competence in technical skills becomes their goal during their branch programme.

Davis's model omits detail regarding how students feel during their transition through the six phases. In the theory presented in this thesis it is evident that the transition from 'anticipatory anxiety' to 'reality hits home' is uncomfortable while the transition from 'reality hits home' to 'being a branch student' is the most difficult transition for students. The changes involved in giving rostered service are unexpected and appear unachievable to students who have up until this point been supernumerary and had little responsibility for direct patient care. Very quickly students are expected to take responsibility for the total care of a group of patients which is both a shock and overwhelming to students. Students with good mentors manage the transition satisfactorily but those with poor mentors may reflect upon whether it is wise to continue on the course. By the end of their first rostered service placement, students are attempting a more holistic approach to patient care.

Students are aware that they have grown through the transition, that their confidence has been enhanced, and that they have become more mature and assertive.

The last phase in Davis's model is stable internalisation where the students' self image is one of a professional nurse. Again there is limited detail regarding the development process involved between the last two phases. In the theory presented in Chapter IX, Davis's last phase is equivalent to 'total surrender of supernumerary status' and 'the end is nigh.' During these phases, the HE Diploma in nursing students fully develop their ability to cope with the responsibility of caring or allocated patients in a holistic manner with the minimum of supervision. They become increasingly independent of their mentor. Indeed they begin to distance themselves from their mentor in preparation for the independent nature of the staff nurse role. Many students also begin to develop 'intuition' during the last two phases of socialisation. This development occurs in tandem with the students' ability to view nursing from a more holistic perspective. This coupled with their increasing independence and subsequent increased responsibility for particular patients leads to the development of intuition.

The 'end is nigh' phase marks the final opportunity for students to practice particular aspects of care which they have identified as requiring more attention. Although the HE Diploma in nursing students have increasingly been very much in charge of their own learning, it is particularly evident during the last two phases in the professional socialisation process. Students acknowledge that they may be slower than their 'traditional' counterparts in terms of delivering care but are secure in the knowledge that they possess the necessary skills to seek out new information and gain faster competency in their first staff nurses' post. They believe they are ready for the role of staff nurse and have internalised the necessity to continue learning.

It is important to note that the last four phases in the theory presented in this thesis occur during the 18 months of the branch programme while in Davis's model students take between one and two years to experience the last two phases; provisional and stable internalisation.

10.3 Key factors in the professional socialisation of HE Diploma in nursing students

In Chapter II, the socialising factors of peer group and significant others (Davis 1990), learning jargon (Kramer 1974) and shift work (Bradby 1990a) are discussed. It is noteworthy that the process of professional socialisation of HE Diploma in nursing students is facilitated by two key factors, namely; the mentor (a significant other) and the learning environment. The influence both these factors have on student learning in practice placements is profound. The Project 2000: A New Preparation for Practice document (UKCC 1986) refers to supernumerary status as being the linch-pin of the new course. In reality the mentor, rather than supernumerary status, is undoubtedly the linch-pin of 'Project 2000.'

The very fact that students are allocated their own mentor for the duration of their placement signals permission for the student to approach that person at any time for guidance and support. Students feel safe knowing that their mentor is there for them and that it is acceptable to expose their uncertainties and worries without being ridiculed. In order for this to occur, a degree of trust must be established between student and mentor. Undoubtedly some staff nurses are better at being a mentor than others and students very quickly identify good and poor mentors.

An important aspect in developing a trusting relationship is the early negotiation between student and mentor at the beginning of the placement. This helps to establish 'ground rules' and both parties know the limits of each others wishes and capabilities. This is supported by other studies (White et al 1993; Davies et al 1994). Without this early negotiation the relationship can become tenuous and lacking in direction. As stated earlier a good mentor acts as an advocate for the student to allow them to be supernumerary when specific learning opportunities occur. A good mentor also moves the student along the observer-participant continuum in line with the student's individual capabilities.

A satisfactory mentor-student relationship facilitates the student's introduction into the ward team and allows the student to learn their mentor's likes and dislikes. Mackay (1989) and Silcock (1991) both comment that in order to receive good practical assessments students must conform to the prevailing ward norms. It is therefore in the students' best interest to learn their mentor's likes and dislikes. Students acknowledge feeling extra pressure to perform well when working with their mentor because they wish their mentor to be proud of them.

The importance of the learning environment has been well documented by Orton (1981); Fretwell (1982); Marson (1982); Ogier (1982; 1989); Jacka and Lewin (1987); Smith (1987) and Orton et al (1993). However until now no-one has incorporated the learning environment into their theory or model of socialisation. The learning environment is a key factor in the socialisation process of HE Diploma in Nursing students.

Studies using HE Diploma in Nursing students all agree that since the ward sister's role is now more managerial, the pivotal role now belongs to the mentor/practice supervisor and placement staff (Orton et al 1993; Macaskill 1994; MacKenzie; Nicklin and Kenworthy 1995). In this study, not only the mentor and practice placement staff are pivotal but also the learning environment which they create. Indeed, the mentor and other staff nurses and the quality of the learning environment seem inseparable. The reader is referred to Chapter VII (7.1.1., 7.1.2) for the students' description of good and poor learning environments.

In Table 28, Fretwell's (1982) findings of the characteristics of a learner orientated ward sister are compared with the HE Diploma in Nursing students' characteristics of a good mentor. All the characteristics expected of the ward sister in Fretwell's work, also appear in the students' description of the mentor's role. The reader is asked to note the important addition of the role of teacher in the mentor column.

Table 28 Comparison between the role of the ward sister within the learning environment with the role of the mentor in the same environment

Ward Sister (Fretwell, 1982)	Mentor role as described by students
Shows interest in students	Willingly spend time with them
Ensures good learner/staff relationship	Good working relationships with staff and respected by peers. Loves job.
Approachable, pleasant, yet strict	Patient and understanding. Enthusiastic and friendly. Approachable. Open and helpful.
Promotes good quality of care	Good role model, knowledgeable about own area of speciality
Gives support and help students generally	Make them feel at home
Invites questions and provides answers	Good communicator
Encourages her staff to work as a team	Good working relationships with staff and respected by peers. Loves job.
	Actively involved in their learning. Paces teaching to suit the developmental needs of students. Facilitates learning. Gives good explanations. Knowledgeable about course and has realistic expectations. Gradually withdraws supervision. Demonstrates confidence and trust in student's ability. Allows students' use of initiative. Incorporates feedback in their teaching.

The comparisons identified between Fretwell's work and the findings of this study demonstrate a move from viewing the ward sister as the key to the creating the ward learning environment to that of the mentor.

Whilst comparing and contrasting the data provided by the students relating to the role of the mentor, it became obvious that students were not only describing the characteristics of a good mentor but also those of a good teacher, a good nurse and a caring nurse. These comparisons can be seen in Table 29.

Table 29 **Comparisons between good teacher, good nurse, caring nurse and good mentor**

Qualities	Good Teacher (Marson 1982)	Good Nurse (Mackay, 1989; Llewellyn-Thomas, 1989)	Caring Nurse (Morrison 1991)	Good Mentor (from study)
Professional qualities	✓	✓	✓	✓
Managerial abilities	✓		✓	✓
Personality traits - approachable and friendly	✓	✓	✓	✓
Empathetic qualities	✓	✓	✓	✓
Teaching abilities	✓			✓
Sets good example at all times	✓			✓
Displays high standards	✓	✓	✓	✓
Always time for students/clients	✓		✓	✓
Gives hints/tips to help learning	✓			✓
Capable and Competent	✓	✓	✓	✓
Always there when help is needed	✓	✓	✓	✓
Gives correction quietly and in private	✓			✓
Explains things simply	✓			✓
Caring		✓		✓
Intelligent, knowledgeable, skilful		✓	✓	✓
Good interpersonal skills		✓	✓	✓
Commitment to role, highly motivated		✓	✓	✓
Leadership abilities		✓		✓
Ability to act as advocate for patient and the profession		✓		✓
Personal integrity, conscientious		✓	✓	✓
Treat people as individuals			✓	✓
Flexible, tolerant, understanding			✓	✓

As can been seen in Table 29, students expected their mentor to fulfil a variety of roles. It is argued that the role of the mentor is crucial to the professional socialisation of the HE Diploma in Nursing students. It is further argued that the mentor should be considered the linch-pin of Project 2000 courses rather than supernumerary status. This assertion has obvious implications for practice and education as it is incumbent on the profession to provide quality mentorship for students.

10.4 Limitations in the conduct of the study

"To become an effective qualitative researcher, one must serve an apprenticeship or seek mentoring from one experienced in the specific type of qualitative research before one is qualified to conduct that type of study" (Burns 1989, p46). Morse and Field (1996) state that conducting a qualitative study is not as straightforward as it is often portrayed. They add that conducting such research without a mentor is more difficult. Leininger (1992) laments that there are too few skilled qualitative mentors available. Support and guidance was given by both supervisors in this study, but unfortunately neither had conducted a grounded theory study themselves. However, the challenge was accepted and this study is the result of the 'researcher's learning.

There are several reasons given as to why a mentor is required for novice qualitative researchers. The nature of the methodology and the manner in which it should best be conducted is more easily communicated on a one-to-one basis than by the written word (Burns 1989). The mentor's role is to guide the novice researcher through the study, ensuring that methodological principles of the method chosen are adhered to. The mentor also enables the researcher to reflect upon the process and findings, ensuring that any emerging theory has developed from a systematic and rigorous application of methodological principles (Leininger 1992). The mentor also facilitates the process of reflexivity.

In grounded theory, coding is the most difficult aspect for a novice researcher, both in terms of understanding and operation (Strauss 1987). In this study, Strauss's assertion was found to be true. This might be attributed to coding being the first part of the process of analysis for at this point the novice researcher not only experiences the fear of the unknown as they embark upon the first transcript but also an insecurity as to whether the procedure is fully understood. It is not surprising that Strauss and Corbin (1990) published their text 'Basics of Qualitative Research' as a means of helping novice researchers. Its prescriptive approach however can be somewhat confusing and has also been strongly criticised by Glaser (1992) for misleading researchers. He states that "many of the wrong ideas in Basics of Qualitative Research are too subtle for the average reader to follow, compare and critique (Glaser 1992, p3). In this study, the original text describing grounded theory was used (Glaser and Strauss 1967) in conjunction with a straightforward and informative article by Turner (1981).

Another problem identified in this study was the use of diaries as a data collection instrument over three years. As discussed in Chapter III the longest period of time diaries had been used in other studies was one year. In this study, all participants and diary-only participants (n=7) kept their diaries for the first 18 months. At two years into the study, five diary-only participants were still keeping their diary. By the end of the study, Lynne was the only participant keeping her diary. The remaining six had failed to keep their diary due to pressure of academic assignments. Lynne had no difficulty during the three years as she habitually kept a diary for her own personal use. It is argued that the maximum optimum time for using diaries as a data collection method is between 12 and 18 months. This is an area requiring further research so that a potentially worthwhile data collection method could be maximised.

The longitudinal aspect of the study allowed insight into the developmental changes which take place in student nurses as they progress through their course. The decision to present the findings chronologically enabled the 'researcher' to convey the changes in such a way that the reader could follow the students' development as it occurred. It also facilitated reflexivity and the establishment of an 'audit' trail.

Open coding of data was facilitated by NUD.IST but axial and selective coding and development of the core category were achieved through the conventional methods of mind mapping and abstract thinking.

Theoretical saturation occurred at different times in the sub-categories and categories. The sub-category, student experiences in their mental health placement, remained unsaturated and there was a similar level of disagreement in the member and outside validation results. It is argued that this is probably due to some students not having the aptitude to nurse patients with mental health problems.

10.5 Argument for the adoption of the term 'practice supervisor' in relation to HE Diploma in Nursing students

As noted in Chapter II there is a demand to adopt an appropriate term for the person who fulfils the 'mentor' role for student nurses (D'A Slevin and Lavery 1991; White, et al 1993; Wilson-Barnett, et al 1995). Butterworth and Faugier (1992) propose a model which advocates that students are mentored and clinically supervised, newly qualified nurses are preceptored and clinically supervised and more experienced practitioners are clinically supervised.

It was argued in the literature review, that the term preceptor was used in North America as a label to describe the staff nurse who worked with senior student nurses. The adoption of preceptor in the UK has become associated with an experienced staff nurse working with a newly qualified practitioner (UKCC 1995a). The term clinical supervisor is also associated with qualified nurses (UKCC 1995b). It is therefore argued that the term practice supervisor is adopted as an appropriate term to describe the person who fulfils what up to now has been referred to as mentor or preceptor.

The underlying basis of the argument to adopt the term practice supervisor is consideration of the theoretical underpinnings of the concepts of mentorship, preceptorship and clinical supervision. Student nurses whilst on practice placement are allocated a member of trained staff to advise, teach, counsel, supervise and assess them.

Depending on the area these registered nurses will either be called a preceptor or mentor. In the classical sense, a mentorship relationship is long term with the focus on career development (Anderson and Shannon 1988; Prestholdt 1990). According to Morton-Cooper and Palmer (1993) mentoring in its classical sense lasts for two to fifteen years. It is argued therefore that the term mentor should be used in relation to trained staff excluding those who are newly qualified.

The UKCC has suggested the implementation of preceptorship for newly qualified nurses for a period of four to six months (UKCC 1995a). Preceptorship is a most suitable term to be used for what is intended for newly registered nurses. Preceptorship was introduced in North America after Kramer (1974) had highlighted the presence of 'reality shock' for newly trained nurses. The transition from the student role to the staff nurse role in the world of work was very different from what they had previously experienced. It was found that these nurses were under a great deal of stress that often resulted in a high attrition rate from the profession.

Kramer (1974, p32) defined the role of preceptor as "a nurse who has the ability to integrate education and work values so that realistic strategies for resolving conflict may be developed. Such a relationship allows for the trainee to work and identify with a competent role model. This involves not only observation by the trainee, but also a planned two-way exchange of approaches and evaluation." The preceptorship relationship is time limited but as yet, there is no empirical evidence as to the optimum length. The focus of the relationship is on role socialisation and clinical competence (Lewis 1986). These aspects are probably the most important for the newly qualified nurse and therefore the implementation and the use of preceptorship in this context is most appropriate.

Where does the practice supervisor fit in? Student nurses are not only used to being taught, guided, supervised and assessed in their practice placements, they actually expect and want it. They value the teaching and guidance within the reality of the clinical setting. Students desire supervision and assessment of their performance so that their strengths and weaknesses can be identified.

Students accept that they have to be assessed in order to prove their competence (Holloway 1994). It is therefore argued that the term practice supervisor is adopted into the world of being a student nurse. This concept would work particularly well because of the short placements (4-8 weeks) where there is little opportunity for the development of any kind of trusting relationship that is necessary to fulfil the role of preceptor and even more so, of a mentor.

It is further argued that the teaching, guidance, support and awareness of one's own level of competence can be seen as a continuum from student to experienced practitioner. The same person could provide practice supervision to a student, preceptorship to a newly qualified nurse, and mentorship to a less experienced or skilled colleague. This person would truly occupy the role of a professional chameleon as suggested by Jarvis (1984). Since every individual outlined above will have differing needs, the individual attempting to meet those needs will have to use a variety of skills and techniques. It is argued that this is no different in caring for patients with differing needs. Diagram 3 illustrates the suggested continuum from student to experienced practitioner.

Diagram 3 Continuum from student to experienced nurse

Student Nurse	Newly Qualified Nurse	Experienced Nurse
Practice Supervisor	Preceptor	Clinical Supervisor and/or Mentor
----------Time---------->		
4 - 8 weeks at any one time	4 - 6 -? months	years

As can be seen in Table 30 the roles adopted by the practice supervisor, preceptor, clinical supervisor and mentor differ slightly but the core roles can be condescend into teacher, supporter, role model, and counsellor. The core relationship is one of friendship and the willingness to fulfil the role.

Table 30 **A comparison between the roles of practice supervisor, preceptor, clinical supervisor and mentor.**

Role	Practice Supervisor	Preceptor	Clinical Supervisor	Mentor
teacher	✓	✓	✓	✓
sponsor				✓
supporter	✓	✓	✓	✓
encourager	✓	✓	✓	✓
role model	✓	✓	✓	✓
counsellor	✓	✓	✓	✓
guide	✓	✓	✓	✓
advisor	✓	✓	✓	✓
inspirer				✓
investor				✓
trusted friend		✓	✓	✓
friend	✓	✓	✓	
supervision	✓	✓	✓	
assessment	✓	✓		
make time for role	✓	✓	✓	✓

Rather than adopting Butterworth and Faugier's model (1992) it is argued that the student nurse has a practice supervisor, the newly qualified nurse is preceptored and the more experienced practitioner is clinically supervised and/or mentored. In this way, the theoretical basis from which these concepts arise is acknowledged. If adopted, this model would also facilitate research as once standard definitions were agreed, researchers would be comparing like with like. Furthermore, the profession could move forward in terms of producing empirical evidence regarding their value.

10.6 CONCLUSIONS

Prior to the introduction of 'Project 2000' concerns were expressed that the 'new' students would be socialised into the traditional ward culture. It was thought this would negate the possibility of a knowledgeable doer becoming a reality (Bradley, Jowett et al 1991; Farley 1992; Hislop, et al 1996). It has been shown in this study, that HE Diploma in Nursing students do indeed become socialised but not in the same manner as students pre Project 2000.

HE Diploma in Nursing students become assertive early in their education to ensure that they observe and practice the variety of tasks and procedures in order to meet their learning outcomes. They also need to be assertive in exerting their right to supernumerary status to ensure that they gain from a diversity of learning opportunities. They depend on their peer group, particularly near the end of the course to voice concerns and worries about specific aspects of care. These concerns or worries make students feel awkward asking their mentor or other trained nurses as they are afraid of making a fool of themselves.

Students furthermore learn to manage their mentor and other staff nurses to acquire opportunities to develop as well as possible. Students mix and match from these role models and integrate differing perspectives and practices to an extent that they become internalised in their own practice.

"The student is, on the whole, master of her own destiny. S(he) selects learning from a wide variety of offerings, depends upon her peer group to a large extent and manages her own relationship with her seniors in order to ensure adequate learning" (Wyatt 1978, p269). This is as true in 1997 as it was in 1978.

10.7 RECOMMENDATIONS

The following are recommended as a result of this research:

1. Consideration should be given to students' expectations of their mentor and mentorship courses should be adjusted as appropriate. Thereafter, effective strategies should be implemented to facilitate the optimum use of mentors in the practice setting.

2. There is a need to develop effective strategies to ensure that the practice learning environment is conducive to HE Diploma in Nursing students since it is a key feature in their professional socialisation.

3. Consideration should be given to the stress engendered in the transition from the Common Foundation Programme to the Branch programme. Teaching staff should acknowledge this and prepare students accordingly.

4. Greater awareness is required by practice staff regarding their changing expectations of the students, especially in the first rostered service component, to facilitate the move from supernumerary status to rostered service,

5. Further research should be conducted into the development of intuition in senior student nurses.

6. A universally agreed definition of supervisor, preceptor and mentor should be a priority as without such definitions the evaluation of research evidence is difficult.

7. Further research should be conducted into determining the optimum use of diaries as a data collection method.

8. A longitudinal study to investigate the optimum length of preceptorship of newly qualified HE Diploma in Nursing students should be conducted.

Letter of Ethical Approval

LOTHIAN health

OUR REF: YOUR REF:

1702/93/3/31
R A Robertson, ext 5607

19 October 1993

Mrs M A Gray
Lothian College of Nursing and Midwifery
St John's Hospital at Howden
Howden Road West
LIVINGSTON EH54 6PP

Dear Mrs Gray

REQUEST FOR ETHICAL APPROVAL - 1702/93/3/31: AN INVESTIGATION INTO THE EFFECTS OF SUPERNUMERARY STATUS AND MENTORSHIP IN STUDENT NURSES

Thank you for submitting the above protocol for ethical approval. The Lothian Healthy Volunteer Studies Research Ethics Sub-Committee will consider this protocol at its next meeting which will be held on 5 November, 1993. I will notify you of the outcome of this consideration as soon as possible.

Under the terms of the Scottish Office Home and Health Department Guidelines on Local Research Ethics Committees a copy of your request has been sent to the Chief Administrative Medical Officer and Director of Public Health for notification to the NHS body under the auspices of which the research is intended to take place. It is that NHS body which has the responsibility of deciding whether or not the research should go ahead taking account of the advice of the Research Ethics Sub-Committee.

Yours sincerely,

R A ROBERTSON,
Secretary
Lothian Healthy Volunteer Studies
Research Ethics Sub-Committee

INFORMED CONSENT FORM

Project Title - An investigation into the effects of supernumerary status and mentorship in student nurses.

Researcher - Mrs Morag A. Gray

The purpose of this research study is to discover the effect(s) supernumerary status and mentorship has on student nurses. Interviews will be conducted at the beginning of training, and on 3 subsequent occasions thereafter. A final interview will take place in term 12. Each interview will last approximately an hour and will be tape recorded. The tapes will be erased after transcription, will not be shared with anyone else, but anonymous quotations may appear in the final report to illustrate points which have been made. A copy of the final report will be made available in the College Library.

Although you may not benefit directly from taking part in this study, the information gained will benefit nurses, nurse educators and the profession as a whole in gaining insight into the experience of being a supernumerary student nurse.

THIS IS TO CERTIFY THAT I _____
Print name

HEREBY agree to participate in the above research study.

I understand that I will be interviewed at various points in my training and that I am free to withdraw from the study at any time without incurring any penalty.

I give my permission to be interviewed by Mrs Gray and for our conversations to be tape recorded. I understand that once the tape has been transcribed, the tape will be erased. The transcription will be coded to ensure anonymity and confidentiality. I understand that although the content of the interviews may be published, anonymity will be preserved.

I understand that I can refuse to answer any questions asked of me and that I will be given the opportunity to ask questions and have an explanation given to me such as to enhance my understanding.

Participant's signature _____

Researcher's signature _____

Date _____

INFORMED CONSENT FORM

Project Title - An investigation into the effects of supernumerary status and mentorship in student nurses.

Researcher - Mrs Morag A. Gray

The purpose of this research study is to discover the effect(s) supernumerary status and mentorship has on student nurses. You are asked to keep a diary whilst out on practice placement. You are required to make a weekly entry on your experiences, feelings and thoughts about being a supernumerary student nurse and the fact that you have a mentor. The diary entries will be transcribed, and will not be shared with anyone else, but anonymous quotations may appear in the final report to illustrate points which have been made. A copy of the final report will be made available in the College Library.

Although you may not benefit directly from taking part in this study, the information gained will benefit nurses, nurse educators and the profession as a whole in gaining insight into the experience of being a supernumerary student nurse.

THIS IS TO CERTIFY THAT I _____
Print name

HEREBY agree to participate in the above research study.

I understand that I will be asked to keep a diary on a weekly basis during my practice placement and that I am free to withdraw from the study at any time without incurring any penalty.

I give my permission for my diary entries to be transcribed by Mrs Gray. The transcription will be coded to ensure anonymity and confidentiality. I understand that although the content of the diaries may be published, anonymity will be preserved.

Participant's signature _____

Researcher's signature _____

Date _____

Adapted from Field, P.A., Morse, J.M. (1985) Nursing Research: The application of qualitative approaches. London, Chapman and Hall.

PARTICIPATION IN RESEARCH INTO SUPERNUMERARY STATUS AND MENTORSHIP

GUIDELINES FOR KEEPING YOUR DIARY

1. Your diary is a reflection of your experiences, your thoughts and feelings about being a supernumerary student nurse and having a mentor. It's about your experiences and no one else's. For this reason, it is vital that you write in a manner you feel comfortable with.

2. Write what you want to write and NOT what you think I would like to read! Remember my aim is to find out what it is like being a supernumerary student nurse and I can only find that out if you tell me!!

3. There is no right or wrong way to write your diary. What is important is that you keep it in a way that is meaningful for you.

4. Remember that everything that you write is confidential and that if any quotations are used they will be anonymous.

5. I would like you to complete your diary at the **end of each week** you are on practice placement. You can write in it more often if you prefer.

6. Date each entry you write in your diary.

7. You may find it helpful to use headings in your diary. For example, supernumerary status, having a mentor. Whether you use headings or not, write down how you feel, what you think and what experiences you have had in the last week in relation to being a supernumerary student nurse and having a mentor allocated to you. Add any other comments you wish to make. **Please be open and honest in what you write.**

8. Don't worry about how your writing will look to me. Do your best to make it easy to read. I am not looking for an eloquent essay but rather I want your frank and honest opinions, feelings and thoughts.

Thanks for taking the time to read this. I look forward to receiving your diary entries.

Morag A. Gray (Researcher)

Course Programme

HOLIDAY	1.1.96	HOLIDAY	2.1.95	HOLIDAY	3.1.94		4.1.93
TERM TEN	8.1.96	TERM SIX	9.1.95	TERM TWO	10.1.94		11.1.93
	15.1.96		16.1.95		17.1.94		18.1.93
	22.1.96	COLLEGE	23.1.95		24.1.94		25.1.93
	29.1.96		30.1.95		31.1.94		1.2.93
	5.2.96	CARE OF ELDERLY and MATERNITY	6.2.95	COLLEGE	7.2.94		8.2.93
	12.2.96		13.2.95		14.2.94		15.2.93
	19.2.96		20.2.95		21.2.94		22.2.93
	26.2.96		27.2.95		28.2.94		1.3.93
	4.3.96		6.3.95		7.3.94		8.3.93
	11.3.96		13.3.95		14.3.94		15.3.93
	18.3.96	COLLEGE	20.3.95		21.3.94		22.3.93
	25.3.96	HOLIDAY	27.3.95	STUDENT HOLIDAY	28.3.94		29.3.93
PRACTICE PLACEMENTS (RSC)	1.4.96		3.4.95	HOLIDAY	4.4.94		5.4.93
	8.4.96	TERM SEVEN	10.4.95	TERM THREE	11.4.94		12.4.93
STUDENT HOLIDAY	15.4.96		17.4.95		18.4.94		19.4.93
HOLIDAY (4)	22.4.96	COLLEGE	24.4.95	PRACTICE PLACEMENTS (a)	25.4.94		26.4.93
	29.4.96		1.5.95		2.5.94		3.5.93
COLLEGE	6.5.96		8.5.95		9.5.94		10.5.93
	13.5.96		15.5.95		16.5.94		17.5.93
	20.5.96	PRACTICE PLACEMENTS	22.5.95	PRACTICE PLACEMENTS (b)	23.5.94		24.5.93
	27.5.96		29.5.95		30.5.94		31.5.93
	3.6.96		5.6.95		6.6.94		7.6.93
PRACTICE ELECTIVE	10.6.96		12.6.95		13.6.94		14.6.93
	17.6.96	HOLIDAY	19.6.95	COLLEGE	20.6.94		21.6.93
	24.6.96		26.6.95	STUDENT HOLIDAY	27.6.94		28.6.93
HOLIDAY	1.7.96		3.7.95	HOLIDAY	4.7.94		5.7.93
TERM TWELVE Man. of Care (RSC) (5)	8.7.96	TERM EIGHT	10.7.95	TERM FOUR	11.7.94		12.7.93
	15.7.96		17.7.95		18.7.94		19.7.93
	22.7.96		24.7.95		25.7.94		26.7.93
	29.7.96	PRACTICE PLACEMENTS (RSC)	31.7.95	COLLEGE	1.8.94		2.8.93
	5.8.96		7.8.95		8.8.94		9.8.93
COLLEGE	12.8.96		14.8.95		15.8.94		16.8.93
	19.8.96		21.8.95		22.8.94		23.8.93
	26.8.96		28.8.95		29.8.94		30.8.93
	2.9.96		4.9.95		5.9.94		6.9.93
	9.9.96		11.9.95		12.9.94		13.9.93
	16.9.96		18.9.95		19.9.94		20.9.93
HOLIDAY	23.9.96		25.9.95	HOLIDAY	26.9.94		27.9.93
	30.9.96		2.10.95		3.10.94		4.10.93
	7.10.96	TERM NINE (3)	9.10.95	TERM FIVE PRACTICE PLACEMENTS (a)	10.10.94	TERM ONE COLLEGE	11.10.93
	14.10.96		16.10.95		17.10.94		18.10.93
	21.10.96		23.10.95		24.10.94		25.10.93
	28.10.96		30.10.95		31.10.94		1.11.93
	4.11.96	COLLEGE	6.11.95		7.11.94		8.11.93
	11.11.96		13.11.95		14.11.94		15.11.93
	18.11.96		20.11.95	PRACTICE PLACEMENTS (b) (2)	21.11.94	NEIGH. STUDY	22.11.93
	25.11.96		27.11.95		28.11.94		29.11.93
	2.12.96		4.12.95		5.12.94		6.12.93
END OF COURSE	9.12.96		11.12.95		12.12.94		13.12.93
	16.12.96		18.12.95	COLLEGE	19.12.94	COLLEGE	20.12.93
	23.12.96	STUDENT HOLIDAY	25.12.95	HOLIDAY	26.12.94	HOLIDAY	27.12.93
	30.12.96						

RSC = Rostered Service Contribut

Please read the following diary entries of a student who is nearing completion of their Adult Branch in the Diploma programme of nurse education (Project 2000).

As you read, place a ✓ or a ✖ in the box provided.

If you can recognise yourself or a colleague in what you read place a ✓ in the box.

If you cannot recognise yourself or a colleague in what you read place a ✖ in the box.

As you read it is important to reflect back to the time indicated in the diary. **There are no right or wrong answers.** What I am interested in is whether you **can identify with the experiences and thoughts that this student has had during training**.

Your comments are anonymous but I would very much appreciate you indicating whether you are male or female and what your age group is and whether you had experience of working as an auxiliary before you started the course.

Male ☐

Female ☐

18-25 ☐ 26-35 ☐ 36-50 ☐ 51+ ☐

Auxiliary experience prior to course YES NO

If you wish to write any comments please feel free to do so either in the margins or on the back of the last page.
Your help is greatly appreciated.
Thanks very much

Morag A. Gray
Researcher

Diary of a Diploma Student

Week before first placement

Well here I am, I never really believed that this time would actually come! The wards next week! Whilst I am really looking forward to it, a bit of me, well quite a big bit truth be told, is really scared. What if I don't know how to do something? What if I don't understand what the nurses are asking me to do? What if I kill someone??? ☐

What will be expected of me? I wish I was like some of the others who have been in the wards before. Quite a few have been auxiliaries so they don't seem to be as nervous as me. I expect it's because they don't need to worry about the same things as me - like will I remember how to bath someone properly, give them a bedpan the right way round or all the things that they will be able to do without thinking too much about it. What if I look like a fool? ☐

There are all sort of rumours flying about. The allocations are late coming out - somebody said to me yesterday it was because the ward staff don't want us. There is still a fair amount of ill feeling surrounding us Project 2000 students. Some of the staff seem to resent us because of the course. What they don't seem to realise is that this is the only course that we can do, we didn't have a choice! ☐

The old course students are still around - I wonder how they will feel about us? They are in a different uniform to us, so we will stick out like sore thumbs! It just excentuates that we are different. I also have heard that some of our predecessors have got staff's backs up by refusing to make beds anymore because they have made enough and they have learnt that skill. ☐

Oh God am I doing the right thing? ☐

I can just see it now, I will get onto the ward and I will follow my mentor around like a lost sheep probably getting in the way in the process. ☐

What if she doesn't like me? ☐

Day before first placement

Well it's now or never - tomorrow is my first day on the wards! GULP!!! I have been thinking quite a bit about it in this last week to try and get things into perspective. I am supernumerary so that means I will not be counted in the ward numbers or in the team. I won't be forced to work certain hours and if I don't want to do something then I don't have to do it. That's quite a comfort because I can watch something be done a few times and then when I feel happy about it I can do it myself with my mentor or a staff nurse supervising me. I will also be allowed to watch things going on in the wards and go and watch other things too. ☐

It will be great to learn on the wards instead of sitting in class listening and trying to imagine what the tutors are talking about.

I hope my mentor is on tomorrow and is nice! It's a good idea to have a staff nurse who is allocated to you because it means that if I am unsure about anything I can just go up and ask her because that is what she is there for. I have been talking about having a mentor with some of the other girls. We feel that they should help us to learn a lot in the ward and that they will stick up for us if the going gets rough!
Oh God I hope it doesn't. Jane reckons that they are there to support us and give advice and guidance and to supervise us when we do things. I hope she is right!

I have also been talking to some of the students in the intakes before us. You hear so many contradicting things about mentors and the wards. I suppose I should go in with an open mind and make up my own mind.

I am actually getting quite excited about it but I can't help wanting my first day just to be over !

Nearing end of Foundation Studies

Well supernumerary status doesn't really work and I am not sure I want to be totally supernumerary anyway. I think it would be best if I could get involved in the ward activities but when something interesting comes up or happens, then I should be allowed to go and watch it. Most of my mentors have helped in this saying that it's important that I am allowed to go which was great. I have been with patients to watch their investigations and I even got to go to theatre to watch an operation. It was mega! I think that if we work hard on the ward and usually it is as a pair of hands, then we should be rewarded by being allowed to go and see things. After all we are there to learn But it's very difficult to insist that you want to go and see something when the ward is going like a fair - besides if I make too much of a fuss, my assessment might suffer.

It really depends on the ward as to whether they allow you to be supernumerary or not
Three of my mentors were great and it worked reasonably well but the other one couldn't have cared whether I was there or not. It really is just the luck of the draw as to whether you get a good mentor or not. I suppose 3 out of 4 isn't too bad but I have heard others complaining that they have had awful mentors. Maybe it will get better as we go through the course and they get used to us more.

I have noticed that in some wards, once you get to know the routine, you are just left to get on with looking after a group of patients bathing and feeding them. The wards seem to short staffed so I suppose its just as well that we can get on and do basic nursing care without having to watched all the time. I just wish there was more time for us to sit down and have tutorials and things. Sometimes your mentor will promise to do something with you but often it doesn't happen.

I really enjoyed my adult placement but would have liked it to have been longer.
Going to the nursery was a waste of time. It would have been much better to have had longer in the adult placement.

Mental Handicap was ok, in fact I really quite enjoyed it by the end of the placement. The staff were friendly and I got to practice a lot of basic nursing care which was good. □

I hated my mental health placement. There was nothing to do all day and you were lucky if the staff looked at you let alone talked to you. We just sat about all day. It was really difficult to talk to the patients because we weren't allowed to do anything for them and we weren't allowed to do close obs or anything which meant that they days were long and usually I went home feeling fed up and reeking of smoke! □
I think it was that we weren't made to feel welcome - maybe because we weren't doing mental health nursing, they couldn't be bothered with us. It was like we didn't have a role to play. □ At least in the other wards and even the nursery there was something we could actually do. □ I suppose looking back it was a reasonable place to improve my communication skills but the staff didn't really want us there so it was really difficult to be enthusiastic about anything! □ The patients didn't seem that interested in us either because we were limited in what we were allowed to do with them. We were ok for a game of cards or scrabble but that was about as far as it went. □

Something that really concerns me now is that we all seem to have had such varied experiences. I was talking to Jane the other day, she said that she still hasn't bed bathed anybody! I haven't given an injection yet and I am really worried about that. I will be in my Branch (if I pass the exam - fingers crossed!) before I get another chance. □
I have done a lot of procedures or tasks during my time on placements. It's funny but I have this mental list of all the things we ought to be doing and I mentally tick them off as I learn different tasks. □ It's a great feeling being able to do things on your own now without always having to go and check first. I really am beginning to feel I am progressing and I am beginning to get my confidence a bit. □

It is good to just muck in and get on with the work on the ward but I keep reminding myself that I am there to learn but it's difficult to go off and do something more interesting when you have the welfare of patients to consider. Sometimes you just have to forget about a learning opportunity because the patient you are with needs you more. After all that's why I came into nursing - to help others! □ There is a happy balance though but often I am too frightened to ask to go and see things because they might feel that I am not pulling my weight. □ But I want to learn to be a nurse and not an auxiliary so I should really take advantage of any learning opportunity. □

Overall, my mentors have been ok. Some have been very good and one was awful. It's just luck of the draw. □ My first mentor was fantastic. She seemed to know all about the course (a rare thing I can tell you), and was interested in me as a person. She seemed genuinely pleased to be my mentor and was keen that I learnt as much as I could. □ She was on duty for my first day and that really does make a great difference. You settle in so much quicker and feel supported straight away. □ She was also good in telling me how I was doing and even how I could improve - that too has been lacking in some of my other mentors. It's not that you want them to spend loads of time with you. It's just so good to have a sit down for 10 or 15 minutes once a week and have her tell you what you are doing well and what is not so good and how she will help you to improve. □ My first mentor was an excellent nurse too so she was a good role model.

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Two of the other mentors were good nurses too but they weren't as good a teacher as my first one and they didn't seem to be quite so interested in me as an individual. Mind you it's very clear that you are just one of their responsibilities and you cannot expect too much as they are pushed and pulled in so many directions. Only one was really poor.

It's also good when your mentor pushes you a wee bit but is there to support you while you are being pushed. It's really scary when they expect you to do things by yourself for the first time. You don't want to be wrapped in cotton wool and not be allowed to do anything but you don't want to be pushed in at the deep end either You also learn from the other staff nurses and the old course students. I was a bit anxious at first when my mentor wasn't on the same shift as me but the other staff nurses would be there to answer any queries. The other students were really good which surprised me because I thought they'd resent us a bit but that wasn't the case. Quite often they would stick up for us. Sometimes it's easier to ask the other students how to do things rather than your mentor because you are scared that your mentor will think that you are a right idiot not knowing how to do something - particularly if it's something pretty basic. It's good when you have a co-mentor as well as a mentor as usually one or other of them is on. Don't get me wrong, it's not that I want to work alongside them all the time but it's nice if they are there to answer any questions you have and for them to see how you are getting on.

That was one of the things that was wrong in some of the other placements. You had your mentor and when she was off everyone else just ignored you as you were not their responsibility. It's like you suddenly become invisible! Once, Sharon got taken for a tutorial by her mentor and when I asked if I could go too she said no, that my own mentor would give me one but she never did. I can't understand why I couldn't have gone and sat in too. Sharon wouldn't have minded.

It's really awful when you get a poor mentor. You feel like you are not learning anything and nobody cares whether you do learn or not. Just as long as you are there to do all the hard work. She was really unapproachable and spent the whole time ignoring me as much as possible. I really felt unwanted. I couldn't have asked her advice on anything because she was so awful. She used to get me to do all the jobs that she didn't want to do and I felt quite stressed because I wanted to say no but I couldn't because she had the ultimate power over me - my assessment! When I compare to the good mentors, she was not as knowledgeable and wasn't as experienced. Her teaching skills were poor because there was no structure to anything and she kept chopping and changing her mind about things. She'd also promise me lots of things but she never kept them once. I have heard that other mentors who aren't so good keep you really on a tight reign as if they are frightened you will do something wrong but this one just left me floundering.

When I reflect back and think how I have changed I am quite pleased with my progress. My confidence and knowledge has increased and I am beginning to be more assertive. I am quite happy with my interpersonal skills. When I think about it I am amazed at how much I have learnt. Not just about patient care but how the wards work. I have now learned a bit about hospital culture so I don't feel as green as I did before.

The girls who had been auxiliaries before were streets ahead of me in that respect but I think I have caught up now. Once you get to know the ward routine, you settle fairly quickly. Usually by the end of my first week I feel reasonably ok You also learn how to fit into the team and not to rock the boat. I suppose it's learning how to be diplomatic and holding your tongue! The other thing that I have noticed is that I want to be supervised by my mentor more at the beginning of the placement and then for her to allow me to things for myself and be more independent nearer the end of the placement.

One thing that I haven't got any better at is changing placements. I worry about what it's going to be like and I can even lose sleep over it! It's just the thought of having to learn new ward routines and layouts and meet new people. It's almost like starting a new job every 4 weeks. I usually feel awkward for the first few days and then I settle ok.

As for how the ward staff feel about Project 2000 students - well most of them are ok about it. They seem to have accepted us but you still get the odd remark particularly from the auxiliaries and the older trained nurses. They say things like oh here is the part-timer or it's alright for some. They seem to resent that we are only supposed to be there for 30 hours a week Jane thinks that they just say it to tease us but I am not so sure.

Anyway, I am glad that Foundation Studies is almost over. I can't wait until I go into Adult Branch.

End of Term 8

In term 7 we were still supposed to be supernumerary but it really didn't work - mostly because of the shortage of staff on the ward. Often you had no option but to muck in but I think that's probably the best way to learn anyway. The last thing you want is to be only allowed to watch things and never get the chance to do anything! If supernumerary status was taken literally it could hold you back.

After my three weeks holiday I started on the ward on rostered service. It was all so different and the ward staff's expectations of me changed. Working those extra hours was more tiring than I had anticipated. When I got off duty, the last thing I felt like was to open a book and catch up on my reading. I suppose this is what it is going to be like from now on.

The ward staff expect so much more from you as a rostered service student. You are expected to take responsibility for a group of patients with less support from staff It can be really frightening, especially when they expect you do be able to do things that you have never done before. It really just depends on your previous placements as to whether you got to learn that skill or not. So it's not really fair of them to expect that you can do things. It's like they have this image of what the old course students could do when they were in their second year and they expect us to be able to do the same.

It can be really stressful, what with the increased responsibility and their increased expectations of you. I am terrified that I forget to do something or do something wrong. I go home at the end of a shift and I am thinking still - did I do that or did I tell her that etc. I really feel that I was put in situations beyond my capabilities. I suppose they would say that it's good to be stretched but I don't think it's a good way to learn. I did learn a great deal but I was stressed out quite a bit of the time.

I have changed though for the better so the experience has been positive I suppose. When I was in Foundation Studies I was very much wanting to learn about tasks. Looking back on it, I suppose it was that I wanted to learn how to do things so I could feel that I could contribute something, however small. Now I look at things completely differently. I feel that I have learnt the basic nursing skills and I am confident that I can do them. When I look after my group of patients I don't just think about a list of tasks that needs to be done. I try to think about my patients holistically and meet their physical and psycho-social needs too. Mind you that can be difficult when the ward staff excluded you from the necessary information about your patients.

It's important that I learn more about the technical aspects of nursing now. The last thing I want to be is a glorified auxiliary! That's really what some of the wards just expect you to be. A pair of hands who can also do all the observations too. You really have to be quite assertive in getting them to allow you to learn the skills that the staff nurses have like writing care plans and giving out medicines.

Some of the wards are better learning environments than others. Even if two areas are equally busy, you can get one ward which is much better than the other. I think it's to do with the staff and their philosophy towards students. The good placements will have excellent staff who work together as an effective cohesive team. You don't mind approaching any of the staff nurses as you know they won't snap at you or think you are asking stupid questions. They are usually enthusiastic and seem to enjoy having students. They really are supportive and seem to genuinely want to help you to learn and improve. It's great when you get a good placement like this because you feel wanted and part of the team. It's really the staff that make a good placement rather than what the speciality of the ward is.

Jane was telling me that she had a really rotten time in one of her placements. The student friendly atmosphere was missing and she felt that she was just used. She got rotten shifts and they made her work most of the weekends. She didn't want to say too much to her mentor because she thought it was better to grit her teeth and get on with it. Thank goodness it was only a 4 week placement for her. I could see that she was really miserable. She didn't get any encouragement and student learning was seen as a low priority and it's not surprising that she felt frustrated, angry and resented the wasted opportunities to learn something. She really felt that she was treated badly.

Well as I go into term 9 I feel I have gained even more confidence in my abilities. It's such as shame about Jane though as she has really had her confidence knocked a bit. Hopefully her wards in term 10 will be better.

I think I am more confident because of the increased responsibility that has been given to me and the fact that I managed to cope with it! I am not so reliant on my mentor but it's good to have one so that you can check things if you need to. I am also definitely picking up cues more from the patients. It's like you are able to notice things more. I suppose it's because you are spending more time with your allocated patients and you become more aware when they are not themselves. Also because your knowledge of signs and symptoms is better I think you pick up on things quicker.

End of Term 10

I must say that I really miss being supernumerary in that I can't go off and see things as much as I did when I was supernumerary. Now that I am rostered service, it's like you just have to get the work done and there is little or no time left to go off and see things.

I really enjoyed my time in my last ward. It was a really good place to learn. It was really well organised and all the staff seemed to share the same philosophy to care. The standard of nursing care was second to none. It was a really student friendly ward. The staff were all approachable, supportive and interested in teaching me. I was made to feel welcome and a part of the team. They were interested in me as individual and respected me as a term 10 student. They actually trusted me and were quite happy with me being independent because they knew I would ask if I was unsure of anything. What's more I wasn't taken a loan of. Something that I have noticed since coming into the branch is that the areas that take PS 2 students are usually well geared up for us too. The staff don't seem to be threatened at all by us and have this very positive attitude to helping you learn. My mentor was good too. She and I discussed what I would like to achieve in the placement and she allowed me to get on with things myself but I could go to her if I needed to. She was good at giving constructive criticism and teaching me

It was nice to end the term on that note because my first placement was diabolical. It was almost the opposite of my last placement. It had a really poor learning environment. The staff nurses didn't care if you learnt anything or not. What was important to them was getting the work done and using me as a glorified auxiliary. Some of the staff really treated me like a hindrance - not terribly conducive to asking questions or learning anything. They didn't work together like the staff in my last ward. It was almost like they did their own thing. So much for a ward philosophy to care. The patients didn't seem all that happy in the ward either and the standard of care wasn't very good. My personal tutor's hair would curl if I told her some of the poor practice I saw. They were very busy and stressed though so that might have been the reason. My mentor was pretty poor actually. I think she was threatened by me at least that is the impression I got. She believed in learning from mistakes and made me feel very demoralised because all she would tell me was what I had done wrong. Not once did she say well done! She really had poor teaching skills. She was certainly not one to model oneself on that's for sure.

I have also noticed that as you get on in the course you don't rely on your mentor as much. Don't get me wrong, you still need a mentor but there is a gradual distancing

I think it's because I am getting more confident, especially after working with critically ill patients. I am much more self reliant and I am quite happy to take on more responsibility and use my initiative. I am also more observant and notice things more quickly. Like I noticed that one of my patients didn't seem his usual self so I took his obs and he was pyrexial. Turned out that he had septicaemia but he was ok. I was so proud of myself that I had noticed it as early as I did because the staff nurses hadn't!

There is a bit of rumblings from the trained staff that we Project 2000 students lack practical skills. They don't usually say it to your face but you get to hear it nonetheless. I agree we probably aren't as efficient and as quick as probably the old course students were but that was because they got more practice in their course. I reckon as soon as I get my first post it will be ok because I'll have more than 4 weeks in the area (I hope!) so I will have plenty opportunity to practise the skills needed in that area and I will be just as good as anybody else. It's not that we can't do it, it's because we haven't had the opportunity It really depend on the type of placements you have had.

COMMENTS

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